Taking Stock

Joint Review of the National HIV Response in Zanzibar
2004 to 2007

20 June 2007
Executive Summary: 

Joint Review of the HIV Response in Zanzibar 

2004 to 2007 

1. INTRODUCTION TO THE JOINT REVIEW

It has been 21 years since the first AIDS case was diagnosed in Mnazi Mmoja Hospital in Zanzibar. Since 1986, three medium term plans to respond to HIV were developed and partially implemented by the Revolutionary Government of Zanzibar (RGoZ) and its partners. The previous review of the HIV response in Zanzibar took place in 2003, when a situation assessment was undertaken to review the implementation of the HIV Medium Term Plan III (covering the period 1998 - 2002). This situation assessment led to the development of the Zanzibar National HIV and AIDS Strategic Plan for the period 2004/5 to 2009/10 – the ZNSP, launched at the start of the 2004/2005 financial year – after which the Health Sector HIV Strategic Plan (HSSP) was developed.

As it is now four years since the Zanzibar AIDS Commission (ZAC) was established, as it is now midway through the ZNSP implementation period, as the HSSP implementation has commenced and as it is now four years since the last situation assessment was undertaken, the RGoZ and its partners agreed that it is an opportune time to review the HIV response in Zanzibar. It was agreed to conduct the review jointly.

Although the basis for the review is the ZNSP and the HSSP, the Joint Review Steering Committee agreed that this Joint Review of the HIV Response in Zanzibar (‘the Joint Review’) would focus on all aspects of the HIV response in Zanzibar – even those not originally planned or anticipated in the ZNSP or HSSP (e.g. male circumcision as an HIV prevention strategy).

2. JOINT REVIEW PURPOSE, GOVERNANCE STRUCTURES AND PROCESS

**Purpose:** The purpose of the Joint Review was to assess the extent to which Zanzibar has mounted a relevant and comprehensive HIV response of appropriate scale, and what should be done in future to improve the HIV response.

**Governance Structures:** The Joint Review was governed by a Joint Review Steering Committee that was chaired by ZAC. The members of the Steering Committee included representatives from different Ministries within RGoZ, civil society, the private sector, faith-based sector, development partners and departments within ZAC.

**Organisation and Process:** The Joint Review was, based on the overall purpose, segmented into the following thematic areas – Drivers of the Epidemic, HIV prevention in the community, HIV prevention at health facilities, HIV care and treatment, HIV impact mitigation, enabling environment for HIV, and HIV monitoring and evaluation.

The Joint Review process involved collecting and analyzing primary and secondary data: secondary data were gleaned from existing reports, reviews, and other documents relating to the HIV response in Zanzibar, whilst primary data was collected from individuals involved in or benefiting from the HIV response in Zanzibar. Primary data was collected through both focus group discussions, small group discussions and individual interviews with persons purposively selected. The Joint Review Proceedings Report (a report prepared separately to this Joint Review of the HIV Response Report) details all the stakeholders that were consulted during the primary data collection phase of the Joint Review. A full list of reference documents is detailed in Section 7 of this Report.
3. MAIN REVIEW FINDINGS

Although the drivers of the epidemic point to very specific MARPs, the HIV services that have been provided have been more general in nature. The main review findings as it relates to the main purpose of the review are presented hereunder for each of the Joint Review’s thematic areas.

3.1 Drivers of the epidemic

Unlike 20 years ago, HIV epidemics are no longer categorised only by the percentage point value of HIV prevalence in the general population. Instead, epidemics are now classified as either: (i) a concentrated epidemic driven by MARPs; (b) a low intensity generalised epidemic driven by higher risk heterosexual intercourse in the general population; or (c) a mixed epidemic driven by both MARPs and higher risk heterosexual contact in the general population (Wilson, 2007).

In order to classify Zanzibar’s HIV epidemic, the ‘proportion of infection’ – *where did the last 100 infections come from* – needs to be known. The Zanzibar MoHSW estimated in 2002 that 90 of the last 100 new HIV infections were as a result of heterosexual transmission in the general population, 4 through vertical (mother-to-child) transmission and the rest through other means (including nosocomial transmission in hospitals) - thereby suggesting a low intensity generalized epidemic. The epidemiological evidence presented in this chapter suggests that the proportion of infection should be recalculated. To determine the proportion of infection, five questions need answers:

1. Who are the MARPs in Zanzibar?
2. How many of them are there?
3. What is the HIV, STI, HBV and HCV prevalence amongst the MARPs?
4. What higher risk behaviour do MARPs display?
5. How do MARPs interact with other MARPs and with the general population?

The Table overleaf provides available data for all MARPs in Zanzibar. It shows that only partial data are available and that more research needs to be undertaken. Once the missing data is known, the proportion of infection can be estimated again. Should the proportion of infection reveal that most of the last 100 infections in Zanzibar were as a result of MARPs, it would be clear that Zanzibar has a concentrated epidemic. Should it reveal that most of the last 100 infections were as a result of heterosexual interaction in the general population, it will confirm that Zanzibar has a low intensity generalized epidemic. Should the proportion of infection estimate produce mixed results, it would suggest that Zanzibar has a mixed epidemic.
### Potential MARPs in Zanzibar

<table>
<thead>
<tr>
<th>Potential MARPs in Zanzibar</th>
<th>Estimate number of MARPs</th>
<th>HIV prevalence</th>
<th>Evidence of higher risk behaviour</th>
<th>Interaction with other MARPs and with general population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Users</td>
<td>500 enrolled in Substance User study in 3 month period, 39% were IDUs</td>
<td>12.9% amongst substance users 28.6% amongst IDUs</td>
<td>Share needles  Share blood  Have multiple, concurrent sexual partners  Do not use condoms  Has penetrative anal sex  Involved in non consensual sex</td>
<td>IDUs are CSWs who interact with general population</td>
</tr>
<tr>
<td>Sex Workers and their Clients</td>
<td>Not known</td>
<td>Study currently being done</td>
<td>Not all use condoms  High numbers of concurrent sexual partners</td>
<td>Interaction with IDUs  Interaction with all other MARPs  Interaction with general population</td>
</tr>
<tr>
<td>Seasonal and mobile employees, including fishermen, clove pickers, transportation sector drivers, tourism sector workers, people who attend social events, health workers</td>
<td>Fishermen: 6000  Hotel staff: 8000  Drivers: 2000 estimate  Farmers: not known  Businessmen: not known  Health workers: 3500</td>
<td>Fishermen: 3.7%  Hotel staff: 10.3%  Drivers: 5.7%  Farmers: 8.4%  Businessmen: 5.6%  Health workers: 11.6%</td>
<td>Own perception of higher risk  Higher risk not confirmed with behavioural data</td>
<td>Interaction with CSWs</td>
</tr>
<tr>
<td>People Under Special Circumstances [Men in Uniform and prisoners]</td>
<td>Not known</td>
<td>Men in uniform: 12.5%</td>
<td>No data available</td>
<td>Interaction with CSWs</td>
</tr>
<tr>
<td>Youth (18 or younger)</td>
<td>Youth: 500 000</td>
<td>0.5%</td>
<td>Low condom use  High age of sexual debut  Non regular partners at young age</td>
<td>Interaction with CSWs</td>
</tr>
<tr>
<td>People with Disabilities</td>
<td>Not known</td>
<td>No data available</td>
<td>High risk behaviour not known  Increased vulnerability due to perceptions that disabled persons cannot have HIV and lack of means to protect themselves</td>
<td>Not known</td>
</tr>
<tr>
<td>Married Women and House Girls</td>
<td>Married women: 300 000  House girls: 3.8%</td>
<td>Pregnant women (assume most are married): 0.87%</td>
<td>Increase in number of women with more than one partner</td>
<td>Interaction with men who have more than one sexual partner</td>
</tr>
</tbody>
</table>

NOTE: In the table below, the HIV prevalence values provided for the different MARPs should be interpreted correctly. See Table 4 for more detailed information about the interpretation of HIV results presented in this table.

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1 The Special Departments are all the men in uniform. There are five groups of men in uniform in Zanzibar: Anti-Smuggling Squad (KMKM), Economic building Brigade (JKU), Prisoner Department (MF), Fire and Rescue Services (KZU), and People’s Militia (KVZ).
3.2 Overall achievements in terms of the HIV response in Zanzibar

Since the launch of the ZNSP in 2005, there have been many achievements in terms of the HIV response. These include guiding tools being in place (national policy, strategic plan, M&E framework, Advocacy strategy), an M&E tools developed and stakeholders oriente, and partnership with stakeholders and development partners has been enhanced (GOZ/DPG meeting, Inter-faith Committee, UWAKUZA, Joint review).

Public sector response including workplace programs has been initiated, the AIDS Business Coalition established to stimulate private sector involvement and participation. Greater and meaningful involvement of PLHAs has been enhanced (representation of PLHAs in the ZAC’s Board, GFCCM and SHACCOMs, involvement in program design and implementation).

Also, HIV/AIDS mainstreamed in the Zanzibar Strategy for Growth Promotion and Reduction of Poverty (ZSGRP). Efforts are being made to collect information for evidence-informed policy decisions and planning (study on substance use and HIV, impact studies, size estimation of MARPs). District response expanded (CARF and DRI funds) – 69 Shehias reached. The capacity of ZAC and implementers strengthened, advocacy on HIV and AIDS issues has been intensified (HIV/AIDS is a national agenda), and a local ‘best practice’ has developed - pre-marital testing as a contribution from the faith-based community to HIV.

3.3 HIV prevention in the community

Relevance of HIV prevention services in the community. There are more prevention efforts in the community in 2007 than in 2004, and the messages communicated are partially relevant because they focus primarily on creating awareness and on the sexual transmission of HIV. However, not all MARPs are reached – the focus seems to be on creating awareness that ‘there is HIV’ (which is already high at 99.8% (NBS and ORC Macro, 2005)). Also, HIV prevention efforts are not linked to substance use prevention (particularly for the youth) or to income-generating activities for the youth and are therefore not relevant to all the drivers of the epidemic.

Comprehensiveness of HIV prevention services in the community. HIV prevention is more extensive than in 2003, but still not fully comprehensive – for seven reasons. First, although the ZNSP stipulates clearly which populations should be targeted, not all MARPs defined in the ZNSP are targeted (prisoners, seasonal workers and persons involved in the transportation sector). There are also some new MARPs that still need to be targeted (e.g. tourism sector employees). Second, HIV prevention efforts in the community have primarily focused on creating awareness about HIV, and not on the HIV prevention services for MARPs and the general population defined in the ZNSP. For example, many of the women interviewed in an education sector impact assessment had never seen a male or female condom or had its use demonstrated (HR Consult, 2007). Third, all available communication media have not been used extensively – e.g. the radio (the most accessible form of mass communication) has not been used. Fourth, there are no programmes to address gender imbalances and efforts to ensure the quality of HIV prevention efforts have only just commenced. Fifth, the issue of positive prevention – prevention of re-infection by HIV positive persons, was not addressed at all. Sixth, the data show clearly that knowledge levels in Pemba are significantly lower and access to services more restricted than in Unguja. This indicates that more effort is required in Pemba. Seventh, workplace programmes have not adequately covered trade unions, the informal sector or private sector.

Scale of HIV prevention services in the community. More persons than in 2003 have been reached with HIV prevention efforts in the community and more institutions from all sectors (civil society, the public sector, and higher learning institutions) are involved in HIV prevention efforts (see Table 32 in Annex F for a summary of HIV prevention efforts to different populations). There are 242 Civil Society Organisations (CSOs) based in Unguja and 137 based in Pemba working in all aspects of development; many of these CSOs provide HIV prevention services to different segments of the population. Almost all CSOs, even those who implement programmes unrelated to HIV, incorporate HIV prevention education in their programmes, which has enabled more people to be reached with HIV information. There is therefore some level of scale-up, but more needs to be done. Only 38 out of 294 shehias reported HIV prevention activities, suggesting that there is a rural/urban divide in access to services.
Achievement of ZNSP Objectives in Terms of HIV Prevention in Communities. There is progress towards the ZNSP objectives for HIV prevention in MARPs and the general population. The only HIV response activity that was not listed as a ZNSP strategy was pre-marital HIV testing. There is, however, a need to focus on (a) the sensitive, practical education that is needed when doing HIV prevention and (b) on reaching the hard-to-reach geographic areas and hidden MARPs, as the ZNSP design originally intended.

3.4 HIV prevention at health facilities

Relevance of medical services provided. Medical HIV prevention services provided at health facilities in Zanzibar are relevant to the HIV response in general as they are based on evidence that condoms are effective in responding to HIV (WHO, UNAIDS and UNFPA, 2004), that HIV is transmitted through contact with infected blood and that unprotected contact with blood or open wounds needs to be avoided (CDC, 1986), that PMTCT services reduce transmission from mother to child (Cochrane, 2004), that knowing one is HIV positive leads to a positive change in behaviour (Merson et al, 2000), and that controlling STI infections is a successful measure to control HIV infections in low prevalence or concentrated epidemics (Orroth et al., 2003). However, one needs to consider the prioritization of HIV prevention services at health facilities in Zanzibar, given the Zanzibari context of an epidemic with a number of MARPs who need services specific to their situations.

New research is prompting reconsideration of two services – PMTCT and VCT:

- **PMTCT:** New research (see Annex I for the details) prompted a WHO consensus statement issued late in 2006 that exclusive breastfeeding for the first six months and then full weaning offers the best protection against MTCT and other infant illnesses unless replacement feeding is acceptable, feasible, affordable, sustainable and safe. (It is important that breastfeeding during the first six months be exclusive, and not mixed with solids or other liquids. Mixed feeding carries a double risk of HIV transmission and other illnesses.) The transmission risk through breastfeeding is greatly reduced if the mother is on HAART. This presents two challenging realities for Zanzibar’s PMTCT programme - 91% of persons in Zanzibar indicated that HIV can be transmitted through breast milk (a message that we now know needs to be more nuanced) and less than 2% of Tanzanian women breastfeed exclusively up to six months, which implies that not all PMTCT education currently undertaken is relevant and that communication messages need to change.

- **VCT:** Studies in Africa have shown that the behavioural changes brought about by VCT are most pronounced amongst HIV positive individuals and amongst discordant couples (Merson et al., 2000). New research evidence (see Annex J) suggests that VCT services, and in particular the rapid testing methodology, may not be helpful for HIV prevention efforts, especially in low prevalence settings where the rapid testing method actually may lead to increases in high risk behaviour amongst persons who test negative. Given these results, the resource constraints in HIV in the health sector, the high levels of stigma, and the high operating costs for VCT sites, innovative changes to the ‘know your HIV status’ efforts are needed. If these research findings are valid, they underline the need to intensify preventive measures among those testing HIV negative through interventions such as peer education and consistent condom use in risky sexual encounters.

Comprehensiveness of HIV prevention services provided at health facilities. Most of the HIV prevention services found at health facilities in other countries are being implemented in some form in Zanzibar – universal precautions and safe blood supply, condom distribution, PMTCT, STI treatment, and VCT. Not many other African countries have harm reduction programmes. The only two types of HIV prevention services typically provided at health facilities in other countries that are not provided in Zanzibar are provider-initiated HIV testing and IDU-friendly HIV services (including services such as methadone treatment,2 relevant HIV education, VCT, PMTCT and STI services in an environment that is safe and open for IDUs without fear of prosecution).

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2 Methadone is a long-acting narcotic medication. It is an effective legal substitute for heroin or other narcotics. It is preferable to heroin (which is injected into the blood stream many times a day) because it is in a syrup format and taken orally only once a day or every second day. It helps to minimise withdrawal symptoms during detoxification, stabilises a drug user’s body physically and keeps the person from continuing to inject drugs, which is where the highest risk of HIV transmission lies.
Services to MARPs are not comprehensive, for two reasons. First, there are gaps in the services that MARPs need. For example: HSV-2 is not currently treated at STI clinics. However, given that research in Mwanza, Tanzania, has shown that genital HSV-2 infection increases the risk of HIV-1 infection, controlling HSV-2 is an important strategy in reducing HIV-1 incidence, especially in most at risk populations. Second, due to discrimination by health workers, many MARPs currently are not accessing the services that they need.

### Scale of HIV prevention services at health facilities

Geographic coverage of service delivery is incomplete and services do not yet reach all persons requiring them. In 2006, PMTCT sites together saw 1 346 persons, or 6 patients a day each. This suggests that the current PMTCT sites have reached their maximum service delivery capacity and that new sites may be needed to expand the service. With respect to condom distribution, not all persons who require condoms can access them – either by purchasing them or freely. Universal precautions and safe blood supply services are available at the national referral hospital and some others, but need to be rolled out to all district hospitals, PHCs and PHCU.s. In STI treatment, managing drug stock-outs to ensure an uninterrupted supply of drugs is important. Every VCT site processed 512 VCT clients a year - an average of just under 2 VCT clients a day. Therefore, VCT sites have not yet reached their full capacity and can see more clients a day. Table 17 below provides some details on the scale of HIV prevention services at health facilities in 2006.

### Table 1: Coverage of HIV Prevention Services at Health Facilities in Zanzibar, 2006

<table>
<thead>
<tr>
<th>Health facilities</th>
<th>Primary Health Care (n = 130)</th>
<th>District (n=4)</th>
<th>National (n=1)</th>
<th>Private (n=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom distribution and promotion</td>
<td>Available as part of family planning services at MCH clinics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMTCT</td>
<td>At 6 ANC sites – 66% of target reached 20% coverage of pregnant women</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>STI treatment</td>
<td>28.5% of patients reached 100%</td>
<td>100%</td>
<td>100%</td>
<td>33%</td>
</tr>
<tr>
<td>VCT</td>
<td>At 27 of 45 STI clinics, VCT sites do not currently run at full capacity. 9% of women and 19% of men know HIV status</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Safe blood supply</td>
<td>Replacement donor system, 100% screened</td>
<td>Replacement donor system</td>
<td>Blood Bank established, all units screened</td>
<td>Replacement donor system</td>
</tr>
<tr>
<td>Universal precautions and PEP</td>
<td>Not in place</td>
<td>At 3 district hospitals</td>
<td>At 1 national hospital</td>
<td>Not in place</td>
</tr>
</tbody>
</table>

Source: Adapted from Zanzibar Health Profile, 2005; other data from focus group discussions

### Achievement of relevant HSSP objectives

**Goal 2 (relating to safe blood supply):** Although some strategies have been implemented, some have not. Most notably, the following still needs to be done: communication between the central blood bank and peripheral health care facilities is still to be strengthened, low risk population groups need to be mobilized to donate blood, and the quality control mechanisms for the replacement blood donor system in the laboratories of all PHC centres, district and referral hospitals need to be strengthened.

**Goal 3 (relating to PMTCT):** The data show that the majority of the strategies in the HSSP for PMTCT have been addressed. The outstanding strategy – to evaluate the PMTCT Plus program in Zanzibar - is planned for 2007.

**Goal 4 (Reduce needle sharing):** The SU-HISP is being launched in June 2007, and therefore this goal has not yet been addressed.

**Goal 5 (relating to STI control and VCT):** The HSSP strategies are being followed, with the exception of ensuring the availability of STI drugs and promoting youth friendly services. The VCT goal has not completely been achieved, as VCT services are not yet provided at all 45 STI clinics in Zanzibar. **Goal 6 (relating to universal precautions and PEP):** Universal precautions and PEP are still in the early stages of being implemented. It is therefore not surprising that not all HSSP strategies have been implemented: now that the guidelines have been developed,
training needs to take place and services need to be rolled out to health facilities (including universal precautions, PEP for accidental exposure, PEP for sexual assault, and appropriate medical waste disposal).

### 3.5 HIV care and treatment at health facilities

**Relevance of HIV Care and Treatment Services.** The HIV care and treatment services planned reflect national needs, an understanding of the HIV epidemic, the local socio-economic, cultural, religious and political conditions, and the latest research on HIV care and treatment. The OI and ARV treatments provided are therefore relevant. HAART, for example, reduces morbidity and mortality, prolongs quality life, can eliminate OIs and reduces risk of HIV transmission to non-infected partners (durable viral suppression to undetectable levels below 50 -400 copies/ml can be obtained in adherent patients, and this drastically reduces, although does not abolish the risk of HIV transmission). It is therefore also an HIV prevention mechanism for uninfected partners in discordant couples.

**Comprehensiveness of HIV Care and Treatment Services.** The HIV and AIDS treatment and care package is not yet comprehensive because there is minimal involvement of CSOs, FBOs and private sector; prophylaxis for all types of OIs is not yet routinely offered to patients, and some MARPs (e.g. prisoners) are not reached with service provision.

**Scale of HIV Care and Treatment Services.** Coverage of ART services is commendable - 50% overall coverage of all eligible PLHIVs in Zanzibar, including 65% coverage of children. The scale of other HIV care and treatment services is limited: the basic HIV care and treatment package is offered at the four hospitals that offer HAART but at only 57% of district hospitals.

**Achievement of relevant HSSP objectives.** OI treatment and some OI prophylaxis are available, but there are drug shortages. ARV treatment is reaching and exceeding its estimated goals, but TB and HIV services are not yet linked and integrated. The dual challenge of scale-up whilst ensuring sustainability is essential – especially because ARV treatment is a lifelong commitment.

### 3.6 HIV impact mitigation

**Relevance of impact mitigation services.** Currently, the programmes being provided focus on individuals – adults and children – either living with HIV or whose parent/s died from AIDS. All the services currently being provided are relevant in addressing their needs. More needs to be done to reduce stigma and discrimination towards PLHIVs within communities (particularly PLHIVs who are also MARPs whose illegal behaviour has resulted in infection with HIV), and to understand whether they have any needs that are not met.

**Comprehensiveness of impact mitigation services.** HIV impact mitigation services are partly but not yet entirely comprehensive for two reasons. *First*, HIV impact mitigation are not structured – i.e. each NGO may provide the support they feel is best, and there are no guidelines on a minimum package of impact mitigation services for adults, children, families, households and communities affected by AIDS. *Second*, not all persons that need support have been reached. The services target some people who need support, but do not consider the whole family unit. Also, there are no programmes that provide support to PLHIV associations to promote self employment, and PLHIVs are not used as a resource to decrease stigma and discrimination or promote HIV prevention.

**Scale of HIV impact mitigation services in Zanzibar.** With the low HIV prevalence of 0.9% in Zanzibar, the impact of HIV is not as devastating as in other countries in the region. However, impact mitigation services should still be available in all communities. These services are not yet up to scale because not all communities provide all them, and less than 10% of the estimated number of adults and children living with HIV are being supported through HBC programmes.

**Achievement of relevant HSSP objectives.** Although impact mitigation services exist in the community and the impact is not of large national scale, the services are delivered *ad hoc*, are not well coordinated, and there is no quality assurance. Therefore, the strategies in the HSSP have not yet been comprehensively addressed.
3.7 Enabling environment for HIV response

In terms of the various objectives in the ZNSP relating to enabling environment, good progress has been made:

**Increase capacity for HIV service planning, implementation, monitoring and evaluation:** Capacity has been built, but more needs to be done at the grassroots level to ensure that stakeholders are not only able to plan, implement, monitor and evaluate HIV services, but that they also have the funds to do so.

**Advocacy to counter stigma, discrimination and denial:** Advocacy efforts have commenced and are now being structured through a national advocacy strategy. Implementing it will be vital to ensure that advocacy efforts are scaled up.

**Mobilise internal and external resources:** There is a vast improvement in the number of development partners and the amount of funding that they have committed, but more needs to be done in terms of ensuring the long-term commitment of development partners, ensuring that all interventions are cost effective, and that unsustainable, unproven or costly interventions are not implemented without operational research first being undertaken.

**Increase awareness, involvement and commitment of private and public sectors:** Compared to 2003, there is significant improvement in terms of the involvement of the public sector – more MDAs are involved, and HIV work planning is mainstreamed within the government’s annual budgeting process. The next step would be to selectively provide increased focus to critical MDAs – e.g. MoEVT, MoTTI, MoHSW, and MoALE – as priority Ministries where the consequences of no action will be vast. The private sector is just in the process of organizing themselves, and a strong focus for the next two years need to be to involve them more meaningfully and increase the number of private sector institutions that are involved in the HIV response.

**Formulate a national multisectoral HIV policy:** This is a major success of the past three years – a national HIV policy has not only been formulated, but also approved by the Zanzibar parliament and cabinet.

**Improve ZAC’s Board Of Commissioners and ZAC operations:** ZAC has organically grown over time and has adapted to its ever-expanding role in a chameleon-like way. However, it would be essential in the next two years to cement, clarify and set boundaries for ZAC’s role; otherwise the institution runs the risk of ‘trying to be everything to everybody’, which would not organizationally be wise.

In addition to the objectives listed above, there are some additional efforts required if this aspect of the HIV response is to be comprehensive. There is a need in the immediate future: (a) to ensure the meaningful and appropriate involvement of political parties; (b) to ensure that the role of the districts in terms of coordination keep pace with local government reform efforts, and their role is mandated, clarified, operationalised and funded; and (c) focus on strengthening and clarify not only the role of ZAC as a coordinating institution, but also the other coordinating institutions – IFF, UWAKUZA, ABCZ, ZANGOC, ZAPHA+, ZACP, OCGS, HMIS and ANGOZA.
3.8 HIV monitoring and evaluation

All objectives are being addressed: the national HIV M&E system has been developed according to the 12 components of a functional HIV M&E system and each of the components are currently being operationalised.

ZAC’s M&E unit and the Monitoring and Evaluation Task Team on HIV and AIDS in Zanzibar, METTHAZ, are leading efforts to operationalise the national HIV M&E system

The second generation surveillance system will be strengthened with the new biological surveillance protocol and the new behavioural surveillance protocol. Capacity in M&E still needs to be built, to cement and ensure that data are used for decision making.

4. MAIN CONCLUSION OF THE JOINT REVIEW

The main conclusion from this Joint Review has been an overwhelming and deepening understanding that in Zanzibar, we need to focus and target the HIV response. ‘Scale up’ in the context of Zanzibar’s HIV response does not mean ‘more of the same’, especially in such a resource constrained environment. Scale-up in the context of Zanzibar’s HIV response means ‘deepening’ the response by targeting those areas needing it the most.

For the HIV response in Zanzibar to be successful, Zanzibar needs to:

(a) prioritise who to reach – and focus efforts to reach them!
(b) prioritise what services are the most important to provide to them – and focus efforts to plan and mobilize resource for it!
(c) figure out the scientifically most cost effective way in which to implement it – and then implement activities with newfound boldness and confidence

5. MILESTONES FOR THE NEXT 30 MONTHS

Based on the findings and conclusions in the Joint Review, a set of recommendations were developed, and summarized as 30 key milestones. What are milestones? The literary definition of a milestone is that it is a “stone post at side of a road to show distances”. Within a programme planning context, a milestone is a “scheduled event signifying the completion of a major deliverable or a set of related deliverables. It is a flag in the workplan to signify some other work has completed. Usually a milestone is used as a programme/project checkpoint to validate how the programme/project is progressing and revalidate work. Milestones are also used as high-level snapshots for management to validate the progress of the programme/project. Milestones can also be described as a significant accomplishment; an intermediate goal, a very important event or a significant point or stage.

Within the context of the ZNPS review, milestones are therefore the critically important recommendations that need to be implemented in order to accelerate and move the HIV response forward in a way that addresses the issues that were raised during the midterm review. 30 milestones have been developed that need to be implemented in the next 30 months.

HIV PREVENTION IN THE COMMUNITY AND AT HEALTH FACILITIES

1. National HIV prevention conference conducted
2. Transport system for the blood transfusion service between national blood bank and district hospitals operational
3. Funding for PEP and universal precautions secured up to 2009
4. PMTCT communication strategy launched by MoHSW
5. HIV implementers signed letters of commitment with ZAC to deliver specific HIV education to specific target audiences
6. Funding for an economic empowerment programme for out-of-school youth has been approved
7. Guidelines for VCT post-test clubs approved by MoHSW
8. Condom Strategy approved by parliament
9. Guidelines for pre-marital HIV testing approved by IFF
10. Detoxification centre built and functioning

**HIV CARE AND TREATMENT**

11. Health sector HSSP costing report re-evaluated
12. MoU between government and private health care providers signed
13. Infant diagnosis facilities for HIV created at laboratory
14. Health sector drug and supply procurement system revised to ensure predictable supply of HIV-related drugs and supplies

**HIV IMPACT MITIGATION**

15. Guidelines for a minimum package of HIV impact mitigation services approved by MoHSW

**ENABLING ENVIRONMENT**

16. Incorporate HIV responsibilities in job descriptions of HIV focal persons at all levels and in all sectors
17. Formalise DACCOMs & SHACCOMs within the decentralisation policy and government structures at the district levels
18. HIV and AIDS mainstreamed in the Government General Orders
19. Comprehensive resource mobilisation plan developed
20. Relevant HIV-related legislation enacted to enforce the provisions of the national HIV policy
21. Implement JAST principles as per JAST implementation plan
22. System for all HIV implementers to submit annual plans to districts to compile district-level HIV plans institutionalised
23. Technical assistance plans and operational manuals for ZAC, ZACP, ZAPHA+, ABCZ, ZANGOC, DACCOMs and IFF developed and implemented
24. Structured national HIV capacity building plan and technical assistance plan developed and implemented
25. Update the communication and advocacy strategy to reflect new developments from the review of the ZNSP
26. Comprehensive community mobilisation campaign implemented

**MONITORING AND EVALUATION**

27. Harmonise and link the national HIV M&E system with the MKUZA monitoring system, MoHSW’s routine HIV monitoring systems and CBMIS
28. Update M&E Road Maps on annual basis
29. Establish the HIV information centre
30. In consultation with stakeholders, plan, coordinate HIV and AIDS research and studies to support planning and informed-decision making
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<th>Description</th>
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<tbody>
<tr>
<td>ABC</td>
<td>Abstain, Be faithful, or Use a Condom</td>
</tr>
<tr>
<td>ABCZ</td>
<td>AIDS Business Coalition of Zanzibar</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>ANGOZA</td>
<td>Association of NGOs in Zanzibar</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral treatment</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>CBMIS</td>
<td>Community Based Management Information System</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CCM</td>
<td>Chama Cha Mapinduzi</td>
</tr>
<tr>
<td>CDC</td>
<td>Center for Disease Control and Prevention</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all forms of Discrimination Against Women</td>
</tr>
<tr>
<td>CMA</td>
<td>Civil Military Alliance</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Minister’s Office</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of Children</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organisation, a collective term implying NGOs, FBOs and CBOs</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial Sex Worker</td>
</tr>
<tr>
<td>CTC</td>
<td>Care and Treatment Clinic</td>
</tr>
<tr>
<td>CUF</td>
<td>Civic United Front</td>
</tr>
<tr>
<td>CVMM</td>
<td>Community Voluntary Mundo</td>
</tr>
<tr>
<td>DACCOM</td>
<td>District AIDS Coordinating Committee</td>
</tr>
<tr>
<td>DANIDA</td>
<td>Danish International Development Association</td>
</tr>
<tr>
<td>DHAP</td>
<td>District HIV and AIDS Focal Person</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>DPG</td>
<td>Development Partners’ Group</td>
</tr>
<tr>
<td>DSAPR</td>
<td>Department of Substance Abuse Prevention and Rehabilitation</td>
</tr>
<tr>
<td>DRI</td>
<td>District Response Initiative</td>
</tr>
<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith Based Organizations</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>FHHD</td>
<td>Female Headed Household</td>
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<tr>
<td>FXB</td>
<td>Francois-Xavier Bagnaud</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GF-CCM</td>
<td>Global Fund Country Coordinating Mechanism</td>
</tr>
<tr>
<td>GIPA</td>
<td>Greater Involvement of People Living with HIV and AIDS</td>
</tr>
<tr>
<td>GPI</td>
<td>Gender Parity Index</td>
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<tr>
<td>GO</td>
<td>General Orders</td>
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<tr>
<td>HAART</td>
<td>High Active Anti-retrovirus Therapy /Treatment</td>
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<tr>
<td>HBC</td>
<td>Home Based Care</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B virus</td>
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Acknowledgements

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Section 1: INFORMATION ABOUT THE JOINT REVIEW

In this section, the history of the HIV response in Zanzibar is summarized, followed by a justification for undertaking this review. Information about the purpose and conceptual framework of the Joint Review, the Joint Review methodology and limitations of the methodology, as well as the structure of the Joint Review Report is also summarized in it.
1.1 History of the HIV Response in Zanzibar

The first three HIV cases in Zanzibar were diagnosed in 1986 at Mnazi Mmoja hospital. RGoZ took early action; after the identification of the HIV index case, the Ministry of Health and Social Welfare (MoHSW) led a newly-established technical committee to address issues on HIV as a disease of public health importance. Furthermore, the RGoZ established a special task force under the Chief Minister’s Office (CMO) with Ministerial Principal Secretaries as its members (ZAC, 2003).

Under the leadership of the technical committee, successive Medium Term Plans [MTP I-III] were formulated and implemented with various levels of achievements and impact (ZAC, 2003). There was a marked difference between MTP I and MTP II on the one hand and MTP III on the other hand: MTP III was a multisectoral plan in which not only MoHSW was responsible for the HIV response, the others were not.

MoHSW established the Zanzibar AIDS Control Programme (ZACP) in 1987 to lead all efforts to respond to the epidemic. Technical AIDS Committees (TACs) were formed in all RGoZ ministries by 2004. The greater part of MTP III was implemented during the donor embargo\(^3\) from 1995 to 2000. The lack of funding severely hampered the implementation of MTP III activities. There was a second challenge for the implementation of MTP3: whilst the management structures (ZACP and TACs) were in place to execute the multisectoral MTP3, ZACP did not have the mandate to coordinate the activities of other sectors.

The first challenge was over after the election results in 2000 were accepted by development partners and funding for HIV was made available again; the second challenge was addressed in June 2002 when an Act by the House of Representatives led to the creation of ZAC, a national entity responsible for coordinating the HIV response within all sectors - including civil society and the private sector. Specifically, ZAC was tasked, first of all, with developing strategic guidance for all sectors to participate in the HIV response in Zanzibar.

Soon after the establishment of ZAC, a situation analysis was carried out with a four-fold purpose: (i) to analyse the status of the HIV epidemic, the determining factors and drivers of the epidemic; (ii) to assess the extent to which MTP III (1998-2002) was implemented as a multisectoral plan; (iii) to identify achievements and constraints encountered; and (iv) to propose recommendations and the way forward as input into the formulation of a multisectoral Zanzibar National HIV and AIDS Strategic Plan – the ZNSP.

The situation analysis revealed 18 key recommendations, which formed the basis of the objectives and strategies of the ZNSP. The ZNSP was launched in June 2005, and covers the time period June 2005 to June 2009 (up to the end of the 2008-09 RGoZ fiscal year). The ZNSP has been ZAC’s guiding document, and thus forms the core of what was planned in terms of the HIV response in Zanzibar.

After the launch of the ZNSP, the MoHSW prepared the Zanzibar Health Sector HIV Strategy (HSSP) for the period 2005-06 to 2010-11. The HSSP defines specific goals, objectives and strategies (in line with the broad ZNSP objectives) for the health sector’s HIV response. Other Ministries followed suit in developing HIV workplace programmes for their Ministries and mainstreaming HIV into their core functions.

1.2 Justification for this Joint Review

It is now five years since the establishment of ZAC, four years since the last review of the HIV response was undertaken, two years after the launch of the ZNSP (i.e. midway through ZNSP implementation period), and 18 months after the finalization of the HSSP. ZAC and its partners therefore agreed that this is an opportune time to review the national HIV response in Zanzibar, so as to enable HIV stakeholders to improve the implementation of the HIV response.

\(^3\) A donor embargo was in place between 1995 and 2000 due to challenges with the election results of 1995. The embargo was lifted in 2000 after new elections took place.
1.3 Purpose and Conceptual Framework of the Joint Review

The main purpose of the Joint Review was to determine to what extent Zanzibar has mounted a relevant and comprehensive HIV response of appropriate scale, and what should be done to improve the HIV response in future. To achieve this main purpose, a number of evaluation questions were developed – as detailed in Annex A.

Conceptual framework of the Joint Review: When the Joint Review of the HIV Response in Zanzibar was designed, a conceptual framework was agreed on. This conceptual framework would not only guide the review process, but also the evaluation questions and the division of labour between the members of the Joint Review team. In terms of the conceptual framework, it was agreed that first, the drivers of the epidemic needed to be understood, as these would influence how the country should respond to HIV. Then, the extent of the HIV response needed to be investigated – i.e. whether the HIV services (HIV prevention services, HIV care and treatment services and HIV impact mitigation services) that were implemented, were relevant, comprehensive and of appropriate scale – this was the second part of the Review. These HIV services can only be implemented if an enabling environment for HIV service delivery exists (legal framework; political will; effective planning, management and coordination; resource mobilisation and utilization; capacity; and advocacy) – therefore, the enabling environment was the third aspect that was investigated. Finally, the fourth aspect that was investigated was the extent to which the HIV response (i.e. the services delivered and enabling environment) are being monitored and evaluated. The conceptual framework described here is illustrated in Annex B.

1.4 Joint Review Methodology and its Limitations

Who governed the Joint Review? The Joint Review was governed by a Joint Review Steering Committee that was chaired by ZAC. The members of the Steering Committee included representatives of, civil society, the private sector, faith-based sector, development partners, departments within ZAC, and different Ministries within RGoZ.

Who undertook the Joint Review? The Joint Review was undertaken by a review team comprising of a team leader and the consultants for each of six thematic areas that were defined – HIV prevention in the community; HIV prevention at health facilities; HIV treatment and care; HIV monitoring and evaluation (M&E); district and community response, and enabling environment.

What methodology was used for the Joint Review? The Joint Review methodology involved collecting and analyzing both secondary and primary data: secondary data were extracted from existing reports, reviews, and other documents relating to the HIV response in Zanzibar (see Section 7 for a full list of reference documents), whilst primary data were collected from key informants4 (judgment sampling was used to select them) through focus group discussions (FGDs), small group discussions or individual interviews. The review team followed these methodological steps in conducting the review:

- Developed individual evaluation questions for each of the thematic areas;
- Gathered and reviewed all relevant secondary data;
- Developed guides for discussions with stakeholders – focus group discussion guides for the FGDs and interview guides for the small group discussions and individual interviews;
- Arranged and conducted the FGDs and interviews;
- Analysed and synthesized secondary and primary data collected;
- Prepared thematic area Joint Review reports and presented these to the Steering Committee for peer review;

---

4 The Joint Review Proceedings Report (a report prepared separately to this Joint Review of the HIV Response Report) details all the stakeholders that were consulted during the primary data collection phase of the Joint Review.
Drafted an overall Joint Review Report to document the Joint Review results (this report);

Presented the draft Joint Review Report to the Steering Committee and a Technical Review panel for peer review;

Developed a set of milestones jointly at the Technical Review workshop;

Finalised the Joint Review Report and milestones; and

Published and disseminated the Joint Review results widely.

Methodological Limitations: As with any research there were some limitations, which are important when interpreting the Joint Review results, to the methodology used. These limitations are:

• **First**, the secondary data used were collected by other teams over which the review team had no control. Therefore, weaknesses or gaps in the secondary data could, potentially, be reflected as weaknesses or gaps in the Joint Review Report. Wherever possible, the review team pointed out these weaknesses or gaps.

• **Second**, there was a lack of data. Not all the surveys, surveillance and research that were identified as priorities in 2004 have been undertaken. There was also not extensive routine data about HIV service delivery in Zanzibar. The reason is that the system that was designed for capturing HIV service delivery data – the Zanzibar HIV and AIDS Programme Monitoring System (ZHAPMoS) – only became operational in October 2006; therefore, only one quarter of data were available (October to December 2006).

• **Third**, the primary data collected were subject to the review team’s interpretation, as in any qualitative data collection process.

1.5 Structure of the Joint Review Report

• **Section 1** contains information about the Joint Review: The justification, purpose, Joint Review conceptual framework, methodology and its limitations, and the structure of the Joint Review report.

• **Section 2** contains the Joint Review findings in terms of the drivers of the epidemic in Zanzibar (the first aspect of the Joint Review conceptual framework).

• **Section 3** details the Joint Review findings in terms of HIV service delivery (the second aspect of the Joint Review conceptual framework). For each HIV service, five components are described: (i) the situation in 2003; (ii) the ZNSP (and HSSP) objectives to address the situation; (iii) the situation as of May 2007; (iv) conclusions about the relevance, comprehensiveness and scale of the particular HIV service; and (v) the main challenges and gaps as of 2007.

• **Section 4** describes the Joint Review findings in terms of an enabling environment (the third aspect of the Joint Review conceptual framework). Each aspect of the enabling environment is elaborated using four headings: (i) the situation in 2003; (ii) the ZNSP objectives to address the situation; (iii) the situation as of May 2007; and (iv) the main challenges and gaps as of 2007.

• **Section 5** provides details as to how the HIV response has been monitored and evaluated since 2004 (the fourth aspect of the conceptual framework). The situation in 2003 is summarized, the ZNSP objectives to address the situation are listed, the situation as of May 2007 is described and the main challenges and gaps as of 2007 are highlighted.

• **Section 6** summarises the recommendations of the Joint Review – what should be done to improve the HIV response in Zanzibar – and provide a set of milestones by which to monitor the implementation of the Joint Review recommendations.

• **Section 7** provides a detailed reference list of all the documents that were sourced as part of the review.
Section 2: JOINT REVIEW FINDINGS: DRIVERS OF THE EPIDEMIC

This section summarises some key demographic data about the populations of Unguja and Pemba islands as it relates to HIV. It then describes available data about HIV prevalence in various populations, comments on existing and potentially new drivers of the epidemic, and concludes by commenting on the importance of understanding the ‘proportion of infection’ in Zanzibar by knowing the behaviour of sub-populations and general population and the HIV prevalence values for them.
2.1 **KEY DEMOGRAPHIC CHARACTERISTICS OF PERSONS LIVING IN UNGUJA AND PEMBA**

Education status, household structure, food security, and employment status are all indirect measures of levels of poverty, and thus standards of living. Research has shown that these factors may all impact on HIV transmission risk. Therefore, this section provides Zanzibar data from the recently-completed Tanzania Demographic and Health Survey [TDHS] (National Bureau of Statistics of the United Republic of Tanzania (NBS) and ORC Macro, 2005).

**Table 2: Education Characteristics of Persons in Zanzibar, 2004**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Unguja</th>
<th>Pemba</th>
<th>Zanzibar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons that are literate</td>
<td>83.2% F 88.8% M</td>
<td>62.5% F 80.3% M</td>
<td>76.8% F 86.0% M</td>
</tr>
<tr>
<td>Persons with no education or pre-primary education only</td>
<td>26.0% F 18.0% M</td>
<td>42.4% F 32.9% M</td>
<td>31.5% F 22.9% M</td>
</tr>
<tr>
<td>Persons with at least secondary education</td>
<td>28.6% F 29.0% M</td>
<td>15.5% F 15.8% M</td>
<td>24.3% F 24.6% M</td>
</tr>
<tr>
<td>Net Attendance Ratio for primary school</td>
<td>75.3% 64.4%</td>
<td>71.4%</td>
<td></td>
</tr>
<tr>
<td>Gender Parity Index for primary school</td>
<td>1.06 0.94</td>
<td>1.02</td>
<td></td>
</tr>
<tr>
<td>Net Attendance Ratio for secondary school</td>
<td>28.0% 18.0%</td>
<td>24.4%</td>
<td></td>
</tr>
<tr>
<td>Gender Parity Index for secondary school</td>
<td>1.11 1.08</td>
<td>1.11</td>
<td></td>
</tr>
</tbody>
</table>

Source: NBS and ORC Macro, 2005

Table 2 above suggests that male and female levels of education at primary and secondary levels are almost similar and that less persons in Pemba than in Unguja completed primary or secondary school. It also shows that there is good gender parity at primary and secondary level – suggesting that equal amounts of boys and girls attend school. The low net attendance ratio at secondary school level suggests that only a quarter of children of secondary school-going age are in school.

**Table 3: Household Electricity, Sanitation, Transport, Food Security of Households in Zanzibar, 2004**

<table>
<thead>
<tr>
<th>Household Characteristics</th>
<th>Unguja</th>
</tr>
</thead>
<tbody>
<tr>
<td>Households with electricity</td>
<td>23.6%</td>
</tr>
<tr>
<td>Houses with no sanitation facility (bush, field, etc.)</td>
<td>32.0%</td>
</tr>
<tr>
<td>Houses with two or less rooms to sleep in</td>
<td>55.7%</td>
</tr>
<tr>
<td>Households that use the bicycle as a means of transport</td>
<td>53.4%</td>
</tr>
<tr>
<td>Households where three meals is the usual number of meals in a day</td>
<td>66.5%</td>
</tr>
<tr>
<td>Households that ‘never’ or ‘seldom’ experiencing problems with satisfying food needs</td>
<td>75.2%</td>
</tr>
</tbody>
</table>

Source: NBS and ORC Macro, 2005

As Table 3 illustrates, most homes do not have electricity, almost a third of homes have no access to sanitation, more than half of the homes have less than two rooms to sleep in, more than half of the homes use bicycles as their main form of transport, and food insecurity is a reality for a quarter of households in Zanzibar. These conditions of poverty could lead to higher risk sexual behaviour and therefore could pose a risk for HIV transmission.

---

5 This is the percentage of children of primary-school age (7 to 13 years) that are in school

6 Gender Parity Index is the ratio of females to males attending school. A GPI of higher than 1 indicate that more females than males are attending school; a GPI of less than 1 indicate that more males than females are attending school
2.2 HIV, HBV, HCV and Syphilis Prevalence in Various Populations in Zanzibar

HIV prevalence measures the percentage of persons infected with HIV in a given population at a given point in time. It therefore provides a snapshot of the presence of the epidemic within the population that was tested. The only way to measure the actual HIV prevalence of the entire population in Zanzibar at a given point in time is to test every person in Zanzibar at the same moment. This is not practically possible and unethical. Therefore, the actual HIV prevalence of the entire population is estimated through mathematical models. The prevalence of HIV, other blood borne viruses and other STIs can all be used as inputs to refine the mathematical model to estimate the actual HIV prevalence of the general population. HBV and syphilis can be transmitted sexually and HCV is transmitted through blood contact: therefore the prevalence of these STIs or blood borne viruses are markers of higher risk sexual or injecting drug use behaviour.

Knowing their relevance, all available HIV, HBV, HCV and syphilis prevalence data are presented in Table 4. Care should be taken when interpreting the data presented in this table - kindly note the information provided in the ‘Type of Data Source’ column. HIV prevalence data from routine data sources and estimated from VCT results are all based on self-selecting samples (a person decides for him/herself whether to go for VCT) and the results are therefore not statistically representative of the population. The HIV prevalence data based on these types of data sources have been shaded grey in Table 4.

Table 4: HIV, HBV and HCV Prevalence of Different Populations in Zanzibar, 1980s to 2006

<table>
<thead>
<tr>
<th>Category</th>
<th>Type of Data Source</th>
<th>Available prevalence data (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prevalence amongst pregnant women7 at antenatal care (ANC) clinics8</td>
<td>ANC surveillance</td>
<td>1980s: 0.3, 2002: 0.6, 2005: 0.87</td>
</tr>
<tr>
<td>HIV prevalence amongst men and women in general population</td>
<td>Population-based HIV prevalence survey</td>
<td>2002: 0.6 all sexes, all ages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2002: 0.9 F, all ages, 0.2 M, all ages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2002: 1.5 ages 25 – 34, both sexes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2002: 1.8 (with non-regular partners)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2002: 0.8 (no non-regular partners)</td>
</tr>
<tr>
<td>HIV prevalence amongst female domestic workers (‘house girls’)</td>
<td>Population-based HIV prevalence survey</td>
<td>2002: 3.8</td>
</tr>
<tr>
<td>HIV prevalence amongst STI patients</td>
<td>Routine MoHSW data</td>
<td>2002: 5.6, 2005: 4.1</td>
</tr>
<tr>
<td>HIV prevalence amongst substance users</td>
<td>Research – RDS sampling</td>
<td>2006: 12.9 all, 30.7 F, 12.0 M</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2006: 3.3 Pemba</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2006: 15.1 Unguja</td>
</tr>
<tr>
<td>HIV prevalence amongst Injecting Drug Users</td>
<td>Research – RDS sampling</td>
<td>2006: 28.4 all ages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2006: 15.2 ages 25 – 34</td>
</tr>
<tr>
<td>HIV prevalence amongst Blood donors</td>
<td>Routine data</td>
<td>1996: 0.7, 1999: 1.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2000: 0.4, 2005: 0.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2005: 33</td>
</tr>
</tbody>
</table>

7 Pregnant women are used as a sentinel population for HIV surveillance because they had to have had unprotected sex (a risk factor for HIV transmission) in order to become pregnant

8 Not all ANC sites were surveyed every year, primarily due to unavailability of test kits.
Joint Review of the National HIV Response in Zanzibar 2004 to 2007

<table>
<thead>
<tr>
<th>Category</th>
<th>Type of Data Source</th>
<th>Available prevalence data (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV prevalence amongst VCT clients</td>
<td>Routine data</td>
<td>2001: 10.3 2004: 4.7</td>
</tr>
<tr>
<td>(also see Annex C for detailed HIV prevalence data per district)</td>
<td></td>
<td>2005: 5.2</td>
</tr>
<tr>
<td>HIV prevalence amongst persons in private sector</td>
<td>ZAC estimates from VCT data – samples not representative</td>
<td>2005: 5.6</td>
</tr>
<tr>
<td>HIV prevalence amongst men in uniform</td>
<td>ZAC estimates from VCT data – samples not representative</td>
<td>2005: 12.5</td>
</tr>
<tr>
<td>HIV prevalence amongst farmers</td>
<td>ZAC estimates from VCT data – samples not representative</td>
<td>2005: 8.4</td>
</tr>
<tr>
<td>HIV prevalence amongst taxi drivers</td>
<td>ZAC estimates from VCT data – samples not representative</td>
<td>2005: 5.7</td>
</tr>
<tr>
<td>HIV prevalence amongst fishermen</td>
<td>ZAC estimates from VCT data – samples not representative</td>
<td>2005: 3.7</td>
</tr>
<tr>
<td>HIV prevalence amongst hotel staff</td>
<td>ZAC estimates from VCT data – samples not representative</td>
<td>2005: 10.3</td>
</tr>
<tr>
<td>HIV prevalence amongst teachers</td>
<td>ZAC estimates from VCT data – samples not representative</td>
<td>2005: 1.4</td>
</tr>
<tr>
<td>HIV prevalence amongst health workers</td>
<td>ZAC estimates from VCT data – samples not representative</td>
<td>2005: 11.6</td>
</tr>
<tr>
<td>HCV prevalence amongst IDUs</td>
<td>Research – RDS sampling</td>
<td>2006: 15.5</td>
</tr>
<tr>
<td>HBV prevalence amongst blood donors</td>
<td>Routine data</td>
<td>2006: 3.8</td>
</tr>
<tr>
<td>Syphilis prevalence amongst IDUs and blood donors</td>
<td>Research – RDS sampling</td>
<td>2006: 10.0 IDUs 2006: 0.9 blood donors</td>
</tr>
</tbody>
</table>

**Sources**: ZACP, 2002; ZAC, 2003; Othman, 2005; ZACP, 2005; Dahoma et al., 2006; ZAC, 2006

Trends in HIV prevalence amongst VCT clients can be skewed by enrolment figures (“selection bias”). Nevertheless, it is interesting to note that HIV prevalence amongst VCT clients has not followed the HIV prevalence pattern of the general population. Four differences are evident:

- **First**, whilst it seems that HIV prevalence amongst VCT clients has decreased over time, this has to be seen in light of the fact that the number of persons tested increased exponentially in the past 5 years.
- **Second**, HIV prevalence varies dramatically from district to district – see Table 29 in Annex C.
- **Third**, HIV prevalence amongst VCT clients does not follow the 5:1 female to male ratio of infection observed in the general population (see Table 28 in Annex C).
- **Fourth**, the HIV prevalence at VCT clinics in Unguja is consistently higher than in Pemba:

<table>
<thead>
<tr>
<th>Year</th>
<th>Pemba</th>
<th>Unguja</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>4.3%</td>
<td>6.6%</td>
</tr>
<tr>
<td>2004</td>
<td>2.8%</td>
<td>6.8%</td>
</tr>
<tr>
<td>2005</td>
<td>5.1%</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

9 In interpreting these VCT statistics about HIV prevalence, keep in mind that the number of VCT sites has increased over time, and that more sites were recently added to Pemba.
2.3 **EXISTENCE OF MOST-AT-RISK POPULATIONS IN ZANZIBAR**

Not all persons in Zanzibar are at equal risk of contracting HIV. Some populations have an increased risk of contracting or spreading HIV. Based on evidence (some anecdotal) available in 2003, ten Most-At-Risk Populations (MARPs) were identified in the ZNSP:

1. Substance Users;
2. Sex Workers and their Clients;
3. Mobile Traders;
4. Passengers on public transportation services;
5. Clove Pickers and people at social events/gatherings [e.g. Uhuru torch rally];
6. Workers and People Under Special Circumstances [military, police, special departments including prisoners];
7. People with Disabilities;
8. Fishermen;
9. Out of School Youth; and

Recent HIV prevalence data, studies on the potential impact of HIV on the education and tourism sectors (HR Consult (draft), 2007; Lugalla et al., 2007) and discussions during the Joint Review FGDs have suggested that there may be new, previously unidentified MARPs: mobile and seasonal employees (employees and communities surrounding tourist hotels, farmers and people who work at road construction sites); people who wash dead bodies before funerals (this is done without protective gear); students who attend student tuition and study camps (where young people of both sexes are away from home for a long time); health workers (due to mobility or nosocomial transmission of HIV) and men having sex with men.

*Mobile persons – persons involved in the tourism sector:* The growing tourism sector provides direct employment for 8 000 people and indirectly benefits another 38 000 (Lugalla et al., 2007). Figure 2 below suggests that tourism sector workers (but not managers) feel that tourism contributes to HIV in Zanzibar. The reason for the high perception of risk may be that most employees in the sector are young (74% are aged 21 to 35%), educated, work away from home (73%), and are not married (over 50%) (Lugalla et al., 2007). Unfortunately, the study did not collect behavioural data that would indicate whether the sexual behaviour of tourism sector workers is any different from the general population.

**Figure 1: Perception of Tourism Industry Workers and Managers as to whether Tourism Contributes to HIV Transmission in Zanzibar, 2007**

![Figure 1](image)

*Source:* Lugalla et al., 2007:23
Men having Sex with Men (MSM): There has been denial about MSM in Zanzibar (only 8% of respondents in the Lugalla et al. study in 2007 acknowledged that it took place). This might be because: (i) the practice is not widespread; (ii) it is illegal – an Act was passed against homosexuality in 2004; (iii) it is against the values of all religions on the island; or (iv) there are generally negative views about it. However, in the Joint Review FGDs there was some recognition of MSM activity. Lugalla et al., (2007:59) reported MSM activity, and Dahoma et al. (2006) confirmed the existence of MSM activity amongst IDUs, and reported that 34% of IDUs prefer penetrative anal sex (with males or females).

In identifying these potential new MARPs it should, however, be noted that: (i) the sizes of some of these sub-populations are not known and may be small; (ii) if the sizes of some of these sub-populations are small, their public health impact will be negligible too; and (iii) the vulnerability of some of these sub-populations is anecdotal and observational and has not necessarily been verified by biological and behavioural HIV surveillance (and does not warrant such an investigation, if the populations are small).

2.4 POTENTIAL DRIVERS OF THE HIV EPIDEMIC

Using what evidence and anecdotal information has shown about the behaviour and characteristics of the general population and the aforementioned MARPs, five main potential drivers – factors that cause some populations to be MARPs – have been identified in Zanzibar: (i) higher risk sexual behaviour, substance use behaviour and varying perception of HIV transmission risk; (ii) stigma and discrimination; (iii) population mobility; (iv) gender imbalances; and (v) other socio-economic and cultural factors (ZAC, 2006).

2.4.1 Higher Risk Behaviour and Accompanying Low Perception of HIV Transmission Risk as a Potential Driver of the HIV Epidemic in Zanzibar

Table 5: Higher Risk Sexual Behaviour in Zanzibar, 2002

<table>
<thead>
<tr>
<th>Percentage of persons who had sex with a non-regular sexual partner (sex with a person who does not regularly live with them or that they are not married to)</th>
<th>2002</th>
</tr>
</thead>
</table>

Table 6: Higher Risk Sexual Behaviour in Zanzibar, 2005

<table>
<thead>
<tr>
<th>Percentage of persons who had sex with a non-regular sexual partner (sex with a person who does not regularly live with them or that they are not married to)</th>
<th>Unguja</th>
<th>Pemba</th>
<th>Zanzibar</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.4% F 17.5% M</td>
<td>1.6% F 3.1% M</td>
<td>8.4% F 13.0% M</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of sexually active female youth who had sex with a non-regular sexual partner</th>
<th>20.8% F 1.5% F 14.1% F</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Percentage of females who used a condom during last sex with a non-regular sexual partner (only data for females was statistically valid. Number of responses was too low in some cases to calculate statistically valid percentages)</th>
<th>36.1% F Not valid 34.5% F</th>
</tr>
</thead>
</table>

| Percentage of persons with two or more sexual partners in the last 12 months | 1.2% F 18.5% M 0.2% F 18.3% M 0.9% F 18.4% M |
### Section 2

<table>
<thead>
<tr>
<th></th>
<th>Unguja</th>
<th>Pemba</th>
<th>Zanzibar</th>
</tr>
</thead>
<tbody>
<tr>
<td>e) Percentage of the youth who have had sex before the age of 15</td>
<td>5.2% F, 0.2% M</td>
<td>2.0% F, 6.0% M</td>
<td>4.1% F, 2.3% M</td>
</tr>
<tr>
<td>f) Percentage of the youth who had sex in the past 12 months</td>
<td>5.6% F, 10.1% M</td>
<td>0.3% F, 1.8% M</td>
<td>4.0% F, 7.1% M</td>
</tr>
<tr>
<td>g) Percentage of the youth who used a condom during first sex (only data for females was statistically valid. Number of responses was too low in some cases to calculate statistically valid percentages)</td>
<td>7.4% F, 1.4% M</td>
<td>5.3% F, 24.0% M</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** NBS and ORC Macro, 2005

As can be seen in Tables 5 and 6 above, the percentage of men who had sex with a non-regular partner remained almost the same over time (12.7% in 2002 and 13.0% in 2005), whilst the percentage of women who had sex with a non-regular partner increased from 7% in 2002 to 8% in 2005. The percentage of women who used a condom during last sex with a non-regular partner increased from 15% in 2002 to 35% in 2005.

Sex with two or more partners is not necessarily evidence of higher risk behaviour in Zanzibar. The reason is that polygamy is an accepted cultural and religious practice for most people who live in Zanzibar. In 2005, 28% of women were in a marriage with one or more co-wife, whilst 18% men indicated that they had two or more wives (NBS and ORC Macro, 2005). This could explain the significant difference between the percentage of men and women that have had sex with two or more persons (1% F versus 18% M – see Table 6 (d)).

The percentage of men and women who have had two or more sexual partners in Zanzibar is on a par with some other countries in the region – see Figure 2.

**Figure 2: Persons in Countries in Region with Two or More Sexual Partners in the Last 12 Months, 1999 – 2005**

In terms of Figure 2, it should be noted that cultural factors in Zanzibar is different to other countries in the region, for two reasons: (i) Zanzibar is primarily an Islamic country (where polygamy is accepted); and (ii)

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10 ‘Youth’ is defined as 15 – 24 year old never married persons
Zanzibar is an island country. Comparing higher risk sexual behaviour in Zanzibar compared with ‘comparable countries’ shows that higher risk sexual behaviour in Zanzibar is significantly lower than in other countries. The percentage of men and women who have had sex with (a) more than one partner (Figure 3) and (b) a non-marital, non-cohabiting partner in the last 12 months in Zanzibar (Figure 4) is significantly lower than in ‘comparable’ countries.

Figure 3: Sex with Two or More Partners – other Islamic countries in Africa & other island countries, 1998 – 2005

![Figure 3: Sex with Two or More Partners](image)


Figure 4: Sex with a Non-regular Partner – other Islamic countries in Africa & other island countries, 1998 – 2005

![Figure 4: Sex with a Non-regular Partner](image)
B: Varying perception of HIV transmission risk amongst general population

Not all persons in Zanzibar consider themselves at high risk of contracting HIV. Less than 50% of education sector stakeholders interviewed in an impact assessment for the education sector in 2007, for example, considered themselves to be at risk of contracting HIV (HRConsult, 2007). In the tourism sector assessment (Lugalla et al., 2007) more than 25% of persons interviewed did not perceive themselves to being at risk of ever being HIV positive.

C: Higher risk behaviour amongst MARPs

Substance Users and Injecting Drug Users (IDUs): There are three reasons why substance users and IDUs in particular have been identified as a MARP: (a) Zanzibar is located along an important corridor for drug trafficking (ZAC, 2003); (b) in recent years Zanzibar has documented increasing numbers of young people using illicit drugs (Mkapa, 2002); and (c) drug trafficking activities increased between 2001 and 2004 (Zanzibar police (2004) quoted by Dahoma et al, 2006).

ZACP, in collaboration with the Department of Substance Abuse Prevention and Rehabilitation (DSAPR) and ZAC, undertook research amongst substance users in 2005 (results published in 2006) to confirm that this group is indeed a MARP. Of 503 substance users surveyed, 5% were females and 18% were from Pemba. The research revealed high percentages of risky behaviour amongst substance users, including:

- 39% of substance users are IDUs
- 46% of IDUs share needles
- 9% of IDUs practice flash blood practices (‘flash blood’ is where two IDUs share the same blood through exchanging needles filled with blood where the substance was just injected into a person’s body)
- Only 30% of IDUs report water cleaning of injecting paraphernalia before needle sharing,
- 77% female and 71% male IDUs reported sex with two or more one sexual partners (compared with 1% females and 18% males in the general population – see Table 5 (b))
- 34% male substance users indicated a preference for anal sex (with a male or female)
- 16% IDUs have participated in group sex
- 50% substance users (300) have witnessed group rape of an overdosed IDU

Commercial Sex Workers (CSWs) and their clients: Another possible MARP that needed to be investigated, was CSWs. Lugalla et al. (2007) reported that 73% of persons (n=333) in a tourism sector study said that the number of CSWs are increasing. A pilot project covering 240 male and female CSWs (89.2% of whom were between 16-35 years of age) in Unguja urban district revealed that CSWs did engage in high risk behaviour (ZAC, 2006):

- 19% of CSWs practiced dry sex
- 28% of male and female CSWs reported anal sex
- 39% CSWs did not use a condom – the main reason was that their clients were “regulars”
- Sexual violence (25% of CSWs), men having sex with men (10% of CSWs) and injecting drug use (9% of CSWs) were reported.

Figure 5 below illustrates the sexual network between a CSW and people in the general population – the CSW can have four types of partners (PP, RP, R-CM and P-visitor), who in turn have other partners. This shows how CSWs can form a bridge population for HIV transmission to the general population.
Figure 5 suggests that only one of the four types of CSW clients are tourists – the rest are either married or unmarried men from Zanzibar. Recently, it has been reported, anecdotally, that “…what the tourist looks for is not to have casual sexual with Africans but to establish a much more permanent relationship with them. But on the part of Africans, we seem to be looking more for casual sex with multiple partners rather than establishing permanent relationships” Lugalla et al. (2007: 30). This statement suggests that sex tourism (tourists coming to Zanzibar to have sex with local CSWs) may be not a significant driver of the epidemic, as recently suggested by the religious sector in Zanzibar and that the risk of CSWs forming a bridge with the local population is higher.

Given the sexual network involving CSWs illustrated in Figure 5, it is clear that clients of CSWs (either members of the community, their own regular partners or their own permanent partners) are at higher risk of HIV infection if they have sex with a CSW without using a condom. Although data for Zanzibar specifically were not available in the TDHS, it was reported that 10.6% of Tanzanian men had paid for sex and that only 59.0% of them used a condom during paid sex (NBS and ORC Macro, 2005).

Behavioural surveillance data about other MARPs to document whether there was any increased high risk behaviours were not available and could therefore not be presented as part of this Joint Review. Also, the sizes of the MARPs are not known. There are, however, studies underway to assess the HIV prevalence, possible risk behaviour and sizes of CSW and MSM populations.

2.4.2 Stigma and Discrimination as a Potential Driver of the HIV Epidemic

Stigma and discrimination against PLHIV: Stigma is widely reported in Zanzibar. Some examples: (i) a survey conducted by the Ministry of Education and Vocational Training (MoEVT) in 2000 found that 60.5% of respondents showed negative attitudes towards PLHIV; (ii) it was reported during the Global Fund Round 6...
proposal writing process that many persons feared children living with HIV and that as a result, they were often left out of programmes for Most Vulnerable Children (MVC) (ZAC, 2006); (iii) an Impact Assessment undertaken amongst tourism sector workers in 2007 showed that 43% would be ashamed to be seen with a PLHIV, that 43% believed that PLHIVs must have been promiscuous and 37% feel that they should bear the consequences (Lugalla, et al. 2007); and (iv) the 2005 TDHS confirmed finding high levels of stigma and discrimination, and higher in Pemba than in Unjuga (see Table 7).

Table 7: Extent of Stigma and Discrimination Against PLHIVs in Zanzibar, 2004

<table>
<thead>
<tr>
<th></th>
<th>Unguja (%)</th>
<th>Pemba (%)</th>
<th>Zanzibar (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Percentage of persons who are NOT willing to care for HIV positive family member at home</td>
<td>6F 2M</td>
<td>10 F 14M</td>
<td>7F 6M</td>
</tr>
<tr>
<td>b) Percentage of persons who would NOT buy fresh food from shopkeeper with AIDS</td>
<td>54F 40M</td>
<td>68F 55M</td>
<td>53F 45M</td>
</tr>
<tr>
<td>c) Percentage of persons who believe HIV positive female teacher should NOT teach</td>
<td>13F 15M</td>
<td>35F 39M</td>
<td>20F 22M</td>
</tr>
<tr>
<td>d) Percentage of persons who would want status of HIV positive family member to remain a secret</td>
<td>49F 41M</td>
<td>51F 52M</td>
<td>50F 43M</td>
</tr>
</tbody>
</table>

Source: NBS and ORC Macro, 2005

Three examples of discrimination against PLHIVs were cited in a recent research report:

1. “One respondent cited an example of a worker who was HIV positive who was not allowed to continue working as a waiter but was shifted so that he/she can work as a cleaner.
2. Another case cited was that of a worker whose contract could not be renewed because he had come out and declared his HIV status.
3. In one shehia, it was reported that the sheha makes public the names of persons who are HIV positive in the shehias, so that other members of the community would stay away from them.” (Lugalla, et al. (draft), 2007:47).

A study on the impact of HIV in the education sector in 2007 revealed that 16% of persons felt that PLHIVs were being discriminated against. Those who responded “yes” to the question, felt that the main way that discrimination is shown is that relationships with PLHIVs are terminated (HR Consult, 2007). PLHIVs even ‘discriminate’ against themselves: In the same study, 30% of PLHIV indicated that they would segregate themselves from others, because they feel that ‘they are destined to die’. It was also reported in the Joint Review FGDs that health care workers discriminate against PLHIV in health care settings.

**Stigma and discrimination against persons engaging in higher risk behaviour (even if they are HIV negative):** Prostitution and MSM activity are not only morally unacceptable to many persons in Zanzibar, they are also illegal. This makes more likely that persons engaged in these behaviours will be discriminated against. It was confirmed in the Joint Review FGDs that health workers discriminate against IDUs, CSWs, substance users and other MARPs who try to access health services.

**Impact of stigma and discrimination:** Irrespective of whether or not a PLHIV and his family are displaying higher risk behaviour, these high levels of stigma and discrimination are likely to result in persons in the general population and PLHIV population being less likely to access the HIV prevention, treatment and care services that they need to protect themselves and their families – inadvertently contributing to the spread of HIV. For example, some religious leaders and persons with tertiary education are afraid to know their status, because there are afraid of the potential stigma if they were to be HIV positive.
2.4.3 Population Mobility as a Potential Driver of the HIV Epidemic

Mobile populations are those populations where persons spend considerable time away from their family and home for economic or other reasons. In the process, they may be exposed to higher risk behaviour. Such mobility may be (i) internal (within the borders of one country, e.g. seasonal workers), or (ii) external (between countries, e.g. tourism sector). Mobility on its own is not a driver of the HIV epidemic. However, mobility combined with higher risk sexual or substance use behaviour is a factor that could increase HIV transmission risk.

There is increased internal population mobility in Zanzibar. Zanzibaris is a mobile population – people relocate to other areas (temporarily or permanently as better employment opportunities arise, for example). Quantitative data about internal mobility to substantiate this statement is not available, but the nature of employment in Zanzibar – seasonal agricultural workers, fishermen, taxi drivers, road construction workers and the like – point to significant internal mobility.

There is also increased external mobility. Persons from other areas are also coming to Zanzibar for (i) employment (of 265 hotel workers surveyed in 2007, 27% were not from Zanzibar (Lugalla et al., 2007)); or (ii) leisure. Figure 6 illustrates the increase in tourists in the past 15 years and the Zanzibar Tourism Commission has noted that there has been a three-fold increase in the number of tourists from countries in Africa, where the HIV prevalence is higher than in Zanzibar.

2.4.4 Gender Imbalances as a Potential Driver of the HIV Epidemic

HIV prevalence data from 2002 suggest that the female: male HIV prevalence ratio was 5:1 (ZACP, 2002). This is not the same as the ratio in VCT site data, where the female: male ratios of infection are closer to 1:1. This discrepancy does not arise because more males than females are tested; in fact, in 2005, 48% of VCT clients in Unguja and 40% of VCT clients in Pemba were female. (Instead, the discrepancy suggests that HIV positive women are much less likely than HIV positive men to access VCT.)

It is clear that there are significant gender imbalances in Zanzibar – fewer women are employed, women are less free to make decisions about their own health care and more women are subject to domestic violence. Gender imbalances are more pronounced in Pemba than in Unguja (see Annex D for a detailed breakdown of gender-related information).

Gender imbalances in Zanzibar even reach the biological level. Not only are women biologically more susceptible to HIV infection than men, but virtually every man in Zanzibar is circumcised. Male circumcision provides men with 60% protection against HIV transmission, making women even more susceptible to HIV infection. The biological disadvantage that women face may go a long way in explaining the high female to male infection ratio.
2.4.5 Other Socio-economic and Cultural factors as Potential Drivers of the Epidemic

In addition to the drivers mentioned above, there are also other socio-economic and cultural factors that are potential drivers of the epidemic. These include the low secondary school enrolment (only 24% of youth of secondary school-going age are in school) and resultant high unemployment amongst the youth; cultural ceremonies such as celebrating the coming of new year (Christmas, “Mwaka Kogwa” etc.), Uhuru torch rallies and other village and national ceremonies; and cultural traditions such as wife cleansing. These factors influence individual’s behaviour and therefore their chances of being exposed to HIV.

2.5 CONCLUSIONS: POTENTIAL DRIVERS OF THE HIV EPIDEMIC IN ZANZIBAR

The data presented clearly shows that there is scientific data to prove that there are Most-At-Risk Populations in Zanzibar who are potential drivers of the HIV epidemic; some of these MARPs engage in illegal behaviour that puts them at risk of HIV transmission. Their existence need to be acknowledged if the HIV response is to be targeted and focused at these MARPs.

Unlike 20 years ago, HIV epidemics are no longer categorised only by HIV prevalence in the general population. Instead, epidemics are now classified as either: (i) a concentrated epidemic driven by MARPs in which preventing infection among MARPs would be highly effective in stopping the epidemic from spreading; (b) a low intensity generalised epidemic driven by higher risk heterosexual intercourse in the general population; or (c) a mixed epidemic driven by both MARPs and higher risk heterosexual contact in the general population (Wilson, 2007).

In order to classify Zanzibar’s HIV epidemic, the ‘proportion of infection’ – *where did the last 100 infections come from* – needs to be known. The Zanzibar MoHSW estimated in 2002 that 90 of the last 100 new HIV infections resulted from heterosexual transmission in the general population, 4 through vertical (mother-to-child) transmission and the rest through other means (including nosocomial transmission in hospitals) – suggesting a low intensity generalised epidemic. The epidemiological evidence presented in this chapter suggests that the proportion of infection should be recalculated. To determine the proportion of infection, five questions need answers:

1. Which populations are “Most At Risk” in Zanzibar?
2. What is the size of each of the MARPs?
3. What is the HIV, STI, HBV and HCV prevalence in the MARPs?
4. What higher risk behaviours do MARPs display?
5. How do MARPs interact with other MARPs and with the general population?

Table 8 summarises available data for all MARPs in Zanzibar. It shows that only partial data are available and that more research is needed. The data seems to suggest that Zanzibar has a mixed epidemic – low grade epidemic in general population and concentrated epidemic amongst some MARPs – but it is premature to classify the HIV epidemic in Zanzibar.

Once the missing data are known, the proportion of infection can be estimated again. If the proportion of infection reveals that most of the last 100 infections in Zanzibar were among MARPs, Zanzibar would have a concentrated epidemic. If it reveals that most of the last 100 infections were the result of heterosexual interaction in the general population, it will confirm that Zanzibar has a low intensity generalized epidemic. Should the proportion of infection estimate produce mixed results, it would indicate that Zanzibar has a mixed epidemic.

Knowing, with some level of certainty, where the last 100 infections came from, is essential before the next ZNSP is developed in 2009.
### Table 8: Summary of HIV-related Epidemiological and Other Data about MARPs in Zanzibar, 2007

<table>
<thead>
<tr>
<th>Potential MARPs in Zanzibar</th>
<th>Estimate number of MARPs</th>
<th>HIV prevalence</th>
<th>Evidence of higher risk behaviour</th>
<th>Interaction with other MARPs and with general population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Users</td>
<td>500 enrolled in Substance User study in 3 month period, 39% were IDUs</td>
<td>12.9% amongst substance users 28.6% amongst IDUs</td>
<td>Share needles  Share blood  Have multiple, concurrent sexual partners Do not use condoms Has penetrative anal sex Involved in non consensual sex</td>
<td>IDUs are CSWs who interact with general population</td>
</tr>
<tr>
<td>Sex Workers and their Clients</td>
<td>Not known</td>
<td>Study currently being done</td>
<td>Not all use condoms  High numbers of concurrent sexual partners</td>
<td>Interaction with IDUs  Interaction with all other MARPs  Interaction with general population</td>
</tr>
<tr>
<td>Seasonal and mobile employees, including fishermen, clove pickers, transportation sector drivers, tourism sector workers, people who attend social events, health workers</td>
<td>Fishermen: 6000 Hotel staff: 8000 Drivers: 2000 estimate Farmers: not known Businessmen: not known Health workers: 3500</td>
<td>Fishermen: 3.7% Hotel staff: 10.3% Drivers: 5.7% Farmers: 8.4% Businessmen: 5.6% Health workers: 11.6%</td>
<td>Own perception of higher risk  Higher risk not confirmed with behavioural data</td>
<td>Interaction with CSWs</td>
</tr>
<tr>
<td>People Under Special Circumstances [Men in Uniform(^\text{12}) and prisoners]</td>
<td>Not known</td>
<td>Men in uniform: 12.5%</td>
<td>No data available</td>
<td>Interaction with CSWs</td>
</tr>
<tr>
<td>Youth (18 or younger)</td>
<td>Youth: 500 000</td>
<td>0.5%</td>
<td>Low condom use  High age of sexual debut  Non regular partners at young age</td>
<td>Interaction with CSWs</td>
</tr>
<tr>
<td>People with Disabilities</td>
<td>Not known</td>
<td>No data available</td>
<td>High risk behaviour not known  Increased vulnerability due to perceptions that disabled persons cannot have HIV and lack of means to protect themselves</td>
<td>Not known</td>
</tr>
<tr>
<td>Married Women and House Girls</td>
<td>Married women: 300 000  House girls: 500 000</td>
<td>Pregnant women (assume most are married): 0.87% House girls: 3.8%</td>
<td>Increase in number of women with more than one partner</td>
<td>Interaction with men who have more than one sexual partner</td>
</tr>
</tbody>
</table>

NOTE: In the table below, the HIV prevalence values provided for the different MARPs should be interpreted correctly. See Table 4 for more detailed information about the interpretation of HIV results presented in this table.

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\(^{12}\) The Special Departments are all the men in uniform. There are five groups of men in uniform in Zanzibar: Anti-Smuggling Squad (KMKM), Economic building Brigade (JKU), Prisoner Department (MF), Fire and Rescue Services (KZU), and People’s Militia (KVZ).
Section 3: Joint Review Findings: HIV Service Delivery

This Section describes the situation in 2003, the ZNSP objectives for different HIV services (HIV prevention, care and treatment, impact mitigation services), and the gaps and challenges in the delivery of HIV services.

The Section shows that HIV service delivery has rapidly increased since 2003, and there have been at least some attempts to reach different populations. However, the communication messages have been too general and have not reached everyone with specific education messages.

Please note: Throughout this chapter, the situation analysis information for 2003 was drawn from ZAC, 2003
3.1 HIV Prevention Services in the Community

3.1.1 Situation in 2003/4

Knowledge about HIV in 2004 focused on the A and B of safe sex practices, and showed that men in Pemba were the least informed: Knowledge about HIV prevention was higher amongst females than males, and higher amongst persons in Unguja than those in Pemba. Males from Pemba were the least informed about HIV (less than 10% had comprehensive knowledge about HIV – see Table 9). There was a high level of understanding that HIV could be transmitted through breast milk and a low understanding of the use of antiretroviral treatment to reduce vertical transmission. Knowledge about the ‘A’ and ‘B’ (abstain, and be faithful) of the “ABCs of safer sex practices” message was higher than knowledge about the ‘C’ (use a condom). Yet, there were high levels of knowledge amongst the youth as to where to obtain condoms, especially amongst men in Unguja. Low levels of knowledge as to where to obtain condoms in Pemba corresponded to the significantly smaller percentages of men and women in Pemba who knew that condoms were an effective way of preventing the sexual transmission of HIV.

Table 9: Knowledge about HIV Transmission and Condom Availability in General Population in Zanzibar, 2004

<table>
<thead>
<tr>
<th></th>
<th>Unguja (percent)</th>
<th>Pemba (percent)</th>
<th>Zanzibar (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Percentage with knowledge that “Abstaining (A of ABCs)” works</td>
<td>88 F 86 M</td>
<td>81 F 30 M</td>
<td>86 F 68 M</td>
</tr>
<tr>
<td>b) Knowledge that “Be faithful - limiting oneself to one partner (B of ABCs)” works</td>
<td>89 F 70 M</td>
<td>86 F 54 M</td>
<td>88 F 70 M</td>
</tr>
<tr>
<td>c) Knowledge that “Condom use as a method of HIV prevention (C of ABCs)” works</td>
<td>67 F 43 M</td>
<td>60 F 26 M</td>
<td>65 F 37 M</td>
</tr>
<tr>
<td>d) Percentage with comprehensive HIV knowledge (correct knowledge about all three, and rejection of two misconceptions)</td>
<td>All population 47 F 30 M</td>
<td>Youth 46 F 25 M</td>
<td>All population 40 F 9 M</td>
</tr>
<tr>
<td>e) Percentage with knowledge that HIV can be transmitted through breastfeeding</td>
<td>92 F 93 M</td>
<td>88 F 84 M</td>
<td>91 F 90 M</td>
</tr>
<tr>
<td>f) Percentage with knowledge that the risk of MTCT transmission can be reduced by taking special drugs during delivery</td>
<td>43 F 32 M</td>
<td>13 F 11 M</td>
<td>33 F 11 M</td>
</tr>
<tr>
<td>g) Percentage of young persons who know of a source for male condoms</td>
<td>69 F 95 M</td>
<td>39 F 17 M</td>
<td>59 F 67 M</td>
</tr>
</tbody>
</table>

Source: NBS and ORC Macro, 2005

The high level of knowledge about abstinence has converted to behaviour change, as evidenced by the late ages of sexual debut among men and women: Women’s median age of sexual debut is 18 years, whilst men’s is 22. In 2004, just 4% women and 2% men had sex before the age of 15 (NBS and ORC Macro, 2005).

Knowledge about condoms and acceptance of condom use education was low, whilst knowledge of source of condoms was high: Only 0.3% of people in Zanzibar were using male condoms as contraceptives. As of 2005, around 65% of women and 38% of men knew that condoms were one of the ways in which HIV transmission could be prevented. However, only 19% of persons interviewed by Lugalla et al. (2007) felt that they would use a
condom to prevent HIV. Acceptance of condom use education was less than 40%, with stark differences between Pemba and Unguja.

Table 10: Support for Education About Condom Use in Zanzibar, 2004

<table>
<thead>
<tr>
<th>Percentage of adults who support education about condom use to prevent HIV</th>
<th>Unguja</th>
<th>Pemba</th>
<th>Zanzibar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>37 F</td>
<td>22 F</td>
<td>33 F</td>
</tr>
<tr>
<td>Male</td>
<td>29 M</td>
<td>49 M</td>
<td>35 M</td>
</tr>
</tbody>
</table>

Source: NBS and ORC Macro, 2005

A high number of the youth - 69% of young women and 95% of young men in Unguja - who knew in 2004 where to source a condom, despite the lack of communication about where to source them. However, in Pemba, only 40% young women and 17% young men knew where to source a condom (NBS and ORC Macro, 2005).

*Most at risk populations identified:* There was a general recognition that some sub-populations were more at risk than others, but no specific programmes were in place for them.

**Limited HIV prevention activities in the community:** As of 2003, limited HIV prevention activities took place in the community, primarily due to a health sector-driven HIV response. HIV activities in the community were implemented by a small number of NGOs and some government ministries (Ministry of Labour, Youth, Women and Children Development (MoLYWCD), Ministry of Education and Vocational Training (MoEVT) and the military) and focused on outreach VCT services, advocacy, peer education, information and education campaigns in the community, limited sexual health education in schools, limited and haphazard activities for out of school youth, and very limited focus on workplace programmes, except for two unions (Sea Men Union and Teachers Union). The most active government institution was the Military (one of nine groups of uniformed personnel in Zanzibar). Clear directives were given, condoms were part of the routine rations, and there were plans in place to commence with VCT and PMTCT at military barracks.

**Technical support for community activities:** ZACP provided technical support to the NGOs working in the field of HIV prevention, and also supported Traditional Birth Attendants (TBAs) and traditional healers.

### 3.1.2 ZNSP Objectives Designed to Address the 2003 Situation

**OVERALL OBJECTIVE:** To increase access to care and positive sexual behavioural change targeting at reducing STI/HIV infections among the vulnerable populations in Zanzibar

**SPECIFIC OBJECTIVES FOR SPECIFIC VULNERABLE POPULATIONS**

<table>
<thead>
<tr>
<th></th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) <strong>Workers and People Under Special Circumstances</strong></td>
<td>To increase STI knowledge [transmission, prevention and predisposing risks] among decision makers and people serving under special circumstances.</td>
</tr>
<tr>
<td>b) <strong>Sex Workers and their Clients</strong></td>
<td>To increase knowledge on prevention and promote positive sexual behavioural change in mitigating STI infections among Sex Workers and their clients</td>
</tr>
<tr>
<td>c) <strong>Substance Abusers</strong></td>
<td>To introduce capacity building schemes to substance abusers on knowledge and prevention of harmful consequences of Substance abuse on the transmission of STI/HIV with special focus to IDUs</td>
</tr>
<tr>
<td>d) <strong>Mobile Traders</strong></td>
<td>To reduce the risk of acquiring new STI/HIV infections among mobile traders</td>
</tr>
<tr>
<td>e) <strong>Clove Pickers and social events/gatherings</strong></td>
<td>To reduce the infection rate of STIs that may result from unsafe sex among clove pickers and other camping populations and their immediate families.</td>
</tr>
<tr>
<td>f) <strong>People with Disabilities</strong></td>
<td>To minimize new STI/HIV infection among people living with various disabilities in the society</td>
</tr>
<tr>
<td>g) <strong>Fishermen</strong></td>
<td>To increase knowledge on the prevention of STI infections to fishermen and their families at homes.</td>
</tr>
</tbody>
</table>
h) **Passengers transportation services**  
To increase STI awareness and knowledge and promote the development of workplace interventions against HIV.

i) **Out of School Youth**  
To increase knowledge and access to user friendly and gender sensitive SRH/STI services and promote life skills among out of school youths aged between 14-24 years.

j) **Married Women and House Girls**  
To increase capacity on STI/HIV knowledge and sexual negotiation skills among women and house girls.

### B: HIV Prevention in the General Population and at Workplaces

<table>
<thead>
<tr>
<th>No.</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Mainstreaming Gender and HIV</td>
<td>To address HIV in a gender sensitive and responsive manner for the prevention of new infections among men and women.</td>
</tr>
<tr>
<td>b)</td>
<td>Protection of Children</td>
<td>To reduce STI transmissions among children by protecting them from sexual abuse and early sexual contacts.</td>
</tr>
<tr>
<td>c)</td>
<td>Education Sector</td>
<td>To prevent HIV infection through advocacy at all levels of education.</td>
</tr>
<tr>
<td>d)</td>
<td>Agriculture</td>
<td>To prevent new HIV infections to farmers/peasants in rural communities.</td>
</tr>
<tr>
<td>e)</td>
<td>Promotion of Traditional, Culture and Religious Values - Faith Based Organizations (FBOs)</td>
<td>To increase HIV advocacy and effective campaign by FBOs in mitigating HIV transmission to the entire community.</td>
</tr>
<tr>
<td>f)</td>
<td>Promotion of Traditional, Culture and Religious Values – Culture</td>
<td>To promote good and sound traditional Zanzibari culture that is sensitive to fight against the spread of HIV infection and living positively with infected and affected population.</td>
</tr>
<tr>
<td>g)</td>
<td>Workers and Employer Organisations</td>
<td>To develop capacity for HIV workplace intervention campaigns on prevention, protection, care and support to the affected/and-infected workers.</td>
</tr>
<tr>
<td>h)</td>
<td>Tourism Sector</td>
<td>To mainstream HIV responses [especially cultural sensitive tourism] in the tourism sector in Zanzibar.</td>
</tr>
<tr>
<td>i)</td>
<td>Promotion of Condoms and Vaginal Microbicides</td>
<td>Increase the availability and access to quality condoms [male and females] and vaginal microbicides to the general community, with special focus on the high risk groups.</td>
</tr>
</tbody>
</table>

### 3.1.3 Situation as of May 2007

#### A: Types of community-based HIV prevention services provided

**A1: Information, Education and Communication (IEC) programmes**

*How do persons access IEC messages?* IEC programmes are proportionately as effective as the number of persons that have access to the communication media used – newspapers, radio and TV being the most prominent. As of 2004, 77% of women and 86% of men in Zanzibar were literate, 20% of households had televisions and 80% of households had radios (NBS and ORC Macro, 2005). Given this context, Table 11 below summarises men and women’s access to the media.

<table>
<thead>
<tr>
<th>Type of media</th>
<th>Unguja</th>
<th>Pemba</th>
<th>Zanzibar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of persons who read <strong>newspaper</strong> once a week</td>
<td>27 F 42 M</td>
<td>10 F 30 M</td>
<td>22 F 38 M</td>
</tr>
<tr>
<td>Percentage of persons who watch <strong>television</strong> once a week</td>
<td>49 F 66 M</td>
<td>12 F 31 M</td>
<td>38 F 54 M</td>
</tr>
<tr>
<td>Percentage of persons who listen to the <strong>radio</strong> once a week</td>
<td>90 F 89 M</td>
<td>73 F 81 M</td>
<td>85 F 86 M</td>
</tr>
</tbody>
</table>

*Source: NBS and ORC Macro, 2005*

The results presented in Table 10 were confirmed by Lugalla et al. (2007), who report that 91% of persons they surveyed accessed HIV information through the radio, 79% through television, and 41% through the newspapers. Figures 6 and 7 below show the communication channels through which men and women have accessed family planning messages. Given that family planning also involves discussion about sexuality and sexual behaviour, access to family planning messages also provides some insight into which communication channels could be effective for communicating about HIV prevention.
Clearly, the most popular form of communication is the radio, followed by live drama, posters and billboards.

_Type of IEC messages communicated:_ Messages about abstinence and being faithful have been more prominent than messages about condom use. Different faiths in Zanzibar have always promoted abstinence-until-marriage as a moral imperative and not necessarily a method of HIV prevention. The last three years saw religious leaders include the prevention of HIV transmission as an _additional_ reason for adhering to the abstinence-until-marriage lifestyle.
**IEC programmes undertaken:** ZACP’s IEC unit and the African Youth Alliance have printed and disseminated IEC materials on PMTCT, and printed and distributed other IEC materials during World AIDS Day. There is also a coordinator in ZACP that provides IEC for religious and community leaders. The Rapid Funding Envelope for HIV, Save the Children (UK) and development partners support small scale IEC projects ranging from the media training, toll-free cell phone hotline for information (TAYOA), and sensitization/stigma reduction training of imams and madrassa leaders, to IEC and impact mitigation work with women’s development CBOs and youth groups. Different faith-based groups have delivered HIV awareness messages for the youth, young parents and married women in madrassas and Sunday schools. AYA and PRAYZ have played a strong role in HIV prevention. There have been specific attempts to provide IEC programmes for people with disabilities – a number of workshops have taken place.

CVM works in all 10 districts and has trained a number of persons (7 665) since 2003 to address HIV in their communities. 79% of persons trained are active in addressing HIV on a voluntary basis.

ZAC has been involved in organizing IEC activities during significant social events such as World AIDS Day (distributed IEC materials and organized activities), Ijitimaye, Mwaka Kogwa, etc. It has also published the bi-annual Jihadhari magazine. ZAC has also undertaken a number of training programmes for the media to train them in how to report on HIV, and how the media could contribute towards HIV prevention.

**A2: Peer Education**

In Zanzibar there used to be only a few active peer educators, but the number has been steadily increasing. There are different types of peer educators – some focus on the general population, and some on specific groups such as MARPs, in-school-youth or out-of-school youth, and some are service-oriented peers.

*Peer education efforts by government:* The best-known peer educators are those working with CSWs in Stone Town.13 These peer educators visit CSWs weekly, orient them on condom use and disposal, distribute IEC materials, train them on Sexually Transmitted Infections (STIs), and distribute condoms. Three ministries have trained peer educators in place: the Ministry of Tourism, Trade and Investment (MoTTI), MoALE, and MoRASD. ZAC recently conducted training-of-trainers in peer education for Ministry HIV Focal Persons.

*Peer education by civil society:* A number of CSOs, including ZANGOC, ZAYADESA and ZAIADA, have peer education programmes that provide HIV awareness for the general public and youth.

**A3: Condom promotion and distribution**

*Promotion of condom access points:* Condom promotion is low, and strong cultural opposition to condoms remains: Population Services International (PSI) Tanzania (a condom social marketing agency), for example, have not been allowed to use billboards, promotional materials or stickers to inform the public about condom sales points.

*Condom ‘promotion’ for discordant couples by religious leaders:* In the last three years, the FBOs’ capacity has been built to engage in discussions around AIDS. Instead of being completely opposed to any kind of condom promotion, religious leaders of the Muslim faith in Zanzibar now promote condom use amongst discordant couples.

*Condom distribution and promotion in the general public:* Condoms are not readily available in Zanzibar, but more limited in Pemba than Unguja. Government does not actively support their distribution and a condom policy has not yet been developed. One of the two political parties promotes individual condom use, but not condom distribution – “where one accesses it, is a private matter”. Condom distribution is *medicalised*, meaning that distribution is primarily through health facilities as a family planning measure. Condoms are also available at

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13 ZACP took over this programme with funding from the Clinton Foundation on HIV and AIDS (CHAI) in 2006 after Medicos Del Mundo (MDM) ceased to exist in March 2006.
a small number of NGOs and pharmacies in urban centres – recently, flavoured condoms have become available at a lower price. Development partners have assisted in procuring, storing and distributing condoms.

Demand for condoms: Despite the limited communication efforts, there is a strong demand for condoms, as proven by these selective distribution figures: MDM procured over 7,6 million condoms for the 2005/6 financial year. Since taking over the CSW peer education programme in Sept 2006, ZACP has distributed almost 39,000 condoms.

A4: HIV Workplace Programmes

How many people in Zanzibar are employed and what work do they do? Table 12 presents data on employment - it shows that more men than women are employed and that there is a great deal of manual labour and persons involved in agriculture.

Table 12: Employment Status and Type of Employment in Zanzibar, 2005

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Unguja (percent)</th>
<th>Pemba (percent)</th>
<th>Zanzibar (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women unemployed in the last 12 months</td>
<td>57</td>
<td>41</td>
<td>46</td>
</tr>
<tr>
<td>Men unemployed in the last 12 months</td>
<td>31</td>
<td>37</td>
<td>33</td>
</tr>
<tr>
<td>Employed persons involved in skilled or unskilled manual labour (e.g. fishing, clove picking, and others)</td>
<td>83 F 44 M</td>
<td>47 F 26 M</td>
<td>30 F 39 M</td>
</tr>
<tr>
<td>Employed persons involved in agriculture</td>
<td>31 F 27 M</td>
<td>61 F 58 M</td>
<td>38 F 36 M</td>
</tr>
</tbody>
</table>

Source: NBS and ORC Macro, 2005

Of all the women surveyed who were employed in agriculture (in mainland and Zanzibar), 92% are employed by family members, 83% of the agriculture sector work is seasonal work, and 78% of the agricultural work is unpaid work. In terms of non-agricultural work, 42% are self-employed.

Need for workplace programmes: Workplace programmes can be an efficient and effective way to deliver services, and some people see a need for them. HR Consult (2007:iii) stated that 48% of participants responded that “discriminatory attitudes [towards PLHIV] could be curbed mainly through more HIV education in the workplace”.

Current extent of workplace programmes: In the public sector, Ministries were trained in HIV workplace programmes with SIPAA funding, and now have workplace programme action plans, with funding from the World Bank to implement them. ZACP has assisted in implementing workplace programmes in the public sector and for unions. HIV is currently being mainstreamed into the General Orders of government. CSOs do not yet have workplace programmes in place. Also, most private sector institutions have not been proactive in addressing HIV at the workplaces, with the exception of a few organisations – see Table 13.

Table 13: Status of Private Sector Workplace Programmes in Zanzibar, 2006

<table>
<thead>
<tr>
<th>Company</th>
<th>Workplace HIV policy</th>
<th>Awareness education</th>
<th>VCT</th>
<th>Care and Treatment</th>
<th>Community outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serena Hotel</td>
<td>None</td>
<td>Done</td>
<td>In place</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>State Fuel &amp; Power Corporation</td>
<td>In development</td>
<td>Done</td>
<td>Done</td>
<td>In place</td>
<td>None</td>
</tr>
<tr>
<td>Tanzania Posts Corporation (Zanzibar)</td>
<td>In place</td>
<td>Done</td>
<td>Done</td>
<td>In place</td>
<td>None</td>
</tr>
</tbody>
</table>

Source: Adapted from Sikira and Kabyemera, 2006

A5: HIV Prevention for out-of-school youth

Youth centres to reach out-of-school youth: Some youth centres are run by CSOs, some by FBOs and others by government – nine in total. Centres mobilize young people aged 13 – 24 to become centre members. They have different HIV interventions for their members, including music entertainment, education, helping with design
of appropriate messages, and discussion sessions with opinion leaders. District governments also support youth centers, which sometimes double-up as mini library and/or information centers. Some FBOs have youth centers in their churches. Some GF sub-recipients also focus on providing youth friendly services.

Success of youth centres: The centres have been successful in providing a forum for young people to meet, discuss and find solutions around the public health challenges they face.

A6: HIV prevention for in-school youth

MoEVT has developed a curriculum, approved by religious authorities and the MoEVT, for middle and secondary schools. Despite this being available, a recent impact assessment in the education sector has shown that HIV is not routinely taught at either primary or high school level (HR Consult, 2007). Most of the HIV prevention work in schools take place through Anti-AIDS clubs, which aim to disseminate scientifically correct information about HIV to in-school youth. Most schools have established clubs – some are active (meet on a regular basis), others are not.

A7: Pre-marital voluntary HIV counselling and testing

This is an example of a good practice that developed locally in Zanzibar, provided that it takes place ethically, confidentially and that it does not increase stigma and discrimination. In just three years, religious leaders have advocated strongly for pre-marital HIV testing – it has now become a norm. Although the practice is not mandatory, communities have come to expect couples who plan to marry to undergo HIV testing. Mothers play a strong role in promoting the practice. Women in polygamous marriages embrace the practice. This data is confirmed by recent VCT statistics from ZACP: in 2005, 37% of VCT clients were married, and 48% had never been married (ZACP, 2006).

A8: HIV prevention for Substance Users (‘demand, supply and harm reduction programmes’)

Extent of efforts in Zanzibar: Substance use is illegal in Zanzibar. Nevertheless, the number of substance users is increasing (Dahoma et al., 2006).

DSAPR coordinates Zanzibar’s efforts for this MARP. Up to this review, efforts have focused on demand and supply reduction and not on harm reduction (see Box). This is expected to change in future. MoHSW has recently developed an integrated Substance Use and HIV Strategic Plan that will cover the entire gamut of HIV prevention, care and treatment services, and substance use care services to be offered to substance users.

- Demand Reduction: The focus in Zanzibar has been on education to prevent substance use and on counselling persons who are already involved in it to quit. Education has been done through NGOs (ZAYADESA), a resource centre focusing on substance use (Zanzibar Association of Information Against Drug Abuse and Alcohol (ZAIADA)), and religious leaders. A rehabilitation centre is also being built.

- Supply Reduction: The Police (anti-narcotics squad) are responsible for supply reduction. Stakeholders felt that the drug policing strategy is inconsistent in its implementation: it seems to focus on punishing substance users, while those who traffic drugs can buy protection from officials in the Department.

Definition of a comprehensive programme for substance users

A comprehensive programme would consist of the following three components: Demand reduction refers to efforts to prevent initiation of substance use, and efforts to assist those already involved in substance use, to end their involvement in it. Supply reduction refers to efforts by law enforcement agencies to reduce access to substances. Harm reduction efforts involve support and care for those who are active substance users, with the main aim of preventing HIV infection whilst using and/or injecting drugs. Harm reduction efforts include preventing sexual transmission of HIV during substance use, and preventing transmission of HIV through needle sharing, flash blood or other practices.
3.2 CONCLUSIONS: HIV PREVENTION SERVICES IN THE COMMUNITY

3.2.1 Relevance, Comprehensiveness & Scale of Community-based HIV Prevention

Relevance of HIV prevention services in the community
There are more prevention efforts in the community in 2007 than in 2004, and the messages communicated are partially relevant because they focus primarily on creating awareness and on the sexual transmission of HIV. However, not all MARPs are reached – the focus seems to be on creating awareness that ‘there is HIV’ (which is already high at 99.8% (NBS and ORC Macro, 2005)). Also, HIV prevention efforts are not linked to substance use prevention (particularly for the youth) or to income-generating activities for the youth and are therefore not relevant to all the drivers of the epidemic.

Comprehensiveness of HIV prevention services in the community
HIV prevention is more extensive than in 2003, but still not fully comprehensive – for seven reasons. First, although the ZNSP stipulates clearly which populations should be targeted, not all MARPs defined in the ZNSP are targeted (prisoners, seasonal workers and persons involved in the transportation sector). There are also some new MARPs that still need to be targeted (e.g., tourism sector employees). Second, HIV prevention efforts in the community have primarily focused on creating awareness about HIV, and not on the HIV prevention services for MARPs and the general population defined in the ZNSP. For example, many of the women interviewed in an education sector impact assessment had never seen a male or female condom or had its use demonstrated (HR Consult, 2007). Third, all available communication media have not been used extensively – e.g., the radio (the most accessible form of mass communication) has not been used. Fourth, there are no programmes to address gender imbalances and efforts to ensure the quality of HIV prevention efforts have only just commenced. Fifth, the issue of positive prevention – prevention of re-infection by HIV-positive persons, was not addressed at all. Sixth, the data show clearly that knowledge levels in Pemba are significantly lower and access to services more restricted than in Unguja. This indicates that more effort is required in Pemba. Seventh, workplace programmes have not adequately covered trade unions, the informal sector or private sector.

Scale of HIV prevention services in the community
More persons than in 2003 have been reached with HIV prevention efforts in the community and more institutions from all sectors (civil society, the public sector, and higher learning institutions) are involved in HIV prevention efforts (see Table 32 in Annex F for a summary of HIV prevention efforts to different populations). There are 242 Civil Society Organisations (CSOs) based in Unguja and 137 based in Pemba working in all aspects of development; many of these CSOs provide HIV prevention services to different segments of the population. Almost all CSOs, even those who implement programmes unrelated to HIV, incorporate HIV prevention education in their programmes, which has enabled more people to be reached with HIV information. There is therefore some level of scale-up, but more needs to be done. Only 38 out of 294 shehias reported HIV prevention activities, suggesting that there is a rural/urban divide in access to services.

3.2.2 Achievement of ZNSP Objectives in Terms of HIV Prevention in Communities

There is progress towards the ZNSP objectives for HIV prevention in MARPs and the general population. The only HIV response activity that was not listed as a ZNSP strategy was pre-marital HIV testing. There is, however, a need to focus on (a) the sensitive, practical education that is needed when doing HIV prevention and (b) on reaching the hard-to-reach geographic areas and hidden MARPs, as the ZNSP design originally intended.

3.2.3 Specific Challenges and Gaps in 2007

Increased knowledge has led not to changes in behaviour: HIV prevention efforts have not resulted in measured behaviour change in the general population, and not enough is known about higher risk behaviour amongst MARPs.
HIV prevention messages are targeted mainly at the general population in urban areas, do not provide practical information, and are delivered through too-narrow communication channels.

(a) HIV prevention target mainly the general population in urban areas. As Table 29 illustrates, most programmes focus on the general population, instead of on MARPs (not only the hidden MARPs, but also the non-hidden MARPs such as prisoners, fishermen, house girls, clove pickers, etc.). Furthermore, new vulnerable populations emerged even during this review have also not been targeted. Interventions are also urban-biased. Even within urban areas, HIV prevention messages are not always available at places of entertainment (from where high risk sexual behaviour originates).

(b) HIV prevention messages are too general, do not provide practical information and does not cover all information that needs to be conveyed. What HIV prevention programmes have achieved to date is to create universal awareness that ‘there is HIV in Zanzibar’. However, knowledge levels amongst the general population are not comprehensive (only 45% women and 23% men had knew the three ways in which the sexual transmission of HIV could be stopped and reject two main misconceptions about HIV (NBS and ORC Macro, 2005), and little is known about levels of appropriate knowledge amongst MARPs. The messages themselves are also general, without providing practical education and know-how and without addressing some of the sensitive messages or practical information (e.g. demonstrating how a condom works). Messages conveyed only focus on the sexual prevention of HIV and do not address other drivers, such as substance use among the youth. Also, the promotion of pre-marital testing for HIV has not been accompanied by messages emphasizing that it should be done ethically, confidentially, voluntarily, that the final choice rests with the couple and that couples should be referred if one or both test positive.

(c) The mechanisms/channels used for the communication are not comprehensive. Disabled persons not only need specific messages and focus due to their increased vulnerability, they also need special mechanisms – e.g. Braille machines – to be able to access the communications messages. Currently, there is only one teacher for blind people in Zanzibar. The radio is not used, and persons with special needs (e.g. the deaf) have not been reached with education programmes.

Lack of regular supply of male and female condoms. In particular, it is those persons who need condoms the most – CSWs, MSM, IDUs (the hidden populations) – who have the most problems accessing condoms.

Mechanisms to reach youth are one-dimensional and not well coordinated. Anti-AIDS clubs for in-school youth and youth centres for out of school youth are the main mechanisms used to reach the youth. These efforts are not comprehensive, not well coordinated, and not linked with income generating activities for the youth.

Workplace HIV programmes have not been implemented in all sectors, do not focus on the informal sector (although most people are employed informally) and only address internal mainstreaming (that is, the workforce, but not clients).

IDUs cannot access the equipment that they need to prevent HIV infection. Integrated supply, demand and harm reduction efforts have not been implemented. Pharmacies refuse to sell syringes to drug users, which limits IDUs’ ability to acquire sterile injection paraphernalia. This makes it much harder for IDUs to protect themselves against HIV infection.

Gender imbalances in society limit women’s access to HIV prevention services. Although women have more comprehensive knowledge than men, they cannot access the HIV prevention services that they need or negotiate safer sex practices.
3.3 HIV Prevention Services Provided at Health Facilities

3.3.1 Situation in 2003

Up to 2003, the focus was more on HIV prevention at health facilities than on activities at the community level. Specifically, the following activities were being implemented:

**Condom distribution at health facilities**: MDM and UNFPA supported free condom promotion and distribution through health facilities for the explicit purpose of HIV prevention, as well as to uniformed personnel, and during special community mobilization events. Condoms were also available at family planning clinics and MCH clinics as a family planning method.

**Blood safety and universal precautions**: Blood safety guidelines were updated, and training was done. Reagents were still not regularly available, and quality control by the national reference laboratory faced capacity challenges. The use of sterile equipment at health facilities (including private facilities and by traditional birth attendants) was promoted, but regular supply of needles and syringes was problematic in 2003. However, in 2004, of the 20% females and 14% males who had received an injection from a health worker in the previous 6 months, 99% witnessed the injection, syringe and needle taken from a newly opened package (NBS and ORC Macro, 2005).

**Prevention of Mother to Child Transmission (PMTCT)**: A PMTCT formative study had been undertaken, but PMTCT services were not yet in place. In 2004, 18% of pregnant women in Zanzibar received HIV counseling during antenatal care (25% in Unguja, 8% in Pemba); 4% of pregnant women (5% in Unguja, 1% in Pemba) were counseled, offered and accepted an HIV test and received their HIV test results (NBS and ORC Macro, 2005).

**VCT at health facilities**: VCT was being provided as part of STI services at some STI clinics; each hospital had at least one counselor in place, but the service was not “youth friendly” and there were shortages of equipment and resources. Cost was a prohibiting factor – test kits were expensive. Planning for VCT in the districts had begun, and some VCT services were offered in private facilities (1,568 persons accessed VCT in private facilities in the 2001–2002 period, with an HIV prevalence of 10.3%).

**STI control and treatment**: Only 0.3% of women and 0.7% of men indicated that they had an STI (NBS and ORC Macro, 2005). STI treatment was revived at 26 health facilities, and training on syndromic management initiated, but limited education materials were produced.

**Integrated HIV prevention programme at Tanzania People’s Defense Force (TPDF) sites were planned**: These efforts included VCT services, PMTCT, and an STI clinic.

3.3.2 ZNSP Objectives Designed to Address the 2003 Situation

**Overall objective**: To increase access to comprehensive services for HIV prevention, treatment, continuum of quality of care and support to infected/affected people.

3.3.3 HIV Objectives in the Zanzibar Health Sector HIV Strategy Plan (HSSP)

Shortly after the ZNSP was launched, an HIV strategic plan for the health sector (HSSP) was developed for the period 2005/6-2010/11. The HSSP details the health sector’s HIV prevention, care and treatment, and support strategies, as well as management structures. Priority Area 1 of the HSSP deals with HIV prevention. It focuses on six goals, each with a number of HIV prevention objectives, as summarized in Table 14 below.
### Table 14: HSSP Goals and Objectives for HIV Prevention in Zanzibar

<table>
<thead>
<tr>
<th>GOAL AND TARGET</th>
<th>HIV PREVENTION OBJECTIVES</th>
</tr>
</thead>
</table>
| **Goal 1**: Reduce the incidence of HIV transmission through unsafe sex practices  
**Target 1**: Reduce new HIV infections through sexual encounters by 50% | Promote safe sex practices  
Extend HIV prevention interventions to the workplace  
Increase access to and the use of condoms (male & female) and vaginal microbicides |
| **Goal 2**: Reduce HIV transmission through unsafe blood transfusion  
**Target 2**: Reduce new HIV infections through blood transfusions by 90% | Provide a safe blood transfusion service |
| **Goal 3**: Reduce vertical HIV transmission and improve care for infected partners  
**Target 3**: Reduce new HIV infections through sexual encounters by 60% | Provide prevention services to eligible expectant mothers (PMTCT program) |
| **Goal 4**: Reduce needle sharing amongst IDUs | Reduce needle sharing amongst IDUs |
| **Goal 5**: Improve STI control  
**Target 5**: All STI cases to be managed syndromically in Zanzibar | Promote the syndromic management of STI patients in the public sector  
Promote the syndromic management of STI patients in the private sector  
Collaborate with traditional healers on STI care  
Make all STI clinics youth friendly |
| **Goal 6**: Reduce HIV transmission post exposure to sexual assault, needle prick injury and unsafe waste disposal  
**Target 6**: All reported cases of needle prick injury and other occupational exposure to HIV as well as sexual assault to be promptly given prophylaxis | Provide HIV prophylaxis post exposure to needle prick injury and other occupational hazards  
Provide HIV prophylaxis post exposure to sexual assault  
Strengthen waste disposal in all district |

**Source**: ZACP, 2006

HIV Prevention Goal 4 of the HSSP is to “Reduce needle sharing among IDUs in Zanzibar”, but the high HIV prevalence amongst IDUs prompted the government to develop a more detailed Substance Use HIV Strategic Plan (SU-HISP) for the period 2007 – 2011. The strategies listed in the SU-HISP override Goal 4 of the HSSP.

#### 3.3.4 Health Sector Infrastructure as of 2005

To review HIV prevention services in the health sector in Zanzibar, it is necessary to understand the distribution of health sector services – see Table 15 below. The health infrastructure ensure that the majority of people in Zanzibar live within 10 kilometers of health care facility (ZACP, 2005).

<table>
<thead>
<tr>
<th>Type of facility and number</th>
<th>Bed capacity and location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Mnazi Mmoja National hospital</td>
<td>Referral facility in Zanzibar</td>
</tr>
</tbody>
</table>
| 4 District hospitals (80-120 beds each)  
2 Special hospitals (Mwembeladu Maternity home (34 beds) & Kidongo Chekundu Mental hospital (135 beds))  
4 Primary health care centres (PHCCs) (30 bed capacity each, 2 in Unguja and 2 in Pemba) | 66 in Unguja and 57 in Pemba |

**Source**: ZACP, 2005
3.3.5 Situation as of May 2007

A: Types of HIV prevention services provided at health facilities

A1: Condom Procurement and Distribution (Goal 1)

Condom procurement and quality control: The condom procurement system is still weak. MDM procured a stock of condoms, which were depleted in Feb 2007. The Clinton Foundation on HIV and AIDS (CHAI) is now providing financial support for procurement of condoms for health facilities; female condoms are not available and therefore not in use. There is no quality assurance testing of condoms.

Condom distribution and routine monitoring: An evidence-based and culturally-sensitive condom distribution, promotion and use strategy has not yet been developed. However, free condoms are distributed at major hospitals through mother and child health (MCH) clinics. These condoms are intended for family planning purposes rather than for STI and HIV prevention (although their use will help prevent infection). Condom distribution at health facilities is routinely monitored as it is included in the health sector indicator list. Condoms are not available in rural areas, and it is hard for the youth to access condoms.

A2: Safe blood supply (Goal 2)

Improved screening for replacement blood donor system: As in 2003, blood transfusion using the replacement blood donor system is still being done at all public hospitals and a few private hospitals (e.g. Al-Rahma). In the past four years, a system has been put in place to screen the replacement donor for HIV, HBV, HCV and syphilis prior to transfusion. The safety of blood and blood products in this system therefore depends on the quality of the laboratory services in the hospital. Mostly, it is men who provide replacement blood – the 2005 VCT results confirm that 1775 men (13% of all VCT patients) and only 9 women attended VCT for the purpose of participating in the blood replacement system.

Initiation of blood transfusion services in Zanzibar: A national blood transfusion policy guideline has been developed; a national blood bank established at the national referral hospital (this is meant to eventually replace the replacement donor system); the promotion of volunteers for blood donations has been initiated; health care workers’ capacity on blood transfusion services improved through training some of them as technicians, phlebotomists, recruiters (2) and a counselor. All donated blood are screened for HIV, HCV, HBV and Syphilis. The blood bank services are only available at the national referral hospital and cannot yet provide stock to other sites.

A3: PMTCT (Goal 3)

Health seeking behaviour of pregnant women: Most pregnant women access ANC (only 0.7% did not access it in 2005), have had 4 or more antenatal visits, and were attended to during delivery by a nurse (48%), a trained birth attendant (22%) or a TBA (21%). Only 1.9% of women in Zanzibar delivered by C-section, and only 1.7% of women in Tanzania (data for Zanzibar only not available) exclusively breastfeed up to age 6 months. After delivery, 92% of women have no postnatal follow-up (NBS and ORC Macro, 2005).

Initiation of PMTCT services: After the PMTCT formative study, PMTCT trainer manuals, participant manuals and pocket guides were developed in June 2006, and guidelines on PMTCT service delivery in October 2006 (Guidelines focus on: Integration with reproductive and child health, Testing and counseling, Standards for ARV prophylaxis and treatment, Continuum of care & treatment, Infant feeding, Stigma and discrimination, Safe and supportive care in the work setting, and PMTCT programme monitoring).
Staff has been trained on PMTCT (90 health care workers, 10 lab staff, 9 clinicians, 71 nurses, 46 staff from new sites & 44 staff from existing sites, and 479 HCWs). ZACP prepared radio announcements, television announcements, developed brochures and posters to communicate information about the importance of PMTCT.

**Number of PMTCT sites and demand for the service:** PMTCT services commenced in 2005. There is high uptake of PMTCT services in RCH clinics (98%) and high acceptance of PMTCT services by clients (99%). By March 2006, 4 012 pregnant women (70% of ANC clients at the three sites) had accessed PMTCT services at three sites with 1.8% HIV positive. By March 2007, 9 553 pregnant women (99% of ANC clients at the six sites) accessed PMTCT at six sites, with 1.3% HIV positive. All HIV positive women at PMTCT sites were referred to Care and Treatment Clinics (ZAC, 2007).

**PMTCT service coverage:** There is an improvement of uptake of PMTCT services in maternity wards (From 5% in 2006 to 14% in 2007). Table 33 in Annex G and data provided by ZACP in 2007 shows that:

a) Although it is routinely offered, only 3% of male partners of ANC clinic attendees who had an HIV test in 2006, were tested for HIV as well.

b) 1.6% of pregnant women who were tested for HIV in 2006 at the six PMTCT sites, were HIV positive.

c) Except for 9 patients in Marie Stopes centre, all other patients who were counseled, received the test.

d) 98% of new ANC attendees at sites that offered PMTCT in 2006 received HIV counseling (compared with 2004 when only 18% of pregnant women received HIV counseling).

e) The increase in the number of PMTCT sites, accompanying capacity building and IEC has led to an increased in the PMTCT coverage - from 0% in 2004, to 3.5% in 2005 when PMTCT started (NBS and ORC Macro, 2005), to 20% of all pregnant women in 2007 (ZACP, 2006).

f) 78% of pregnant women who delivered at hospitals were given Nevirapine in 2006 (n=32), compared with 71% of HIV positive women in 2007 (n=73) (ZACP, 2007).

**A4: Harm, Supply and Demand Reduction (Goal 4)**

*Development of Strategic Plan for HIV-substance use:* No specific strategies have been put in place to reduce needle sharing amongst injecting drug users. However, a Substance Use and HIV Strategic Plan (SU-HISP) was developed in January 2007. The goal of SU-HISP is to reduce new HIV/STI infections by 50% by 2011, and to provide treatment, care and support to substance users with special focus on IDU and their affected families. Kindly see Annex H for more details regarding this strategy.

*Implementation of SU-HSIP:* Resources to implement the strategy has been mobilised through the Global Fund Round 6. UNDP has supported capacity enhancement of the DSAPR. A site has also been identified for a detoxification centre – as funds for it has been mobilized.

**A5: VCT (Goal 5)**

*Number of VCT sites:* In 2004 there were 12 VCT sites. By June 2007, there were 27 functional VCT sites in Zanzibar. The public sites were supported up to March 2006 by MDM. There is an uneven distribution of VCT sites in the country. Most sites are located in urban/peri-urban settings and are stand-alone sites. VCT outreach services have also been undertaken by the Zanzibar NGO Coalition (ZANGOC) in collaboration with the MDM mobile van (during festivals and other popular events).

*Provider-initiated testing:* Guidelines for HIV counseling and testing and a training manual for HCWs were developed in December 2006 (and includes provider-initiated testing)
Demand for VCT and knowledge of HIV status: Demand for VCT services is growing, particularly as a result of the promotion of pre-marital testing. Data from the MoHSW indicate that the number of clients who accessed the services increased rapidly from just over 1,500 in 2001 to 13,577 in 2004 and 13,817 in 2005. HIV positive cases at VCT sites increased from 180/year to 690/year (ZAC, 2006). By 2004, 9% of women (11% Unguja; 4% Pemba) and 19% of men (18% Unguja; 21% Pemba) knew their HIV status (NBS and ORC Macro, 2005). The increase in VCT service uptake is illustrated in Figure 9.

The data about VCT update should be balanced by the 2007 survey data showing that 53% of interviewees in a tourism sector study thought that people at workplaces were willing to undergo VCT to “a large extent” (Lugalla et al., 2007:50). HR Consult (2007:iii, draft) reported that in a study of the education sector, “the majority of the respondents had not gone for voluntary HIV testing (61%) but they were ready to take it (56%) mainly in hospitals (57%). Individuals could be encouraged to take an HIV test mainly by having assurance of availability of ARVs in case one is found HIV positive (35%)”.

Accessing VCT by females and VCT service coverage: Data from ZACP show that in 2005, 48% of those tested in Unguja and 40% of those tested in Pemba were female (ZACP, 2005). In terms of geographic coverage, Table 16 below provides data on the number of VCT clients per 10,000 district-population. This table shows significant variances in VCT service coverage in different districts:

- In 2005, the number of people who used VCT services in Pemba and Unguja was about proportionate to their shares of the Zanzibari population (66% of 2005 VCT clients were from Unguja, and about two-thirds of the population of Zanzibar live on Unguja island);
- Micheweni had the most rapid increase, from 16 VCT clients tested for HIV per 10,000 district-population in 2003 to 257 in 2005;
- VCT-based HIV test numbers fell in Wete and North A and North B districts between 2004 and 2005;
- There was a 50% increase from 2003 to 2004 and then a sharp reduction in 2005 in Urban district;
- There was a dramatic increase from 76 to 753 HIV tests per 10,000 district population in South district; and

Table 16: Clients Tested for HIV at VCT sites per 10,000 district-population in Zanzibar, 2003 to 2005

<table>
<thead>
<tr>
<th>District</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>People Tested</td>
<td>District population¹⁶</td>
<td>HIV tests per 10,000 population</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unguja</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>348</td>
<td>63,826</td>
<td>55</td>
</tr>
<tr>
<td>North 'A'</td>
<td>671</td>
<td>86,167</td>
<td>78</td>
</tr>
<tr>
<td>North 'B'</td>
<td>300</td>
<td>53,752</td>
<td>56</td>
</tr>
</tbody>
</table>

¹⁶ The annual district population was calculated by using the district population in the 2002 census and by applying to it the Annual Average Intercensal Growth Rate for 1988-2002 Censuses

Figure 9: VCT Service Uptake in Zanzibar, 2001 – 2005

Sources: ZAC, 2003; ZACP, 2006
### Section 3

<table>
<thead>
<tr>
<th>District</th>
<th>2003 People Tested</th>
<th>2003 Population</th>
<th>2003 HIV tests per 10 000 population</th>
<th>2004 People Tested</th>
<th>2004 Population</th>
<th>2004 HIV tests per 10 000 population</th>
<th>2005 People Tested</th>
<th>2005 Population</th>
<th>2005 HIV tests per 10 000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>South</td>
<td>251</td>
<td>33 351</td>
<td>76</td>
<td>311</td>
<td>34 919</td>
<td>90</td>
<td>2 751</td>
<td>36 561</td>
<td>753</td>
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<tr>
<td>Urban</td>
<td>3 044</td>
<td>209 782</td>
<td>146</td>
<td>4 545</td>
<td>213 768</td>
<td>213</td>
<td>1 071</td>
<td>217 830</td>
<td>50</td>
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<tr>
<td>West</td>
<td>2 705</td>
<td>201 151</td>
<td>135</td>
<td>2 484</td>
<td>219 657</td>
<td>114</td>
<td>2 385</td>
<td>239 866</td>
<td>100</td>
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<tr>
<td>Pemba</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chake Chake</td>
<td>1 164</td>
<td>84 907</td>
<td>138</td>
<td>1 718</td>
<td>86 860</td>
<td>198</td>
<td>2 279</td>
<td>88 858</td>
<td>257</td>
</tr>
<tr>
<td>Micheweni</td>
<td>132</td>
<td>85 098</td>
<td>16</td>
<td>656</td>
<td>86 971</td>
<td>76</td>
<td>1 945</td>
<td>88 885</td>
<td>219</td>
</tr>
<tr>
<td>Mkoani</td>
<td>533</td>
<td>94 508</td>
<td>57</td>
<td>963</td>
<td>96 588</td>
<td>100</td>
<td>973</td>
<td>98 713</td>
<td>99</td>
</tr>
<tr>
<td>Wete</td>
<td>633</td>
<td>104 204</td>
<td>61</td>
<td>1 338</td>
<td>106 393</td>
<td>126</td>
<td>1 166</td>
<td>108 628</td>
<td>108</td>
</tr>
</tbody>
</table>

**Sources:** Calculated by author from data supplied by the Zanzibar Office of the Chief Statistician General, 2002; ZACP, 2006

### A5: STI Control (Goal 5)

**Number of STI clinics:** From 2002-2006, MDM played a central role in supporting the control and management of STIs in Zanzibar. The number of STI sites in Zanzibar has almost doubled from 26 in 2004 to 45 in 2006 and as of 2007, STI services are available in 60 health facilities in Zanzibar.

**STI treatment guidelines, capacity building and IEC:** Zanzibar uses Tanzania mainland’s STI syndromic management guidelines, which were printed and distributed to all health facilities offering STI services. Staff at PHCUs and both public and private hospitals have been trained in the syndromic management of STIs. ZACP has used the radio, television and other media to run IEC programmes about STIs and to promote early treatment seeking behaviour.

**STI service delivery and service coverage:** ZACP has distributed STI drugs, HIV test kits and condoms to all STI clinics, and have started to collect STI data as part of the HMIS. Youth-friendly service has been established by NGOs, whilst some operate as part of youth-friendly reproductive health services for the youth. Supervision of STI sites has commenced. On average, 600 newly diagnosed STI clients are treated per month; around 60% of STI clients are married couples (ZAC, 2006). It was estimated in 2006 that 50% percent of patients with STIs are treated using syndromic management STI guidelines, compared with the target of 100%. Traditional healers have also been briefed on the need to refer STI patients that they cannot manage.

### A6: Universal Precautions and PEP (Goal 6)

**Availability of equipment ('protective gear') for universal precautions:** It was reported that the availability of equipment for universal precautions (gloves, adequate supply of needles and syringes, aprons) has improved in the four hospitals in Zanzibar in the last three years. Coverage is 100% in Mnazi Mmoja hospital, and has just started in Chake Chake. Other health facilities do not yet have universal precaution programmes in place.

**Capacity building for preventing nosocomial transmission of HIV**\(^{17}\): Mnazi Mmoja hospital and Chake Chake hospital are pilot hospitals for implementation of a health facilities protective gear project, supported by John Snow International. The project has trained over 110 health workers on preventing nosocomial infections, waste management and post exposure prophylaxis. IEC materials have also been developed and are available at hospitals.

**Post Exposure Prophylaxis (PEP)**\(^{18}\): PEP guidelines (Prevention of Exposure to Blood Borne Pathogens and Post Exposure Prophylaxis), a facilitator’s guide and a training manual were developed late in 2006 for use in all

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\(^{17}\) Nosocomial transmission refers to the transmission of HIV in hospital settings, through exposure with infected blood. It can be avoided by implementing universal precautions and making protective gear available in all health care settings

\(^{18}\) PEP involves providing a person who has been accidentally exposed to HIV positive blood accidentally in a health care setting with antiretrovirals to prevent primary infection taking place. If primary infection does not take place, the person will not become HIV positive
health facilities. Pilot training programmes are planned for 2007. PEP guidelines for use after sexual assault were developed with support from CHAI, and some clinicians have been trained.

*Medical waste disposal:* Incinerators\(^\text{19}\) are available at Mnazi Mmoja, Makunduchi and Bububu hospitals, but not any other sites. Some education of health attendants have been done, but coverage is not 100%.

### 3.4 CONCLUSIONS: HIV PREVENTION AT HEALTH FACILITIES

#### 3.4.1 Relevance, comprehensiveness and scale of HIV prevention services provided at health facilities

**Relevance of medical services provided**

Medical HIV prevention services provided at health facilities in Zanzibar are relevant to the HIV response in general as they are based on evidence that condoms are effective in responding to HIV (WHO, UNAIDS and UNFPA, 2004), that HIV is transmitted through contact with infected blood and that unprotected contact with blood or open wounds needs to be avoided (CDC, 1986), that PMTCT services reduce transmission from mother to child (Cochrane, 2004), that knowing one is HIV positive leads to a positive change in behaviour (Merson et al., 2000), and that controlling STI infections is a successful measure to control HIV infections in low prevalence or concentrated epidemics (Orroth et al., 2003). However, one needs to consider the prioritization of HIV prevention services at health facilities in Zanzibar, given the Zanzibari context of an epidemic with a number of MARPs who need services specific to their situations.

New research is prompting reconsideration of two services – PMTCT and VCT:

- **PMTCT:** New research (see *Annex I* for the details) prompted a WHO consensus statement issued late in 2006 that exclusive breastfeeding for the first six months and then full weaning offers the best protection against MTCT and other infant illnesses unless replacement feeding is acceptable, feasible, affordable, sustainable and safe. (It is important that breastfeeding during the first six months be exclusive, and not mixed with solids or other liquids. Mixed feeding carries a double risk of HIV transmission and other illnesses.) The transmission risk through breastfeeding is greatly reduced if the mother is on HAART. This presents two challenging realities for Zanzibar’s PMTCT programme - 91% of persons in Zanzibar indicated that HIV can be transmitted through breast milk (a message that we now know needs to be more nuanced) and less than 2% of Tanzanian women breastfeed exclusively up to six months, which implies that not all PMTCT education currently undertaken is relevant and that communication messages need to change.

- **VCT:** Studies in Africa have shown that the behavioural changes brought about by VCT are most pronounced amongst HIV positive individuals and amongst discordant couples (Merson et al., 2000). New research evidence (see *Annex J*) suggests that VCT services, and in particular the rapid testing methodology, may not be helpful for HIV prevention efforts, especially in low prevalence settings where the rapid testing method actually may lead to increases in high risk behaviour amongst persons who test negative. Given these results, the resource constraints in HIV in the health sector, the high levels of stigma, and the high operating costs for VCT sites, innovative changes to the ‘know your HIV status’ efforts are needed. If these research findings are valid, they underline the need to intensify preventive measures among those testing HIV negative through interventions such as peer education and consistent condom use in risky sexual encounters.

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\(^{19}\) Incinerators are devices used to dispose of (usually through burning) medical waste
Comprehensiveness of HIV prevention services provided at health facilities

Most of the HIV prevention services found at health facilities in other countries are being implemented in some form in Zanzibar – universal precautions and safe blood supply, condom distribution, PMTCT, STI treatment, and VCT. Not many other African countries have harm reduction programmes. The only two types of HIV prevention services typically provided at health facilities in other countries that are not provided in Zanzibar are provider-initiated HIV testing and IDU-friendly HIV services (including services such as methadone treatment\textsuperscript{20}, relevant HIV education, VCT, PMTCT and STI services in an environment that is safe and open for IDUs without fear of prosecution).

Services to MARPs are not comprehensive, for two reasons. First, there are gaps in the services that MARPs need. For example: HSV-2 is not currently treated at STI clinics. However, given that research in Mwanza, Tanzania, has shown that genital HSV-2 infection increases the risk of HIV-1 infection, controlling HSV-2 is an important strategy in reducing HIV-1 incidence, especially in most at risk populations. Second, due to discrimination by health workers, many MARPs currently are not accessing the services that they need.

Scale of HIV prevention services at health facilities

Geographic coverage of service delivery is incomplete and services do not yet reach all persons requiring them. In 2006, PMTCT sites together saw 1 346 persons, or \textbf{6 patients a day each}. This suggests that the current PMTCT sites have reached their maximum service delivery capacity and that new sites may be needed to expand the service. With respect to condom distribution, not all persons who require condoms can access them – either by purchasing them or freely. Universal precautions and safe blood supply services are available at the national referral hospital and some others, but need to be rolled out to all district hospitals, PHCs and PHCU’s. In STI treatment, managing drug stock-outs to ensure an uninterrupted supply of drugs is important. Every VCT site processed 512 VCT clients a year - an average of just under \textbf{2 VCT clients} a day. Therefore, VCT sites have not yet reached their full capacity and can see more clients a day. Table 17 below provides some details on the scale of HIV prevention services at health facilities in 2006.

Table 17: Coverage of HIV Prevention Services at Health Facilities in Zanzibar, 2006

<table>
<thead>
<tr>
<th>Health facilities</th>
<th>Primary Health Care (n = 130)</th>
<th>District (n=4)</th>
<th>National (n=1)</th>
<th>Private (n=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom distribution and promotion</td>
<td>Available as part of family planning services at MCH clinics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMTCT</td>
<td>At 6 ANC sites – 66% of target reached</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>20% coverage of pregnant women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI treatment</td>
<td>28.5% of patients reached</td>
<td>100%</td>
<td>100%</td>
<td>33%</td>
</tr>
<tr>
<td>VCT</td>
<td>At 27 of 45 STI clinics, VCT sites do not currently run at full capacity, 9% of women and 19% of men know HIV status</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Safe blood supply</td>
<td>Replacement donor system, 100% screened</td>
<td>Replacement donor system</td>
<td>Blood Bank established, all units screened</td>
<td>Replacement donor system</td>
</tr>
<tr>
<td>Universal precautions and PEP</td>
<td>Not in place</td>
<td>At 3 district hospitals</td>
<td>At 1 national hospital</td>
<td>Not in place</td>
</tr>
</tbody>
</table>

\textsuperscript{20} Methadone is a long-acting narcotic medication. It is an effective legal substitute for heroin or other narcotics. It is preferable to heroin (which is injected into the blood stream many times a day) because it is in a syrup format and taken orally only once a day or every second day. It helps to minimise withdrawal symptoms during detoxification, stabilises a drug user’s body physically and keeps the person from continuing to inject drugs, which is where the highest risk of HIV transmission lies.
3.4.2 Achievement of HSSP Objectives

**Goal 2 (relating to safe blood supply):** Although some strategies have been implemented, some have not. Most notably, the following still needs to be done: communication between the central blood bank and peripheral health care facilities is still to be strengthened, low risk population groups need to be mobilized to donate blood, and the quality control mechanisms for the replacement blood donor system in the laboratories of all PHC centres, district and referral hospitals need to be strengthened.

**Goal 3 (relating to PMTCT):** The data show that the majority of the strategies in the HSSP for PMTCT have been addressed. The outstanding strategy – to evaluate the PMTCT Plus program in Zanzibar – is planned for 2007.

**Goal 4 (Reduce needle sharing):** the SU-HISP is being launched in June 2007, and therefore this goal has not yet been addressed.

**Goal 5 (relating to STI control and VCT):** The HSSP strategies are being followed, with the exception of ensuring the availability of STI drugs and promoting youth friendly services. The VCT goal has not completely been achieved, as VCT services are not yet provided at all 45 STI clinics in Zanzibar.

**Goal 6 (relating to universal precautions and PEP):** Universal precautions and PEP are still in the early stages of being implemented. It is therefore not surprising that not all HSSP strategies have been implemented: now that the guidelines have been developed, training needs to take place and services need to be rolled out to health facilities (including universal precautions, PEP for accidental exposure, PEP for sexual assault, and appropriate medical waste disposal).

3.4.3 Specific Challenges and Gaps in 2007

In general, challenges in the health sector in Zanzibar are the slow pace and/or late start of planned interventions, limited coverage of programmes, lack of materials and equipment, the ongoing need for capacity building, the severe human resource shortages and the lack of predictable, long-term funding.

- **HR shortages:** The human resource challenge in the health sector impacts on the entire sector, not only HIV service delivery. The 2004 Human Resources for Health (HRH) Plan states that “gross under-funding of the health service as a whole affects HRH performance”. In this Plan, it is indicated 35.5% of posts are vacant and that most staff employed in urban sites. As the salaries of health workers in Zanzibar are lower than on Tanzania mainland, there is no incentive for staff to accept posts available in Pemba, in rural areas or the small, hard-to-reach islets.

- **Financial shortages and sustainability of funding:** The shortage of skilled human resources at all levels in the health sector affects the ability of the health sector in Zanzibar to absorb the financial support pledged by development partners. On the other hand, development partner funding is not committed indefinitely, which will affect the long-term sustainability of all HIV services.

In terms of the delivery of HIV prevention services in the health sector that are defined in the HSSP, the following specific gaps exist:

- **In terms of condom distribution and use,** the two main gaps/challenges are: (a) inadequate and irregular supply of condoms caused by lack of procurement procedures, and exacerbated by the lack of proper central storage facilities, and the lack of regular distribution mechanisms; and (b) the limited training on the proper use of condoms, their storage and disposal.

- **In terms of safe blood supply,** the main gaps/challenges are: (a) the lack of an effective distribution system for donated blood from Mnazi Mmoja hospital to other health facilities; as well as (b) the lack of an
incentive scheme (non financial) to voluntary blood donors; (c) the stigma surrounding blood donations; (d) the limited access to the blood bank, given that it is centrally located and the lack of a regular and predictable supply of reagents for HIV tests; and (e) the lack of skilled human resources to carry out services associated with managing a blood bank.

- **In terms of PMTCT**, specific gaps/challenges are: (a) the lack of a communications strategy to deal with the new WHO statement on exclusive breastfeeding; (b) the lack of post natal follow-up (almost 95% of pregnant women receive no post-natal follow up), (c) the lack of referrals between PMTCT and pediatric ARV treatment; (d) the low male partner involvement in PMTCT; (e) lack of universal coverage of PMTCT services (and resultant high number of women who deliver with unknown HIV status); and (f) research to assess whether or not PMTCT, in a country with low prevalence amongst pregnant women, is an efficient use of resources.

- **In terms of harm reduction**, the biggest challenge will be how to roll out the new SU-HISP strategy in such a way that it does not increase discrimination and stigma that substance users face every day.

- **In terms of VCT**, gaps/challenges are: (a) the lack of research into the effectiveness of VCT services and the approaches followed in Zanzibar; (b) the lack of MARP-friendly services to encourage MARPs to know their status; (c) the lack of partner / couple testing to locate and protect discordant couples; (d) increasing the uptake of VCT at existing VCT sites; (e) managing increased demand on VCT due to pre marital testing in a way that is ethical and confidential; (f) the lack of a clear strategy on provider-initiated testing; (g) the location of current services and the stigma associated with entering a stand-alone VCT site; (h) accommodating the needs of persons with disability (e.g. ensuring that sign language can be used during counseling sessions).

- **In terms of universal precautions**, the gaps/challenges are (a) the limited reach of the current pilot project in universal precautions; (b) the shortage in reagents, human and financial resources to purchase the necessary equipment and consumables; and (c) the lack of standardized procedures.

- **In terms of the control and treatment of STIs**: Gaps to be addressed, are: (a) incorporating research on HSV-2 infection into all STI treatment protocols; (b) STI drugs stock-outs at STI clinics, brought on by under-funding by MoHSW; (c) how to integrate STI services into the four district hospitals; and (d) how to ensure that STI clinics are MARP-friendly, given that 26% of IDUs in 2006 had an STI (Dahoma et al., 2006), compared with only 0.3% of the general population (NBS and ORC Macro, 2005).

Other potential gaps in terms of new HIV prevention efforts at health facilities:

- **Male circumcision**: In the past 18 months, the results of three randomized control trials confirmed that male circumcision offers around 60% biological protection against HIV, although the mechanism is not yet clear (De Witte et al., 2007). Following the release of the male circumcision results, an expert group on male circumcision met to discuss the public health implications; this group recognized that it is not a panacea and recommended that male circumcision be promoted as an HIV prevention strategy in countries with generalized epidemics. Although Zanzibar does not have a generalized epidemic, it neighbours countries that have this type of epidemic. It is therefore inevitable that some information about male circumcision (possibly incorrect and incomplete) would reach Zanzibar – the main message being: ‘if you are circumcised, you are protected against HIV’.

It is not suggested that male circumcision be offered in Zanzibar as an HIV prevention strategy (almost all men in Zanzibar are already circumcised). Rather, it suggests that this new evidence is a challenge for Zanzibar. It raises questions around how Zanzibar will prevent dis-inhibition, i.e. how will it prevent possible negative behaviour changes if men in Zanzibar start to believe that, because they are
circumcised, they are fully protected against HIV and therefore do not need to follow the ‘ABCs of safer sex practices’.

- **Stigma and discrimination exhibited by health workers poses another set of challenges.** There is no peer education ‘for health workers, by health workers’ that would help to reduce the discrimination that MARPs feel they experience when they try to access health services.
3.5 HIV Care and Treatment Provided at Health Facilities

3.5.1 Situation in 2003

Provision of HIV treatment and care services in MoHSW: An HIV clinic was introduced at Mnazi Mmoja hospital after an initial pilot to treat HIV-positive persons and provide HIV prevention services. The community was designated as part of the continuum of care, by caring for PLHIV and vulnerable children. The importance of guidelines to ensure good quality of care, even when provided at home, was recognised (ZAC, 2003).

Opportunistic infections were not treated, due to drug stock-outs and the lack of guidelines (treatment algorithms were developed, but not yet printed). An agreement had been signed between MoHSW and a pharmaceutical company in 2003 to provide Fluconazole\(^\text{21}\) free of charge at all public health facilities.

ARV provision: The importance of ARVs in reducing stigma and motivating persons to know their HIV status was recognised, but it was felt that the prohibitive cost, the lack of treatment guidelines and lack of human capacity to administer ARVs would hamper the roll-out of ARVs in Zanzibar. It was acknowledged that ARVs would need to be funded by external development partners.

3.5.2 HIV Objectives in the Zanzibar Health Sector HIV Strategy Plan (HSSP)\(^\text{22}\)

Table 18: HSSP Objectives for the Health Sector’s HIV Treatment and Care Programme in Zanzibar, 2005

<table>
<thead>
<tr>
<th>GOAL AND TARGET</th>
<th>OBJECTIVES</th>
</tr>
</thead>
</table>
| **Goal 7:** Strengthen the facility based care and support services to PLHIV  
**Target 7:** All hospitals in Zanzibar to offer a basic package of HIV care and support | Improve the clinical management of opportunistic infections  
Integrate TB and HIV services with the purpose to provide VCT services to all TB patients |
| **Goal 8:** Promote confidentiality in the provision of HIV and AIDS related services  
**Target 8:** All health care facilities to formulate and disseminate confidentiality guidelines; 90% of health care workers trained | To advocate for confidentiality in HIV and AIDS service provision  
To enforce disciplinary measures |
| **Goal 9:** To reduce stigma and discrimination against PLHIV among health care workers  
**Targets:** 100% of reported cases of discrimination investigated and disciplinary procedures conducted; 90% of health care workers trained | To promote patients’ rights  
To enforce disciplinary measures |
| **Goal 11:** To strengthen the laboratory diagnostic and monitoring capacity for HIV and AIDS  
**Target 11:** All designated laboratories at ARV sites to have HIV and AIDS diagnostic and monitoring capability by year 2 | To upgrade laboratory infrastructure and equipment  
To provide adequate human resources to implement HAART  
To strengthen the health system in support of HAART  
To increase adherence to therapy |
| **Goal 12:** To initiate and scale up the provision of highly active antiretroviral therapy (HAART)  
**Target 12:** Meet the 3 by 5 targets by end of year 1 | |

Source: HSSP, 2005

\(^{21}\) Fluconazole is used in the treatment of two common opportunistic infections - oral candidiasis and cryptococcal meningitis

\(^{22}\) Given that the HSSP is more detailed than the ZNSP and that it was developed after the ZNSP was developed, the status of the HIV response in 2007 was described using the HSSP objectives and strategies.
3.5.3 Situation as of May 2007

A1: Treatment of Opportunistic Infections (OIs) and Integrating TB services (Goal 7)

OI treatment is important: OI prophylaxis and relevant OI treatment reduces mortality and morbidity even without HAART.

Extent of TB as one of the main Opportunistic Infections: TB is one of the main opportunistic infections. There are an average 300 new annual TB cases per year, with about two-thirds being smear-positive. (Case detection rates are not available). In 2002 that 25% of TB patients were HIV-positive; this has increased to 33% since 2002. The relapse rate for TB is high – around 6% (ZACP, 2005; ZAC, 2006).

Provision of capacity building, OI drugs and treatment protocols: ZACP trained some civil society organizations on treatment of opportunistic infections. OIs are treated according to the National Clinical Guidelines on the Management of HIV and AIDS. The initiative to avail Fluconazole supported by Pfizer was re-started in 2005 and is now widely available. Prophylactic therapy for OIs using co-trimoxazole has been introduced in the guidelines. Isoniazid prophylactic therapy has not yet been introduced in treatment guidelines. Pfizer provides free Diflucan as one of the key medication against fungal OIs.

TB and HIV integration: TB and HIV care are not integrated but discussions are underway, partly because of the inadequate human and infrastructural capacity in ensuring quality integrated service provision, technical know how and promoting HIV & TB overlaps.

A2: Laboratory support (Goal 11)
Infrastructure rehabilitation to support laboratory, counselling and testing, adherence counselling and ART delivery has taken place. The CD4 laboratory service was launched in July 2005, and quality assurance for CD4 services initiated in November 2005. All quality assurance results show that quality is of acceptable standard. To date (July 2005 to March 2007), the following tests have been performed:

<table>
<thead>
<tr>
<th>Test</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>9518</td>
</tr>
<tr>
<td>CD4</td>
<td>2124</td>
</tr>
<tr>
<td>Hematology</td>
<td>5727</td>
</tr>
<tr>
<td>Chemistry</td>
<td>9770</td>
</tr>
<tr>
<td>RPR (Syphilis)</td>
<td>2697</td>
</tr>
</tbody>
</table>

A3: ARV Treatment (Goal 12)
Who are our clients? In the Zanzibar context, MARPs have high HIV prevalence and ultimately severe immunosuppression warranting antiretroviral treatment. There are over 700 people who are eligible for HAART in Zanzibar – most of these persons are MARPs. Providing ARVs to MARPs is essential – it will help reduce the risk of HIV transmission to the general population but will reduce the efficiency of transmitting HIV infection to the general population.

Initiation of ART services: The introduction of ARVs using a triple therapy protocol started at Mnazi Mmoja and Chake Chake hospitals in 2005 with support from development partners in training, equipment procurement and management, M&E, training of HCWs, as well as procurement of drugs/supplies and reagents. The rollout expanded to another two hospitals in 2006. Provision of ARVs to Bububu military hospital is planned for 2007. In total, there will be four Care and Treatment Centres (CTCs) where the continuum of care will be provided to PLHIVs in the future.

Coverage of CTC services: Current estimates suggest that between 3,500 and 9,000 adults and children in Zanzibar live with HIV, which accounts for 4.0% of hospital beds. By May 2006, the care and treatment programme had registered 820 PLHIVs, and by March 2007, 1,289 patients were enrolled for care and treatment. Over the persons enrolled for care and treatment, 88% of the target of 300 PLHIVs were placed on
ARVs in 2006, and 98% of the targeted 600 PLHIVs were placed on ARV in 2007. Table 19 contains details of ART coverage in Zanzibar.

Table 19: ARV Treatment Coverage in Zanzibar, 2006

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Target</th>
<th>Actual Number reached (Denominator)</th>
<th>Percent ARV Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of suspected AIDS cases in Zanzibar</td>
<td>791</td>
<td>Number on ART: 350</td>
<td>44%</td>
</tr>
<tr>
<td>Number of suspected adult AIDS cases in Zanzibar</td>
<td>681</td>
<td>Number on ART: 311</td>
<td>46%</td>
</tr>
<tr>
<td>Number of suspected pediatric AIDS cases in Zanzibar</td>
<td>80</td>
<td>Number on ART: 39</td>
<td>49%</td>
</tr>
<tr>
<td>Number of hospitals with potential to deliver ART</td>
<td>7</td>
<td>Number of hospitals delivering ART: 4</td>
<td>57%</td>
</tr>
<tr>
<td>Number of health care workers involved in HIV and AIDS Care and Support delivery</td>
<td>2000</td>
<td>Health care workers trained: 100</td>
<td>5%</td>
</tr>
</tbody>
</table>

Sources: Basstanie, 2006; ZACP, 2007

Part of the CTC services, is a food for prescription programme23. Those with a Body Mass Index of less than 18, HIV positive women, persons starting ARVs, HIV positive children younger than 15, and patients with TB and HIV co-infection are enrolled for the first 3 months. Coverage as of March 2007 is as follows:

<table>
<thead>
<tr>
<th>CLIENTS</th>
<th>MALE</th>
<th>FEMALE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients enrolled for support</td>
<td>108</td>
<td>193</td>
<td>301</td>
</tr>
<tr>
<td>Adults enrolled for support</td>
<td>70</td>
<td>133</td>
<td>200</td>
</tr>
<tr>
<td>Children &lt; 15 yrs</td>
<td>38</td>
<td>60</td>
<td>98</td>
</tr>
<tr>
<td>Clients who have completed 3 months</td>
<td>20</td>
<td>28</td>
<td>48</td>
</tr>
<tr>
<td>Clients who have completed 3 months and continued for two months</td>
<td>10</td>
<td>161</td>
<td>26</td>
</tr>
</tbody>
</table>

3.6 CONCLUSIONS: HIV CARE AND TREATMENT

3.6.1 Relevance, Comprehensiveness and Scale of HIV Care and Treatment Services

Relevance of HIV Care and Treatment Services

The HIV care and treatment services planned reflect national needs, an understanding of the HIV epidemic, the local socio-economic, cultural, religious and political conditions, and the latest research on HIV care and treatment. The OI and ARV treatments provided are therefore relevant. HAART, for example, reduces morbidity and mortality, prolongs quality life, can eliminate OIs and reduces risk of HIV transmission to non-infected partners (durable viral suppression to undetectable levels below 50 -400 copies/ml can be obtained in adherent patients, and this drastically reduces, although does not abolish the risk of HIV transmission). It is therefore also an HIV prevention mechanism for uninfected partners in discordant couples.

23 The monthly package consists of: 10 kg of rice, 10 kg of maize flour, 5 kg of sugar, 5 kg of beans, and 5 liters of cooking oil
Comprehensiveness of HIV Care and Treatment Services
The HIV and AIDS treatment and care package is not yet comprehensive because there is minimal involvement of CSOs, FBOs and private sector; prophylaxis for all types of OIs is not yet routinely offered to patients, and some MARPs (e.g. prisoners) are not reached with service provision.

Scale of HIV Care and Treatment Services
Coverage of ART services is commendable - 50% overall coverage of all eligible PLHIVs in Zanzibar, including 65% coverage of children. The scale of other HIV care and treatment services is limited: the basic HIV care and treatment package is offered at the four hospitals that offer HAART but at only 57% of district hospitals. HIV care and treatment services are provided at district level but not below (Table 20).

Table 20: Proportion of Health Facilities at All Levels that Offer HIV Care and Treatment in Zanzibar, 2006

<table>
<thead>
<tr>
<th>Health facilities</th>
<th>PHC</th>
<th>District (n=4)</th>
<th>National (n=1)</th>
<th>Private (n=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OI prophylaxis</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>Not known</td>
</tr>
<tr>
<td>OI treatment</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
<td>Not known</td>
</tr>
<tr>
<td>TB treatment</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>ART</td>
<td>0%</td>
<td>75%</td>
<td>25%</td>
<td>0%</td>
</tr>
<tr>
<td>Laboratory diagnosis of HIV infection</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
<td>Not known</td>
</tr>
</tbody>
</table>

Source: Adapted from Zanzibar Health Profile 2005

3.6.2 Achievement of HSSP Objectives Regarding HIV Care and Treatment
OI treatment and some OI prophylaxis are available, but there are drug shortages. ARV treatment is reaching and exceeding its estimated goals, but TB and HIV services are not yet linked and integrated. The dual challenge of scale-up whilst ensuring sustainability is essential - especially because ARV treatment is a lifelong commitment.

3.6.3 Specific Challenges and Gaps in 2007
Some general challenges mentioned for HIV care and treatment services are: (a) the fear of disclosure of HIV status and the resultant stigma and family/partner rejection (especially for women) because of being HIV-positive; (b) labeling, mistreatment, stigma and discrimination of PLHIVs by health workers; (c) low coverage of HIV care and treatment at PHC level due to limited funding, inadequate infrastructure, and human resource shortages; (d) low coverage of training; (e) unavailability of some guidelines, resulting in HIV care and treatment interventions that are not comprehensive; (f) sustainability, in light of the fact that government’s allocation to the HIV response is still very low; and (g) ensuring that all people from Zanzibar who need ARVs, access it readily and predictably.

Specific gaps in HIV service delivery for care and treatment of adults and children living with HIV, include:

- **OI treatment**: OI treatment faces structural and institutional challenges. Gaps include: (a) supply of some OI drugs is erratic; (b) not all health care workers have been trained in OIs; (c) patients allergic to cotrimoxazole cannot access dapsone provided for leprosy treatment by the TB and leprosy programme, because the HIV and TB programmes are not integrated (there is a high prevalence of co-infection of Tuberculosis and HIV in Zanzibar, so TB patients should be screened for tuberculosis, and tuberculosis patients should be screened for HIV).

- **ARV treatment**: Gaps in ARV roll-out are: (a) geographical inaccessibility (existing ART sites are in urban areas only (Mnazi Mmoja, Chake Chake); (b) financial inaccessibility (patients need to pay for treatment of
most OIs, except for diflucan; and nutrition for ARV patients is essential but expensive); (c) acceptability of services for MARPs; (d) sustainability of funding for ARV drugs and reagents; (e) ART literacy in the community is low and (f) inability to diagnose infants due to the absence of the necessary equipment.

- **Laboratory capacity and skills**: Laboratory capability is inadequate in district hospitals for monitoring of ART, drug adverse effects, and opportunistic infections diagnosis. Specimen transfer from Pemba to Unguja is difficult and patient referral to the national Mnazi Mmoja Hospital for monitoring is ineffective. This is exacerbated by low human resources capacity.

- **Harm reduction among substance users and injecting drug users**: The SU-HISP includes care and treatment programmes specifically to manage HIV service delivery amongst MARPs. It excludes methadone maintenance therapy as a mechanism to reduce cravings and injecting drug use behaviour.
3.7 HIV Support Services (‘HIV Impact Mitigation’) in the Community

What is Impact Mitigation? Impact Mitigation is a set of non-biomedical interventions implemented in the community to complement care and treatment services provided at health facilities. Impact mitigation focuses on psychosocial support, which includes emotional/spiritual, nutritional, educational, legal support and economic (financial) support through mechanisms such as home-based care. These are all ways of mitigating the impact of HIV on individuals, households and communities. Target audiences for these services include:

- PLHIV
- Affected individuals, households, communities
- Poor people, HIV negative but at risk of getting infected
- Most Vulnerable Children (MVC)
- Care givers (usually women)
- Elderly people looking after MVC or terminally ill people
- Disabled people
- Female headed households
- Child headed households.

In the ZNSP and the HSSP, ‘impact mitigation’ is termed ‘HIV support’ and is grouped with the health sector HIV response; the impression is created that it is part of the health sector HIV response. Given that HIV impact mitigation involves activities beyond those for which the health sector is responsible, it has been handled separately in this Joint Review.

### 3.7.1 Situation in 2003

**Estimated number of PLHIV:** Based on the HIV prevalence data, estimates of the number of PLHIV range from 3500 (using HIV prevalence in 2002 amongst men, 2005 ANC data and population estimates (Basstanie, 2006)) to 9 000 people (using HIV prevalence at ANC sites as a proxy (ZACP, 2006)).

**Estimated number of orphans in Zanzibar and where they live:** Orphanhood is not necessarily a determinant of a child’s vulnerability (Ainsworth and Filmer, 2000). Nevertheless, data on orphans provide some estimate of the magnitude of MVC. The 2002 Tanzania Population Census showed that there are 42 364 orphans in Zanzibar – 26 588 in Unguja and 15 776 in Pemba – see Table 21. This corresponds with the 2005 TDHS, which suggested that 7.4% of children are orphans (37 000 orphans, out of an estimated 500 000 children). Figure 10 also provides data about where children live, suggesting that a significant percentage does not live with either parent.

### Table 21: Number of Paternal, Maternal and Double Orphans Per District in Zanzibar, 2005

<table>
<thead>
<tr>
<th>District</th>
<th>Number of Orphans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unguja</td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>3 105</td>
</tr>
<tr>
<td>North ‘A’</td>
<td>3 239</td>
</tr>
<tr>
<td>North ‘B’</td>
<td>2 466</td>
</tr>
<tr>
<td>South</td>
<td>1 409</td>
</tr>
<tr>
<td>Urban</td>
<td>9 083</td>
</tr>
<tr>
<td>West</td>
<td>7 286</td>
</tr>
<tr>
<td><strong>TOTAL UNGUJA</strong></td>
<td><strong>26 588</strong></td>
</tr>
</tbody>
</table>

**Source:** Calculated from the United Republic of Tanzania 2002 Population and Housing Census

<table>
<thead>
<tr>
<th>District</th>
<th>Number of Orphans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pemba</td>
<td></td>
</tr>
<tr>
<td>Chake Chake</td>
<td>3 715</td>
</tr>
<tr>
<td>Micheweni</td>
<td>3 423</td>
</tr>
<tr>
<td>Mkoani</td>
<td>3 778</td>
</tr>
<tr>
<td>Wete</td>
<td>4 860</td>
</tr>
<tr>
<td><strong>TOTAL PEMBA</strong></td>
<td><strong>15 776</strong></td>
</tr>
</tbody>
</table>
Support for PLHIVs: Support for PLHIV was primarily through home based care (HBC). There were problems with HBC roll-out after training, due to shortages of volunteers, skill levels of volunteers and shortages of equipment. Under the continuum of care principle, HBC was intended as an extension of the services provided at health facilities and volunteers therefore needed a medical background.

Support for MVC: Although the social welfare section of MoHSW was tasked with supporting orphans, there were no guidelines for this support. Dahoma et al. (2002) noted that typically, children affected by AIDS in Zanzibar received care through the communal kinship system with women usually being the caregivers. It was noted that some NGOs were providing for the daily needs of MVC, and that probably included children other than ‘AIDS orphans’ (500 orphans were being supported at the time). Child labour was found amongst fishermen, tourist hotels, sea weed and clove plantation farmers and in the informal sector in Stone Town (Gonza, 2001).

3.7.2 ZNSP Objectives Designed to Address the 2003 Situation

<table>
<thead>
<tr>
<th>a) Support for PLHIV</th>
<th>Reduce stigma and discrimination of PLHIV through provision of access, inclusion, participation and greater involvement of PLHIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Community Home Based Care and Support</td>
<td>Increase coverage and access to comprehensive quality home based care and support for PLHIV</td>
</tr>
<tr>
<td>c) AIDS Orphans [sic] and Children in Difficult Circumstances</td>
<td>Promote an effective and sustainable system of supporting and caring for AIDS orphans</td>
</tr>
</tbody>
</table>

---

24 Although this term, AIDS orphan, is used in the ZNSP, there was an agreement not to use it in this review, as it has come to be regarded as a derogatory term that increases stigma and discrimination towards children whose parents have died of AIDS.
3.7.3 HSSP Objectives to Address the 2003 Situation

Table 22: HSSP Objectives Relating to HIV Impact Mitigation

<table>
<thead>
<tr>
<th>GOAL AND TARGET</th>
<th>OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 10:</strong> To provide adequate HBC services to cover all 10 districts of Zanzibar.</td>
<td>Improve the technical quality of HBC services.</td>
</tr>
<tr>
<td><strong>Target 10:</strong> Establish at least 1 HBC service per health district; 100% HBC workers trained.</td>
<td>Increase the number of HBC programme to cover all 10 districts.</td>
</tr>
<tr>
<td><strong>Goal 13:</strong> To provide prompt care to orphans and vulnerable children (MVC).</td>
<td>To promote an effective and sustainable system of supporting and caring for AIDS orphans.</td>
</tr>
<tr>
<td><strong>Target 13:</strong> All orphans and vulnerable children registered by the year 2009; A policy to fast track MVC access to health care adopted by 2009.</td>
<td>Contribute to the development (ECD) programme.</td>
</tr>
</tbody>
</table>

Source: ZACP, 2006

3.7.4 Situation as of May 2007

**A: Types of HIV impact mitigation services currently provided in the community**

*Initiation of Home-Based Care Services:* HBC guidelines were developed in 2005. The HBC unit at ZACP has trained 154 community HBC providers. Family training or coaching is provided by volunteers and HBC providers.

*Scope of HIV impact mitigation services to PLHIV in the community:* PLHIV support has expanded from only HBC to also include palliative care, nutrition support and access to PLHIV associations.

- **To ensure a continuum of care,** development partners have been supporting MoHSW, FBOs and CSOs to scale-up HBC in Zanzibar. HBC services have been linked with the PHCU’s and the community in eight out of ten districts in Zanzibar. By June 2006, 842 households had benefited from HBC. As of May 2007, HBC services were provided by 154 public health workers (assisted by volunteer community HBC providers) from 100 health care facilities.
- **Palliative care** is offered at health care institutions and as part of HBC services. Relatives in the household also contribute to palliative care. There are no formal institutions offering hospices services in Zanzibar.
- **A household assessment has just been undertaken to assess nutritional needs.** The universal PLHIV nutrition support programme proved not to be sustainable, and will now be replaced with a three-month “food for prescription” support scheme.
- **PLHIV associations** have been in existence for more than 10 years. These associations offer PLHIV support activities, information, referral, condom distribution, limited nutrition assistance, and community outreach. As the umbrella organization for PLHIV associations, ZAPHA+ is supposed to establish new PLHIV associations and build their capacity. However, ZAPHA+ does not fulfill its mandate as an umbrella organization.

*Coordination, stakeholders and policy for MVC:* The Department of Social Welfare (DSW) at MoHSW has just been identified to coordinate support to MVC; other key ministries are MoLYWCD and MoEVT. The MVC policy has not yet been developed.
Coverage of MVCs: Government, civil society, and individual family members care for MVCs through orphanages, financial support, a pilot project to identify MVC in districts, and interventions to reduce child labour in 12 Shehias covering 350 children.

3.8 CONCLUSIONS: PROVISION OF HIV IMPACT MITIGATION SERVICES IN ZANZIBAR

3.8.1 Relevance, Comprehensiveness and Scale of HIV Impact Mitigation Services

Relevance of impact mitigation services (Are we doing the right thing?)
Currently, the programmes being provided focus on individuals - adults and children - either living with HIV or whose parent/s died from AIDS. All the services currently being provided are relevant in addressing their needs. More needs to be done to reduce stigma and discrimination towards PLHIVs within communities (particularly PLHIVs who are also MARPs whose illegal behaviour has resulted in infection with HIV), and to understand whether they have any needs that are not met.

Comprehensiveness of impact mitigation services in Zanzibar (Are we doing it right?)
HIV impact mitigation services are partly but not yet entirely comprehensive for two reasons. First, HIV impact mitigation are not structured – i.e. each NGO may provide the support they feel is best, and there are no guidelines on a minimum package of impact mitigation services for adults, children, families, households and communities affected by AIDS. Second, not all persons that need support have been reached. The services target some people who need support, but do not consider the while family unit. Also, there are no programmes that provide support to PLHIV associations to promote self employment, and PLHIVs are not used as a resource to decrease stigma and discrimination or promote HIV prevention.

Scale of HIV impact mitigation services in Zanzibar
With the low HIV prevalence of 0.9% in Zanzibar, the impact of HIV is not as devastating as in other countries in the region. However, impact mitigation services should still be available in all communities. These services are not yet up to scale because not all communities provide all them, and less than 10% of the estimated number of adults and children living with HIV are being supported through HBC programmes.

3.8.2 Achievement of HSSP Strategies in HIV Impact Mitigation

Although impact mitigation services exist in the community and the impact is not of large national scale, the services are delivered ad hoc, are not well coordinated, and there is no quality assurance. Therefore, the strategies in the HSSP have not yet been comprehensively addressed.

3.8.3 Specific Challenges and Gaps in 2007

Lack of a policy for Vulnerable Persons: One of the main gaps is the lack of a legal and social framework for rights provision and protection of all vulnerable populations - a policy that would not only target MVC and PLHIV, but also the elderly, child-headed households, and others.

Not reaching all who need support: Children involved in substance use and IDU are “hidden” and have not been supported. Low coverage is also partly the result of a lack of community sense of responsibility for HIV impact mitigation at the shehia level.
Registers of vulnerability are not functional: There are no accurate baseline data on the numbers of MVC, care givers, disabled, female headed households, child-headed households identified, registered and reached. This makes it difficult to understand the magnitude of the problem. Numerous initiatives by CSOs exist but activities are not systematically coordinated or reported, or based on the registers in the communities of ‘who is vulnerable’.

**HBC services:** HBC services are mostly run from health facilities as outreach services by health care workers who have other institutional duties and cannot allocate adequate time for home care. Gaps are: (a) dire shortages in health facilities contribute to the inefficiency of facility-based HBC services. HBC services are still primarily facility-based and not community-based; (b) not all districts have a HBC programme; (c) linkages and referrals between the facility and the community are weak, so there is significant loss to follow up; (d) Nutritional support for PLHIVs is unsustainable; (e) economic, domestic and emotional support is not provided routinely to PLHIVs and their families; (f) the quality of HBC programmes leave much to be desired; and (g) PLHIVs are not trained as HBC volunteers - they would be more committed than other volunteers to support those who need help.

**Support for PLHIV associations:** Gaps are: (a) Support to PLHIVs and their associations is still not sufficient; (b) There are no efforts to increase PLHIV’s access to employment – either through self or wage employment; and (c) PLHIVs are not used as a resource to promote HIV prevention programmes, which could also generate income for PLHIVs.
In this Section the Joint Review findings on an enabling environment for the HIV response are discussed. For an effective HIV response to be well managed, coordinated, monitored, evaluated and executed, the environment needs to be supportive, complementary and conducive for HIV services to be delivered. An enabling environment for the HIV response exists when the following elements are in place:

1. There is political will and commitment at all levels from all political parties to be involved in the HIV response.
2. There is a comprehensive national legal, strategy and policy framework to guide the implementation.
3. There is effective coordination at the national level of all stakeholders, and their contributions (resources and activities) link with national strategies and policies.
4. The HIV response is well coordinated and implemented at the sectoral level – with respect to both intra-sectoral and inter-sectoral coordination, so that sectors maintain focus and exploit synergies and complementarities.
5. Resources needed for proper implementation of the national HIV strategy are mobilized in sufficient amounts and on a sustainable basis.
6. There is sufficient advocacy to address gender imbalances, stigma and discrimination, and other issues that may negatively affect the HIV response.
7. There is enough relevant human resource capacity.

This chapter analyses and assesses the current situation of these 7 elements of an enabling environment.
4.1.1 Situation in 2003

Lack of commitment from political parties before 2002: HIV was not included as an issue in the election manifestos of political parties in 1995 or 2000.

Commitment from parliament as of 2002: The House of Representatives approved the Act that established ZAC in 2002. The President, Chief Minister and members of parliament have discussed HIV ‘on a regular basis’ (ZAC, 2003). An NGO was formed to deal with HIV issues in parliament – UWAKUZA. Parliamentarians felt in 2003 that “…at present we want to participate actively, but we do not know what our exact role should be, we don’t know what we should be saying” (ZAC, 2003:70)

4.1.2 ZNSP Objectives Designed to Address the 2003 Situation

There are no specific ZNSP objectives relating to political will and commitment.

4.1.3 Situation as of May 2007

Political commitment to HIV at the highest level: The First Lady of Zanzibar is actively involved in the HIV response, and is in particular interested in providing services to MARPs. The Presidents of Zanzibar and Tanzania made a joint statement to the public on World AIDS Day on 1 December 2006.

Commitment from political parties: HIV was included in the election manifestos for the 2005 election of both main political parties in Zanzibar – CCM and CUF. The main difference on HIV between the two parties is that CCM promotes condom use (not condom distribution), whilst CUF promotes neither. UWAKUZA’s HIV strategic plan states that: “The major gap is that all the manifestos are silent on addressing the epidemic among their followers, on how HIV would be addressed as part of the party’s daily operations, and during the election process itself” (UWAKUZA, 2007: 14). Both political parties are also involved in HIV service delivery, and encourage their elected members to raise awareness about HIV during political meetings.

Coordination of HIV efforts of House of Representatives: UWAKUZA, the NGO tasked with coordinating the HIV efforts of the House of Representatives, recently completed an impact assessment, developed a strategy for the HIV response within parliamentary structures, created an action plan and costed it.

4.1.4 Specific Challenges and Gaps in 2007

Specific gaps and challenges are: (a) Political parties do not base the HIV policy statements in their election manifestos on all the latest scientific evidence on prevention of HIV transmission, which could lead to the electorate not being given the latest information; (b) how to address the desire of political parties to implement HIV prevention programmes in the community; (c) there are no workplace programmes within political party administrative structures; (d) how to facilitate a process through which all political leaders in the United Republic of Tanzania can commit jointly to HIV; (e) how to create uniform understanding HIV-related issues among Members of the House of Representatives; and (f) how to implement UWAKUZA’s strategy on time.

4.2 Legal, Policy and Strategic Framework

4.2.1 Situation in 2003

Laws: The Zanzibar AIDS Commencement Commission Act (2002) was passed in 2002, giving birth to ZAC. HIV was not yet included in the Labour laws of RGoZ. The Sexual Offenses Act of 1998 criminalized sexual offenses (gender-based violence is one of the drivers of the epidemic in Zanzibar).

Policies and strategies: There was no national HIV policy, and no national workplace policy. There was also no HIV policy in the health sector on provision of OI or ARV drugs. The Medium Term HIV Plan III, the third
strategic plan for addressing HIV, had just expired. HIV was also not included in government or private sector labour laws and there were no safeguards in place to prevent discrimination at the workplace based on HIV status.

4.2.2 ZNSP Objectives Designed to Address the 2003 Situation

*Overall objective:* To increase HIV advocacy capacity of implementing institutions through the formulation of a national multisectoral HIV policy.

*Zanzibar Poverty Reduction Plan (ZPRP):* To make the ZPRP more responsive to the HIV epidemic by integrating HIV interventions into main economic and social policies.

4.2.3 Situation as of May 2007

*Legal Issues:* There is still no HIV law to protect those not infected from willful HIV infection. The Act that led to the formation of ZAC has not yet been amended to reflect the new role of ZAC, as agreed to in the ZNSP. Labour laws have been amended to protect employees against discrimination due to HIV status.

*HIV policy and other related sectoral policies:* The national HIV policy was approved in November 2006. The policy is comprehensive: it addresses every aspect of the HIV response, except the role of political parties. Some sectors had mainstreamed HIV in their own sectoral policies before the HIV policy was launched, and so may not reflect the latest policy positions as stated in the national HIV policy.

*National HIV Strategy and related sectoral strategies:* The ZNSP was launched in 2005. It called for the formulation of sectoral strategies, which are in the process of being developed. Other strategies have also been developed: the National HIV Advocacy and Communication Strategy; the Health Sector HIV Strategic Plan; the HIV and AIDS Strategic Plan for Substance Abuse; National HIV Monitoring and Evaluation Operational Framework; and strategies for UWAKUZA and for ABCZ.

*Integration of HIV into MKUZA:* HIV was listed as a crosscutting issue in the ZPRP (2002 - 2005), and has now been fully mainstreamed into the Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP), or MKUZA (2006 - 2010).

4.2.4 Specific Challenges and Gaps in 2007

The following gaps and challenges exist: (a) Legally, the roles of ZAC and ZACP are not clear (The ZAC Act needs to be amended to reflect the operational role of ZACP and to amend the constitution of the ZAC Board of Commissioners); (b) the new Zanzibar HIV policy is not yet known to all stakeholders; and (c) the inclusion of HIV into the GOs is a long and slow process.

4.3 Coordination in all Sectors at the National Level

4.3.1 Situation in 2003

*Newly established ZAC and Board of Commissioners:* In 2003, when the situation analysis on which the ZNSP is based was written, there were 10 ZAC Commissioners and a few staff members who were seconded from other government departments.

*ZACP as the coordinator of the HIV response in the health sector:* ZACP was established in 1986 to coordinate the implementation of government’s medium term HIV plans. When ZAC was formed, ZACP’s role changed: it

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26 MoEVT and MoTTI have both recently undertaken HIV impact assessments for their sectors.
27 Three entities are involved in coordinating the HIV response at the national level: Zanzibar AIDS Commission, the Zanzibar AIDS Control Programme at MoHSW and the Development Partners Group.
became responsible for coordinating the HIV response in the health sector. ZACP’s management of the HIV response was hampered at the time by human resource shortages in the health sector (36% of posts were vacant in 2004) and the lack of a legal mandate to coordinate.

**Development Partners Group (DPG):** The DPG was formed in 2002 to communicate and harmonise their efforts on HIV.

### 4.3.2 ZNSP Objectives Designed to Address the 2003 Situation

**Overall objective:** To increase HIV advocacy capacity of implementing institutions through the formulation of a national multisectoral HIV policy.

**Zanzibar AIDS Commission:** To increase knowledge and management capacity of ZAC commissioners and ZAC secretariat in mitigating STI/HIV in Zanzibar and to mobilise and advocate for the involvement of all sectors in the society [political, religious and community leaders] in the fight against HIV.

**Public and Private Sector involvement:** To increase awareness, involvement and commitment of private and public sectors in mitigating HIV.

### 4.3.3 Situation as of May 2007

#### A: Coordination by ZAC

**Governance:** ZAC is semi-autonomous: it answers to the Chief Minister’s Office, but also has its own Board of Commissioners. The ZAC Board of Commissioners, which has no constitution, meets every quarter. The membership has been stable, and attendance is good. Operationally, the ZAC Board of Commissioners acts as an advisory and governance oversight body, but does not oversee ZAC’s day-to-day operations.

**Organisational structure at ZAC Head Office in Unguja:** ZAC is managed by an Executive Director, answerable to its Board of Commissioners and to the Principal Secretary of CMO. The Executive Director is supported by a Head of Division for Policy, Planning and National Response; a Head of Division for Advocacy and Information Education and Communication; and a Head of Division for Finance and Administration. ZAC has grown exponentially to a current complement of 31 staff. Recently, ZAC reviewed its organisational structure and created a new monitoring and evaluation unit.

**ZAC Pemba Sub-Office:** To coordinate the HIV response in Pemba, ZAC has a sub-office in Pemba with 4 staff, which is inadequate. This office reports directly to the CMO representative in Pemba (as do staff of all other Ministries stationed in Pemba). This implies that ZAC Head Office does not manage the ZAC Pemba sub-office staff directly; the ZAC Pemba Coordinator does not have any authority over the MDAs and cannot enforce the implementation of HIV plans within the public sector – close follow up is needed to ensure that Ministries in Pemba mainstream HIV within their budgets. Generally, there is a good relationship between the ZAC head office and ZAC Pemba office, which has alleviated some of these problems. ZAC head office and ZAC Pemba office also consult with each other and with the CMO about all issues of national concern.

**Effectiveness of ZAC in executing its roles:** ZAC has a management and coordination role, an advocacy role, a capacity building role, a resource mobilisation role, and a monitoring and evaluation role. Overall, stakeholders expressed satisfaction during all FGDs and individual interviews that ZAC has been very successful at raising awareness at the national level, putting HIV in the forefront of the development agenda and making every national level stakeholder consider HIV in its planning processes. “There is a lot happening at ZAC and they are always moving forward”, one interviewee said. ZAC has implemented its roles in the following ways:
ZAC has been successful in carrying out its management and coordination functions at the national level: all main national level stakeholders – the government, CSOs, FBOs, and CBOs, private sector, political parties, top government leadership, development partners – are involved, to a greater or lesser extent, in HIV.

ZAC has been less successful in coordination and management at the decentralised levels (i.e. in the districts and shehias). This is partly because the HIV response at these levels are not coordinated by ZAC, but through district-level structures, shehia-level structures and District HIV and AIDS Focal Persons (DHAPs) - none of which report directly to ZAC. The delay in the local government reform has negatively impacted the districts’ coordination of the HIV response. See Section 4.5 for more details.

ZAC has been active in advocacy - Section 4.7 contains more information about ZAC’s advocacy activities.

In capacity building, ZAC has been very active in some sectors - see Section 4.8.

In the last few years, ZAC has been successful in resource mobilisation. The number of development partners increased from one (UNDP, which continued to operate during the donor embargo from 1995 - 2000) to at least eight (UNAIDS, UNDP, WHO, CDC, Global Fund, US Government’s PEPFAR funding, Rapid Funding Envelope, The World Bank) - see Section 4.6.

ZAC has not only mobilised resources, it is also actively involved in managing the resources (as a grant-making body). It does, therefore, get involved in operational and implementation decisions about which organisations to fund, supervises their work plans, receives reports from them, etc. In this sense, ZAC has exceeded its intended mandate to mobilise resources by now also acting as a grant-making body and being actively involved in grant management.

ZAC has established a national monitoring and evaluation (M&E) system to provide and manage information about the HIV response - see Section 6.

B: Coordination of the medical/clinical HIV response by ZACP

ZACP is in the MoHSW and mandated to coordinate all HIV activities taking place at health facilities managed by the public sector, private sector and civil society. ZACP’s work is guided by the HSSP, which identifies all clinical/medical HIV activities to be carried out in Zanzibar.

One of the anomalies in the HSSP is that there is a goal and strategies dealing with IEC: there are strategies around ZACP supporting other ministries with workplace programmes, and in running IEC programmes. ZACP also has an IEC unit that looks at issues broader than just medical HIV-related IEC.

C: Coordination by Development Partners

Role of the DPG: The role of development partners, as the name suggests, goes beyond donating funds to technical support and joint planning with government. The DPG meets quarterly to facilitate communication among development partners involved in HIV, and also tries to coordinate the efforts of its members. It does not yet collaborate - the third level of working together (communication, then coordination and then collaboration). This is primarily due to the differences in funding modalities. The Public Expenditure Review on HIV, costing the HSSP, and this Joint Review of the HIV response in Zanzibar are, for example, all efforts that have been coordinated with input from the DPG.

Role of the GF-CCM: In addition to the DPG and the ZAC Board of Commissioners, the Global Fund uses a Country Coordinating Mechanism (GF-CCM) to coordinate, review and approve proposals for Global Fund funding. GF-CCM is intended to ensure the full involvement of NGOs and CSOs in country proposals. The CMO is the secretariat to the GF-CCM and the GF Principal Recipient.

D: Coordination by HMIS unit at MoHSW and OCGS
Other units are also responsible for coordinating aspects of the HIV response - the Office of the Chief Statistician General (OCGS) is responsible for coordinating HIV surveys and surveillance, whilst the Health Management Information System (HMIS) unit at MoHSW is responsible for collecting all routine data in the health sector.

### 4.3.4 Specific Challenges and Gaps in 2007

Specific gaps and challenges relating to national level coordination are: (a) Neither ZAC nor ZACP has clear operational procedures on how to execute their mandates; (b) Although ZAC and ZACP work well together, ZACP has taken on coordination of IEC, which is not a health sector function; (c) The GF-CCM’s role in oversight and governance of GF funding needs to be strengthened; (d) development partners and the RGoZ have not cemented their relationship in writing; and (e) the capacity of the OCGS and HMIS units to coordinate the aspects of the HIV response for which they are responsible, needs to be strengthened.

### 4.4 Coordination by and Involvement of the Sectors in the HIV Response

#### 4.4.1 Situation in 2003

**A: Public Sector**

Technical AIDS Committees (TACs) were established in the early 1990s and had to be revived in 2001. Most of the resuscitated TACs met only a few times between 2001 and 2003. Some TACs were weak and some strong. Not all Ministries were clear on what to tackle first. All Ministries were asked to nominate HIV Focal Persons who reviewed their Ministries’ action plans in 2004. Despite this review, there was no evidence of workplace programmes for HIV being implemented in the public sector. Although Ministries were expected to be involved in the HIV response, HIV was not included in the MTEF budget guidelines and HIV was not systematically addressed by sectoral Ministries.

There is currently a process underway to include HIV in the General Orders of government, which will help HIV mainstreaming in the public sector.

**B: Private Sector**

The private sector was not involved much in the HIV response in 2003, and there was no oversight body to advocate, build their capacity, or coordinate their involvement.

**C: Civil Society (International and local NGOs, FBOs and CBOs)**

Individual NGOs were involved in HIV prevention and treatment activities to varying degrees, as detailed in Section 3 of this report. Many FBOs denied HIV, refused to discuss some HIV issues (especially condoms) and were not sure how to address HIV within the boundaries set by religious teachings. The Office of the Mufti outlined an HIV intervention programme for all madrassas.

Efforts to coordinate CSOs in Zanzibar started in 1993 through the Association of NGOs (ANGOZA). The Zanzibar NGO Coalition (ZANGOC) was formed in 2002 with the intention to coordinate the efforts of CSOs working on HIV. In 2003, ZANGOC had 29 members.

Some progress has been made in the Greater Involvement of Persons living with HIV (GIPA) principle. PLHIVs are represented in a number of decision-making bodies such as the ZAC Board of Commissioners, GF-CCM and DACCOMs and SHACCOMs. They have also been involved in GF proposal preparation and are invited to seminars that ZAC hosts. They also contribute as peer educators and expert patients.
4.4.2 ZNSP Objective Designed to Address the 2003 Situation

Public and Private Sector involvement: To increase awareness, involvement and commitment of private and public sectors in mitigating HIV

4.4.3 Situation as of May 2007

A: Coordination by and Involvement of the Public Sector

Coordination by TACs and Ministerial HIV Focal Persons: All public sector ministries have TACs and Ministerial HIV Focal Persons. Some are more functional than others, and TAC members feel that they need more capacity building to execute their tasks well. They also need to be supported in their HIV advocacy efforts.

Development of HIV work plans by Government Ministries: ZAC and MoFEA have helped MDAs to develop HIV work plans that were included in their Medium Term Expenditure Framework (MTEF) budgets for the 2005/6 financial year. This support was catalytic: it built capacity on how to budget for HIV programmes within an MDA. HIV has now been included in the Budget Guidelines and given a separate line item in the Government budget.

Implementation of HIV activities by public sector ministries: Most funding for public sector HIV activities comes from the World Bank’s TMAP programme and not from Government’s own budget (which has sustainability implications as TMAP ends in 2008). A recent review (in 2007) of the Ministries funded under TMAP revealed varying levels of performance in planning and implementing HIV activities – as illustrated in Table 23 below.

Table 23: Implementation of TMAP-funded activities by MDAs in 2006

<table>
<thead>
<tr>
<th>Sector</th>
<th>Activities implemented</th>
<th>Quarterly progress reports submitted</th>
<th>Annual reports submitted</th>
<th>Accounts and records kept</th>
<th>Quarterly financial reports submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoALE</td>
<td>All</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>MoFEA</td>
<td>All</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ministry of Water, Construction, Energy and Lands</td>
<td>All</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>MoLYWCD</td>
<td>All</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes (late)</td>
</tr>
<tr>
<td>MUFTI</td>
<td>All</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ministry of Tourism, Trade and Investment</td>
<td>Some</td>
<td>Yes (late)</td>
<td>No</td>
<td>Yes</td>
<td>Yes (late)</td>
</tr>
<tr>
<td>Ministry of Communication and Transport</td>
<td>Some</td>
<td>Yes (except 1st quarter)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>MoEVT</td>
<td>Some</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>MoRASD</td>
<td>Some</td>
<td>Yes (late)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>The President’s Office</td>
<td>Some</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>The Ministry of State, Constitutional Affairs and Good Governance</td>
<td>Some</td>
<td>Yes (late)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Source: TMAP Public Sector Progress Report, 2007

HIV efforts for those in Special Departments: Programmes for persons in Special Departments under RGoZ have commenced, but implementation of programmes for persons in special departments under the Union Government (TACAIDS’s responsibility) lags behind.
B: Coordination of and Involvement by Civil Society Organisations

Involvement of civil society organisations: A recent CSO mapping and ranking assessment identified 242 CSOs in Unguja and 137 CSOs in Pemba; of which 59 and 37 have been given the green light as having capacity to implement HIV interventions in Unguja and Pemba respectively. NGOs and CBOs have implemented the bulk of HIV activities in Zanzibar. FBOs are more organized than other CSOs and seem to be more effective in delivering their message, although they are selective in the HIV prevention messages they convey.

Involvement of persons living with HIV: Persons living with HIV are represented in Zanzibar by ZAPHA+, which is a registered NGO. ZAPHA+ membership is less than 10% of PLHIV in Zanzibar. ZAPHA+ provides HIV services for individual members and associations that belong to ZAPHA+. The question has been asked whether ZAPHA+ is an umbrella for PLHIV groups or whether it is an organization that delivers services (food, shelter, loans etc) for a small group of PLHIVs in Stone Town. Wherever possible, CSOs and ZAC involve ZAPHA+ members in activities.

Coordination of CSOs: ZANGOC is supposed to be the umbrella organisation of CSOs working in the field of HIV, but its role as an umbrella organisation has been questioned. Rather, it seems that ZANGOC provides HIV services to target beneficiaries, like other CSOs working on HIV. The FBOs have established the Inter-Faith Forum (IFF), which is very active in advocating for faith-inspired HIV responses. In addition to regular meetings with ZAC, the IFF has distributed guidelines for HIV and AIDS education in their schools (Katende et al., 2004). One of the outcomes of IFF has been the establishment of the Zanzibar Interfaith Association on AIDS and Reproductive Health (ZIADA). This association, with the assistance of ZAC, has already been registered; and UNFPA has shown interest in assisting the association.

C: Coordination of and Involvement by of Private Sector Organisations

Establishment of coordination structure: The AIDS Business Coalition of Zanzibar (ABCZ) was formed in 2006 with the help of development partners and the AIDS Business Coalition of Tanzania (ABCT) mainland – an Executive Committee of 4 founder members was established. A Strategic Plan developed for ABCZ sets out its vision and core strategies – “To have the private sector workforce and community in Zanzibar free from HIV and AIDS epidemic and which cares and supports all those infected and affected by HIV and AIDS” (ABCZ, 2006) – and defines ABCZ’s potential membership as 35 to 50 private sector organisations.

Involvement of individual organisations: To date, the private sector has been lacklustre in its response, for two reasons: (a) it failed to recognise the private and social benefits of responding early to HIV; and (b) because the benefits are not recognised, contributing to the HIV response is seen as a net cost to businesses. The new HIV policy (which clearly defines the role of the private sector) and the newly formed ABCZ are expected to energise private sector involvement in future.

D: Involvement of Institutions of Higher Learning

Participation of Higher Learning Institutions (HLIs), in particular, universities, was at first peripheral, perhaps because the ZNSP assumed they were part of the MoEVT response. However, the 2006 HIV policy assigns a specific role to universities. Thus, efforts have started with the establishment of a Steering Committee to coordinate the HIV response at the tertiary education level.

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28 The author of this chapter was the facilitator for Consultative Group Meetings for Mainstreaming in ZSGRP in January to March, 2006, financed by UNDP and coordinated by ZAC (See ZAC-UNDP Report, 2006). The view of the majority of participants in the private sector consultative meeting was that workplace programmes were an additional cost that needed to be avoided - by testing and “sifting” workers at the time of employing them to decide who should be employed; and thereafter to gauge their continued employment conditional on their remaining HIV negative.
4.4.4 Specific Challenges and Gaps in 2007

Public sector involvement: Gaps and challenges are: (a) There is still limited joint inter-sectoral coordination or collaboration in terms of HIV work planning, and MDA work plans for HIV do not target families of employees. (b) TACs do not share experiences; (c) HIV Focal Persons in MDAs do not report on a regular basis; (d) the root causes why some Ministries are not involved, is not known; (e) poorly performing ministries are not provided with stringent oversight and technical assistance; (f) there is no career path for HIV Focal Persons; (g) TACs in key service-oriented Ministries are not yet focusing on external mainstreaming (health and social welfare, education, women and youth, trade and tourism); (h) all Ministries are treated equally – there is not prioritization of Ministries to be involved in the HIV response; (i) TACs are not functioning in all MDAs; and (j) HLI is a special category of public sector institution for which coordinating the HIV response in their sector is new.

Involvement of private sector: Gaps and challenges are that (a) formal private sector organisations are not yet mainstreaming HIV activities, and those employed informally are not targeted through any kind of programme; and (b) ABCZ, as the private sector umbrella organization, is new and needs mentoring and support as it grows in its stature and focus as an umbrella organization for HIV-related issues in the private sector.

CSO involvement: Challenges and gaps are that (a) the lack of a consistent, predictable flow of funds to CSOs and the need to strengthen capacity for CSOs to mobilise resources; and (b) the lack of strategic management plans for ZANGOC and ZAPHA+ to define, clarify and operationalise their roles as umbrella organisations instead of as AIDS service organisations.

4.5 Planning and Coordinating the HIV Response at the District and Community Levels

4.5.1 Situation in 2003

DACCOMs were established in some districts, but not all. The District Response Initiative (DRI) was started in 2004 to support the districts and broaden CSO activities in rural areas. In 2003, Government had just begun a process of local government reform that would imply decentralizing some of the functions of central government to local government structures. This reform would fundamentally affect the provision and coordination of all government-funded and government-coordinated services, including coordination of the HIV response at district level.

4.5.2 ZNSP Objectives Designed to Address the 2003 Situation

There is no specific ZNSP objective dealing with the district-level response to HIV.

4.5.3 Situation as of May 2007

Activities in which DACCOMs and SHACCOMs have been involved: During the past three years, three types of HIV activities have been implemented at district and community levels: (i) Activities planned and funded through ZAC and carried out by DACCOMs; (ii) activities planned and funded through ZAC and carried out by SHACCOMs, and (iii) activities planned and funded by other funders and carried out by CSOs. DACCOMs have developed their own HIV work plans, and submitted them to ZAC for funding. These work plans were not always informed by the strategies in the ZNSP (they stated that they were not aware of this strategic plan) or by the directives in the national HIV policy (the policy is new). Districts have not implemented workplace programmes for district level staff and shehia staff (internal mainstreaming). Districts also have not carried out
advocacy activities, as defined in the National HIV Advocacy and Communication Strategy and Roadmap. These two important documents are being revised to define clearly the role of the Districts in advocacy.

**Support for the DACCOMs and SHACCOMs to implement HIV activities:** The DRI was established to support the districts and shehias to carry out their HIV mandate. Currently, all districts are involved in the DRI with 299 shehias implementing activities. The DRI has focused on implementation of different types of HIV activities at the district and shehias levels, including training in Community Mapping and Theatre Against AIDS (COMATAA), training of peer educators, capacity building, developing by-laws related to HIV, community sensitization and MVC support. DACCOMs, CSOs and SHACCOMs have also been supported through capacity building; financial support; provision of material and financial support for MVC; renovation of office space; construction of youth centers; provision of IEC materials; provision of office furniture and equipment; and provision of motorcycles for transport.

**Funding for activities at the district and shehia levels:** RGoZ confirmed that so far, no allocations for HIV have been made within the government budget to districts and shehias. Districts have been accessing funds for HIV through the DRI and from ZAC directly. A MoU between ZAC and TASAF was signed in January 2006 to expand mechanisms through which funds could reach shehias and CSOs working in the districts. This MoU tasked TASAF with managing grants to CSOs and communities on behalf of ZAC. No funds have yet been disseminated by TASAF. The main reasons for the delays in awarding grants are: (a) a lack of clear procedures for disseminating funds to CSOs; (b) different organizational styles and expectations; and (c) communication breakdowns between the two organizations.

**Capacity to coordinate the HIV response at the district level:** It is evident from the districts’ HIV work plans that they planned to implement HIV services and not to coordinate all other organizations working in the field of HIV (DACCOM meetings offer a limited opportunity for coordination - only the efforts of those involved in the meeting can be coordinated). Reasons suggested were: (a) lack of funds for coordination; (b) lack of capacity to coordinate; and (c) lack of defined coordination procedures. DACCOMs, SHACCOMs and CSOs dispelled the perception that they do not have the capacity to coordinate, plan and implement HIV activities in the districts and in shehias. District representatives indicated during the Joint Review that given the funds, they can implement activities successfully. Not all stakeholders share this view, citing experiences from the DRI. Whilst some CSOs have perceived DACCOMs as being effective in encouraging teamwork, some development partners have expressed frustration at the DACCOMs’ lack of capacity to manage the DRI.

**Local government reform:** At present, the HIV response at district and shehia levels is the responsibility of MoRASD; after local government reform has been completed, districts will be responsible directly to ZAC for this function. The new national HIV policy stipulates that districts should be directly responsible for coordinating the HIV response in their area of jurisdiction, which is in line with local government reform. The HIV policy further states that the DACCOM and SHACCOM structures should fulfill this coordination role. DACCOMs and SHACCOMs are chaired by the District Commissioners and shehas, respectively. DACCOMs consist of stakeholders from all government Ministry representatives working in a district, district council staff, CSOs working within a particular district or shehias, and shehia representatives. There are, however, delays in the local government reform process that impair the commitment of districts to coordinate the HIV response at district level. The delays are due to the lack of workable statutory and administrative arrangements - districts and shehias lack, for example, decision-making power, are not fully accountable for financial resources given to them, and have no line function responsibility to coordinate the MDA staff who work at the district level. Once local government reform is a reality, coordination at the district and shehia levels will be a lot easier.

### 4.5.4 Specific Challenges and Gaps in 2007

The main governance challenges and gaps are: (a) DACCOMs and SHACCOMs lack a legal mandate as they were not created with the regular government structures; (b) DHAPs are not fulltime staff and also have other
non-HIV responsibilities; and (c) there is not a comprehensive unified HIV work plan for the district which would capture the District’s own activities, as well as the HIV activities of CSOs, other MDAs and SHACCOMs in the district.

The main funding challenges and gaps are: (a) There has been only one funding channel for Districts, through ZAC (government has not assigned any funding for Districts to implement HIV activities); (b) there have been delays in funding; (c) Districts were not always able to account for how funds were spent; (d) funds have not always been used for their intended purpose; and (e) funding application procedures have not been clear.

In communication and reporting, the main challenges and gaps are that: (a) before ZHAPMoS, there was no formal and regular communication channel between ZAC and the districts; and (b) ZAC has not communicated reasons for refusing or limiting funds to the Districts.

The main gaps in coordination and capacity building, are: (a) HIV service delivery is haphazard, not coordinated, not comprehensive, unintentionally duplicative; and not sustainable; (b) there are no clear operational procedures for the districts to carry out their coordination function; and (c) capacity building efforts focus on staff at headquarters or the districts, not grassroots organizations who need it most.

For involvement of PLHIVs at the district level, the main challenge is the language barrier; ZAPHA+ noted that some meetings and communications take place in English, making it difficult to understand.

### 4.6 Resource Mobilisation

#### 4.6.1 Situation in 2003

*Health Sector financing:* It was noted in 2003 that overall health sector financing by government had decreased “from 11.0% in 1998/99 to just 5.8% in 2003/04 of the total government budget” – see Figure 8 below. Actual disbursement to the sector has been less than 60% of the allocated amount due to limited revenues inflows in the country” (ZAC, 2003:38).

**Figure 11: Health Sector Financing as a Percentage of Overall Funding in Zanzibar, 2006**

![Figure 11: Health Sector Financing as a Percentage of Overall Funding in Zanzibar, 2006](source: ZAC, 2003:39)
Joint Review of the National HIV Response in Zanzibar 2004 to 2007

ZACP managed to mobilize resources from different development partners and from government. For example, between 1992 and 2003, ZACP received all their requirements for salary needs from government.

Prior to ZNSP, avenues for resource mobilization were narrow; few development partners were involved in the HIV response. Secondly, HIV issues had not been mainstreamed in the national budget framework and the government’s commitment of resources to HIV was small. Thirdly, there were fewer CSOs involved in the HIV response which limited human resources involved in resource mobilisation.

4.6.2 ZNSP Objectives Designed to Address the 2003 Situation

**Objective:** To mobilize sufficient and necessary resources from internal and external sources for effective implementation of HIV programme activities.

4.6.3 Situation as of May 2007

**A: Overall financing of the HIV response**

ZAC, ZACP and CSOs have mobilised resources from different sources through multilateral and bilateral arrangements. Not all funds mobilised are channelled through ZAC. Some of the funding the ZAC receives is for its own operations; other funds are to “on-grant” to other organisations to fund their HIV plans. Table 24 provides data on budgeted and actual expenditures from 2004 to 2006; Table 25 summarises the relative contribution of all stakeholders.

**Table 24: Overview of Public Sector Expenditure and Financing of HIV and AIDS Activities and Significant CSO Funding for Period July 2004 to June 2007 (TSH billion) in Zanzibar**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Expenditure (Exp.)</td>
<td>261.60</td>
<td>47.46</td>
<td>220.70</td>
<td>80.05</td>
<td>494.35</td>
</tr>
<tr>
<td>Donor Public Sector Support captured in Gov. Budget</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>484.56</td>
<td>-</td>
</tr>
<tr>
<td>Donor Public Sector Support not captured in Budgets</td>
<td>2,726.53</td>
<td>1,296.70</td>
<td>3,859.68</td>
<td>2,001.83</td>
<td>4,171.46</td>
</tr>
<tr>
<td>Total Donor Public Sector Support</td>
<td>2,726.53</td>
<td>1,296.70</td>
<td>3,859.68</td>
<td>2,001.83</td>
<td>4,171.46</td>
</tr>
<tr>
<td>Donor funds channelled to CSOs</td>
<td>371.11</td>
<td>320.08</td>
<td>692.44</td>
<td>627.74</td>
<td>1,716.86</td>
</tr>
<tr>
<td>Total Public Sector Exp. on HIV</td>
<td>2,988.13</td>
<td>1,344.17</td>
<td>4,080.38</td>
<td>2,081.88</td>
<td>4,665.81</td>
</tr>
<tr>
<td>Total Donor HIV Support in Zanzibar</td>
<td>3,097.64</td>
<td>1,616.78</td>
<td>4,552.12</td>
<td>2,629.57</td>
<td>5,888.32</td>
</tr>
<tr>
<td>International NGO expenditure on HIV</td>
<td>415.86</td>
<td>415.86</td>
<td>699.00</td>
<td>699.00</td>
<td>292.31</td>
</tr>
<tr>
<td>Total Public Sector and CSO Exp. on HIV</td>
<td>3,782.16</td>
<td>2,080.10</td>
<td>5,522.95</td>
<td>3,433.41</td>
<td>6,706.71</td>
</tr>
</tbody>
</table>

**Source:** Kibau and Islei, 2007
Table 25: Relative Contribution of all Stakeholders to the HIV Response in Zanzibar, 2004/5 to 2006/7

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Expenditure as % of Total Public Sector Expenditure</td>
<td>9%</td>
<td>4%</td>
<td>5%</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>Donor Funding as % of Total Public Sector Exp.</td>
<td>91%</td>
<td>96%</td>
<td>95%</td>
<td>96%</td>
<td>89%</td>
</tr>
<tr>
<td>% of Public Sector HIV Expenditure captured in Gov. Budget</td>
<td>9%</td>
<td>4%</td>
<td>5%</td>
<td>24%</td>
<td>11%</td>
</tr>
<tr>
<td>Donor Funds channelled to CSOs as % of Total Expenditure on HIV</td>
<td>10%</td>
<td>16%</td>
<td>13%</td>
<td>19%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Source: Kibau and Isei, 2007

The data in Tables 24 and 25 shows that:

a) In the past three financial years (2004/05 – 2006/07) there has been an increase in expenditure on HIV activities, in nominal and in real terms.

b) Government’s budget allocation to HIV has increased over time (4% in 2005/6 to 11% in 2006/7).

c) As a percentage of GDP, actual expenditure on HIV and AIDS activities grew from 0.42% of nominal GDP to 0.59% of nominal GDP (A study by Deloitte and Touche (2007) estimated the needed expenditure on HIV activities to be about 1.5% of GDP).

d) The real per capita expenditure rose from Tshs. 1 936 in 2004/05 to Tshs. 2 871, and is projected to rise to Tshs. 5 014 in 2006/07.

Costing related to HIV: A detailed costing of the HSSP was recently completed. This pointed to some startling results, which are yet to be disseminated. The costing suggests that there is a 95% funding gap in delivering all the health sector HIV strategies defined in the HSSP (including development partner contributions up to the end of 2008). The current costing of MKUZA includes HIV budget line items.

4.6.4 Specific Challenges and Gaps in 2007

Budgeted and actual expenditure for HIV activities in government differ: Every year, the actual amount disbursed to MDAs from RGoZ and actual expenditure is lower than budgeted expenditure, mainly because HIV funding is not ring-fenced within the government budget system. Funds allocated in the MDAs’ work plan for HIV activities are used for other purposes.

There are severe shortage in ZNSP and HSSP budgeting and funding: The 2007 PER indicates that actual expenditure in the health sector is Tshs 7.142 billion, whilst the HSSP costing indicates that Tshs 97.625 billion is required for the five years starting in 2007 to fund all future health sector expenditure. There is also a shortage of USD 16 million to implement all ZNSP strategies.

ZAC is responsible for managing grants: ZAC’s role in managing grants should be reviewed so that ZAC can focus on coordinating sectors rather than coordinating award of funds and implementation. ZAC should also develop fast track procedures to make the CARF fully functional, and then roll out funding on a national scale.

ZAC does not coordinate all funding: Though a large proportion of the resources are already coordinated under ZAC, there should be a mechanism to coordinate all funds, even those not directly awarded to ZAC. This does
not imply that all funding flows through ZAC, but ZAC should be aware of all funding sources and what money is used for.

Private sector’s contribution to the HIV response is small: ZAPHA+ has received some support from the private sector. The private sector should become involved both in implementing HIV activities and in funding them. HIV is a classic ‘public good’; programmes to strengthen the HIV response benefit everyone, including the private sector.

Uncertainty about where funding beyond 2009 for the HIV response will come from: This is probably the biggest challenge of the HIV response in Zanzibar. Development partners left with no warning in 1995, and may do so again for a number of reasons. Yet, 89% of the HIV budget is funded by development partners. There is an urgent need to do scenario planning, after a national operational plan has been developed. The scenario planning should look at answering the question: What can Zanzibar’s HIV response afford with different levels of funding, and what should be prioritized with different levels of funding? This is especially important in the light of the general global undertones on the ‘exceptionality of AIDS’. Some fundamental questions are being asked about whether HIV is over-funded relative to other health sector needs, and this may affect future HIV funding availability. Beyond 2009, no HIV funding is secured for Zanzibar, a matter of grave concern.

4.7 Advocacy

4.7.1 Situation in 2003

Coordination of advocacy activities: ZACP, who were mandated to coordinate the HIV response prior to 2003, did not focus on advocacy. The main reasons were that ZACP was not in a position at the time, as a government agency, to coordinate the efforts of government ministries.

4.7.2 ZNSP Objectives Designed to Address the 2003 Situation

Objective: To identify and incorporate effective and sustainable HIV advocacy mechanisms and strategies in public and non-public sectors that will counter stigma, discrimination and denial.

4.7.3 Situation as of May 2007

Nature of advocacy efforts: Advocacy has been undertaken at two levels: (a) Advocacy aimed at the general public to raise awareness about HIV and communicate key information; and (b) advocacy aimed at decision-makers in government to increase political and financial commitment from government.

Results of advocacy efforts: Advocacy efforts have contributed to a large extent to (a) increasing participation of stakeholders from all sectors in the HIV response; (b) ensuring that labour laws have been reviewed; (c) efforts to review the GOs are taking place; (d) there is a special line in the national budget for HIV interventions; and (e) IEC materials have been developed by civil society and other sectors for their own IEC efforts.

However, reading the documentation about the HIV response in Zanzibar and listening to what is being said in communities and in newspapers, there is an alarming trend: In its zealousness to advocate for HIV, the main message that seems to emanate from many sectors is that ‘HIV is a big problem in Zanzibar’ and ‘the HIV situation is about to explode in Zanzibar’. Yet the epidemiological data do not presage an ‘explosion’ or that it is a big problem – in over 10 years, the HIV prevalence grew from 0.6% to 0.9% - hardly an explosion. Some community members alluded to this, saying that: “Our leaders tell us that there is HIV in our community, but we don’t see it”. This poses a credibility threat for HIV communication.
4.7.4 Specific Challenges and Gaps in 2007

Challenges and gaps are that (a) Advocacy efforts to date have not focused on issues that could have the highest impact in reducing HIV incidence and prevalence; (b) Advocacy efforts have not been coordinated through an institutionalized body to guide activities and messages; (c) No networks have been formed for sharing experiences leading to stronger impact; (d) Advocacy efforts have not managed to actively involve senior decision makers to make changes in the legislative environment; (e) MARPs were not well targeted; and the media was not well utilized for delivering messages to target populations; and (f) The focus of advocacy messages has created the impression that ‘HIV is a big problem in Zanzibar that has had a major impact’ – a message which cannot be substantiated by persons living in Zanzibar, some of whom have said that “there is no HIV in Zanzibar – our leaders tell us that there is, but we don’t see it”.

4.8 Capacity and Institution Building

4.8.1 Situation in 2003

Nature of capacity building efforts: Some capacity building had taken place, most notably for health care workers in the provision of STI services and treatment. CSWs were trained in peer education by MDM, and 96 community volunteers were trained in HBC. Capacity building of NGOs that are members of ZANGOC focused on M&E, project proposal writing skills and techniques; VCT and HBC; and a study tour. The curriculum used at Kizimbani Agriculture College contained elements of HIV where students, extension workers and farmers are sensitized on the dangers of HIV and preventive measures against contracting STI HIV. SHACCOMs were trained, and an HIV curriculum included in the college of health sciences.

4.8.2 ZNSP Objectives Designed to Address the 2003 Situation

Strengthening Capacity of HIV Implementing Institutions: To increase capacity and coverage of HIV implementing institutions in advocacy, treatment, care and support to PLHIV, AIDS orphans and affected families at all levels with special focus on district or community levels.

4.8.3 Situation as of May 2007

Capacity is seen as the biggest constraint to effective HIV responses. It is a constraint at all levels, from the coordinating organizations (ZAC, ZACP, OCGS, HMIS, ZANGOC, ABCZ, ZAPHA+ and others), to the Ministries and Districts, and the CSOs. ZAC cannot strengthen capacity on its own; all sectors have a role.

Addressing Capacity Needs at ZAC: A 2004 technical and managerial assessment identified key areas of capacity that needed to be built (Muchirah et al., 2004). Recommendations included reorganizing the management, enhancing technical capacity, and reviewing the scheme of service. ZAC has enhanced the technical capacity of its own organisation through a review of its organisational structure, new recruitments, short-term courses, familiarization tours, and increasing physical assets. Progress has been made in addressing the ZAC scheme of service to provide incentives for ZAC employees to remain with the organisation and to work hard. A proposed new scheme of service was approved by the ZAC Board of Commissioners. Development partners are supporting specific areas of capacity building, such as involvement in the ARCAN initiative.
Addressing Capacity Needs of CSOs: In addition to capacity constraints that ZAC faced, CSO capacity was weak. ZAC therefore implemented an extensive capacity strengthening plan for CSOs in 2004 and 2005, after a capacity needs assessment, and continues to work with CSOs to address their needs in this area. For example, it has regular meetings with the Inter-Faith Forum (IFF); it has conducted a mapping of CSOs with a view to identifying areas that need to be improved.

Addressing Capacity Needs of MDAs: Technical capacity was uneven and very low in some MDAs. This posed a serious threat to the expected achievements of the HIV response. In trying to address these capacity problems, ZAC has been coordinating with and assisting MDAs to formulate work plans, and capacity building has taken place in various ways.

Addressing Capacity Needs in districts and communities: Districts and shehias also were not able to coordinate the HIV response well mainly because of their limited capacity in general (not only concerning HIV issues). ZAC has supported the districts by facilitating the establishment of DACCOMs, building capacity of DACCOMs and providing them with transport, and by supporting the districts to develop district plans that include HIV. CVM, the DRI and MSH have particularly focused on capacity strengthening of the districts.

4.8.4 Specific Challenges and Gaps in 2007

Challenges and gaps are that (a) The ZAC Scheme of Service has not yet been finalized or implemented; (b) improved capacity has not been harnessed and has not necessarily translated into improved implementation of interventions; (c) although the capacity of some sectors has been built, there are still stakeholders – especially at grassroots level and within districts and shehias – whose capacity needs to be built; (d) there is no quality assurance of capacity building programmes; and (e) capacity building efforts such as training workshops are misconstrued as events to ‘earn money’ from “sitting allowances” and per diems for attending workshops – this results in the same persons attending different training workshops.

4.9 Achievement of ZNSP Objectives relating to Enabling Environment

Good progress has been made towards the ZNSP objectives relating to an enabling environment:

**Increase capacity for HIV service planning, implementation, monitoring and evaluation:** Capacity has been built, but more needs to be done at the grassroots level to ensure that stakeholders are able to plan, implement, monitor and evaluate HIV services, and that they have the funds to do so.

**Advocacy to counter stigma, discrimination and denial:** Advocacy efforts have commenced and are now being structured through a national advocacy strategy. Implementing it will be vital to ensure that advocacy efforts are scaled up.

**Mobilise internal and external resources:** There is a vast improvement in the number of development partners and the amount of funding that they have committed, but more needs to be done to ensure the long-term commitment of development partners, that all interventions are cost effective, and that unsustainable, unproven or costly interventions are not implemented without operational research first being undertaken.

**Increase awareness, involvement and commitment of private and public sectors:** Compared to 2003, there is significant improvement in the involvement of the public sector – more MDAs are involved, and HIV work planning is mainstreamed within the government’s annual budgeting process. The next step would be to selectively provide increased focus to critical MDAs – e.g. MoEVT, MoTTI, MoHSW, and MoALE – as priority Ministries where the consequences of no action will be vast. Private sector entities are in the process of organizing themselves, and a strong focus for the next two years needs to be to involve them more meaningfully and increase the number of private sector institutions that are involved in the HIV response.
Formulate a national multisectoral HIV policy: This is a major success of the past three years – a national HIV policy has been formulated and approved by the Zanzibar parliament and cabinet.

Improve ZAC’s Board Of Commissioners and ZAC operations: ZAC has grown organically over time and has adapted to its ever-expanding role. However, in the next two years, it is essential to cement, clarify and set boundaries for ZAC’s role; otherwise the institution runs the risk of ‘trying to be everything to everybody’, which would not be wise organizationally.

In addition to the objectives listed above, some additional efforts are required to make this aspect of the HIV response comprehensive. There is a need in the immediate future: (a) to ensure the meaningful and appropriate involvement of political parties; (b) to ensure that the coordination role of the districts keeps pace with local government reform efforts, and that their role is mandated, clarified, operationalised and funded; and (c) focus on strengthening and clarifying the role of ZAC as a coordinating institution, and also the other coordinating institutions – IFF, UWAKUZA, ABCZ, ZANGOC, ZAPHA+, ZACP, OCGS, HMIS and ANGOZA.
Section 5: **JOINT REVIEW FINDINGS: MONITORING AND EVALUATING THE HIV RESPONSE**

This Section of the Joint Review Report provides information about the national HIV M&E system - The situation as of 2007 is being described using the 12 components of a functional HIV M&E system – see Figure 12 below:

**Figure 12: Twelve Components of a Functional HIV M&E System**

*Source: The World Bank, 2006*
5.1 Situation in 2003

Data available in 2003: Monitoring and evaluation is undertaken for the purpose of using data to improve decision making. Therefore, the status of data available in 2003 and the extent to which the data were used, is a measure of the status of the M&E system and M&E processes. In 2003, some biological surveillance had also been undertaken, and some operational research undertaken. Programme monitoring was central, and focused on medical HIV services delivered by MoHSW. A number of Knowledge, Attitude, Practice and Behaviour (KAPB) studies relating to HIV were completed:

- KAPB study by Africare
- KAPB study on sexual reproductive health, HIV and STIs on Policy /decision makers
- KAPB study on fishermen at North “A” district Zanzibar (Saadat, 1999)
- KAPB study on women of Unguja and Pemba
- MEES KAP study in 2000 in the education sector, which focused on HIV-related knowledge on students, HIV-related knowledge of Teachers, and on information on parental approval on MEES
- The Lumumba School Study by Othman et al, 2001
- The HIV Magnitude Validation Study (ZACP, 2003)
- Study Report on Knowledge level, attitudes, practices, perceptions and biases of policy level decision makers, community leaders and NGOs on Gender, sexual reproductive health, rights and STIs, HIV and AIDS, Advocacy and Gender Project Zanzibar, June 2004
- A Study on analysis of the policies and laws related to sexual and reproductive health and rights in Zanzibar by Ali Ali Hassan and Usu Mallya, April 2004

At the time, there was also mounting concern about the lack of data: “Although there isn’t sufficient information to make a comprehensive assessment of the extent to which adolescents have changed their sexual behaviour in response to the AIDS threat, there is need to put in place programmes that will promote a change in behaviour of adolescents so that they are less vulnerable to HIV infection” (MoYEWC, 2002)

HIV Research: HIV research was of particular concern. Some HIV research was of either low caliber due to methodological concerns and particular social sciences research was undertaken without ethical approval. Concurrently, the ethical components during the conduct of most of these studies were not effectively considered; coordinated and hence their adoption and utilisation to the planning process were very slim. At the time, there was a rampant shortage of researchers in all areas of specialisation in Zanzibar. HIV being a relatively new disease, required persistent investigation. There was therefore, at the time, calls for a multisectoral research institution.

5.2 ZNSP and HSSP Objectives Designed to Address the 2003 Situation

ZNSP Objectives:
Surveillance and Health Research: To increase capacity and quality of surveillance, monitoring and research in STI
Monitoring and Evaluation: To develop a national HIV monitoring and evaluation plan

HSSP Objectives
Goal 15: Improve the quality of strategic information. Targets include second-generation surveillance system in place by 2007
Goal 16: Improve the supervision system. Targets include 95% adherence to supervision schedules by year 2009
5.3 Situation as of May 2007

**HIV M&E Human Resources:** ZAC appointed a new, national HIV M&E four-person unit to manage the national HIV M&E system. The unit has had a technical advisor and technical support from a UN volunteer for the past 12 months. At the district level, the DHAPs have been assigned M&E responsibilities, but their functions have not been included in the national HIV M&E system.

**HIV M&E Partnerships:** There is a national coordinating body for HIV M&E – the Monitoring and Evaluation Task Team on HIV and AIDS in Zanzibar (METTHAZ). METTHAZ has active membership from the government agencies, and was recently trained in HIV M&E. The development partners who are meant to be METTHAZ members are not active and rarely attend meetings.

**HIV M&E Framework:** The national HIV M&E operational framework has been developed and was launched in May 2006. It has been printed, disseminated and a shortcut version of it in Swahili has been prepared.

**HIV M&E Road Map:** The National HIV M&E Road Map has been developed, costed, and approved. Development partner contributions have been added to it, and the Road Map was used as the basis for applying for M&E funds for Global Fund Round 6 funding (which was approved). A district M&E capacity assessment was developed, which formed the basis for developing District M&E Road Maps that were also costed.

**Strategic Information Flow:** There are four types of strategic information flow: surveillance; surveys; routine programme monitoring data about non-medical HIV services; and routine programme monitoring data about medical HIV services.

- In terms of surveillance, only ANC surveillance has been done, but a new protocol has been developed that will survey IDUs, CSWs and MSM every second year, alternating with ANC surveillance. Biological surveillance amongst IDUs was done in 2006, and biological surveillance amongst CSWs and MSM are currently being planned.

- In terms of surveys, a national HIV prevalence validation survey was executed in 2002. Further, a number of KAP studies have been undertaken and data for Zanzibar was collected and analysed separately as part of the Tanzania DHS (NBS and ORC Macro, 2005). However, a planned second generation surveillance system is still not active and behavioural surveillance data is lacking. Behavioural surveillance amongst CSWs and MSM is also being planned – together with the biological surveillance for these two MARPs – for 2007. Service availability mapping has been conducted for all districts in Zanzibar and the results are expected to be shared soon in collaboration with stakeholders. The National HIV M&E operational framework requests for the following surveys to be undertaken every two years: behavioural surveillance amongst the general population, behavioural surveillance amongst MARPs, a Quality of Health Services Survey (to monitor quality of HIV service delivery at health facilities), a Condom Quality and Condom Availability Survey, and a National Workplace Survey.

- In terms of routine programme monitoring data about community-based HIV service delivery, ZAC launched and is operationalising the national Zanzibar HIV and AIDS programme monitoring system (ZHAPMoS). The first quarter of data have been collated (Oct to December 2006) and a routine quarterly HIV service coverage report (QSCR) has been prepared. 56 out of 158 organisations (35%) that were trained in ZHAPMoS have reported in this first quarter of reporting. This report shows, for example, that:
  - 15,443 IEC materials have been disseminated
  - 1,511 male condoms have been distributed
  - 2,098 employees targeted through workplace programmes, of which 1,987 was in the urban region
  - 1,360 MVC; 72 elderly persons; and 23 widows supported
  - 988 persons trained in HIV service delivery
In terms of routine programme monitoring data about medical HIV services, ZACP and HMIS both collect data about the medical HIV services – see Table 26 below for the levels at which data are collected. Data about most medical HIV services are available from ZACP nationally, but not at the district level. A monitoring database (paper based and electronic systems) have been initiated in all ARV sites. However, more investments are needed in scaling and support the smooth running of the information system as well as decentralising HIV and AIDS care and treatment monitoring services in Zanzibar.

Table 26: Levels of Data Collection in MoHSW in Zanzibar, 2007

<table>
<thead>
<tr>
<th>Data level</th>
<th>Data collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient level data from some clinics and summary level data from all clinics</td>
<td>The patient level data includes variables such as patient age and sex, and ARV status, ARV regimen, pregnancy, TB status, pregnancy status on different visits. The summary level data counts number of patients and number on ARVs and also consists of cohort analysis numbers of patients staying on ARVs for different lengths of time.</td>
</tr>
<tr>
<td>Client level data</td>
<td>Includes variables such as age, sex, occupation, shehia/district, marital status</td>
</tr>
<tr>
<td>Patient level data</td>
<td>Includes variables such as age, sex, marital status, syndrome, shehia/district, occupation, case type (i.e. new, re-attendance), number of tablets of different medication given and numbers of condoms given</td>
</tr>
<tr>
<td>Summary level data from clinics</td>
<td>The ANC section of the database includes counts of numbers of patients starting ANC, numbers with different HIV status, and numbers on NVP/AZT/HAART therapy. The maternity section of the database includes numbers of deliveries (births), numbers with different HIV status, numbers who were on AZT/NVP/HAART therapy, numbers of infants on NVP/ARV therapy and numbers of infants on breast feeding and replacement feeding.</td>
</tr>
</tbody>
</table>

Source: Baker, 2007

There are four types of databases at MoHSW where HIV data are contained: Data in the District Health Information System (DHIS) which is managed by the Health Management Information Systems (HMIS) unit; other data collected by the main parts of the Ministry of Health which is not in the DHIS; Data in Zanzibar AIDS Control Programme (ZACP) databases; and other data collected by ZACP. Even amongst all these data sets, not all the medical HIV service indicators in the national HIV M&E system have been addressed.

Currently, the Mnazi Mmoja Hospital Care and Treatment Clinic (CTC) offer technical assistance to other CTCs in the country. Also, the MMH site offers opportunity for clinical ART training. An electronic database system has recently been introduced for clinical performance monitoring at Mnazi Mmoja Hospital and at PMTCT sites. To date, the database shows that only one patient is on the second-line ARV regimen in Zanzibar. Data on the actual number of people in Zanzibar who access ART from private or Tanzanian mainland health facilities and their health status are not available.

Currently, all STI/VCT information that are collected in the sites has been integrated in the HMIS of the MoHSW. A national STI surveillance system is being established, but not yet functional. This is particularly important, given the recent data about the link between HSV-2 and susceptibility to HIV infection.

The HMIS faces some challenges, including: lack of transport for the units to collect filled in forms; lack of funds at MoHSW for activities at the districts; incorrect filling of stroke forms due to not knowing how to do it; lack of material resources at Statistics Unit e.g. stationary and computers; some information never reaches the Statistics Unit at all (information on laboratory and drugs); no information is available on patients,
diseases and deaths from private health facilities; trained personnel leave the MoHSW for private hospitals; low morale due to lack of incentives, negative reinforcement, lack of functioning equipment and lack of materials; misallocation of staff – some health orderlies have been posted to work as typists, messengers and watchmen; lack of doctors and clinical officers at some health facilities which may lead to wrong diagnosis and therefore disease patterns that are not necessarily the true ones; poor record keeping of patient’s information in register books or stroke forms; lack of training for persons handling data; lack of cooperation with vertical programmes; lack of feedback to DHMTs and health facilities due to lack of stationery.

National HIV Database: Technical specifications for the national HIV database were developed and a contract was awarded for the National HIV database to be developed. Development is currently underway and will be concluded in July 2007. The database will allow for district-level data capture, once the districts’ IT capacity has been strengthened.

Supervision and data auditing: Supervision and data auditing is required for all routine HIV data – the data collected by MoHSW for medical HIV services and the data collected through ZHAPMoS for non-medical HIV services.

a) For MoHSW supervision: MoHSW is planning to train their staff in supervision of implementation and in supervision of M&E (i.e. data recording, collection, capture and analysis). Supervision has not yet taken place. Supervision and quality control in the health sector are currently inadequate due to are limited skilled professionals, limited and un-integrated supervisory guidelines and checklists and vertically inclined programme interventions

b) For ZHAPMoS supervision: Supervision guidelines have been developed for ZAC to supervise the DHAPs, and for the DHAPs to supervise the HIV implementers. Supervision has not yet taken place.

Harmonised capacity building: In general, an M&E capacity assessment carried out in 2005 by SIPAA ActionAid showed that capacity in M&E needed to be built at all levels of the system. The capacity of ZAC staff and METTHAZ members at the national level have been (and continues) to be built through a 2-week training session and ongoing technical support from the ZAC’s national HIV M&E advisor, and other development partners. MoHSW is planning to develop training programmes on monitoring, surveillance and research; and to strengthen the capacity of ZACP to manage and monitor second-generation surveillance system. At the district and HIV implementer level, ZAC has developed standard training curricula – one in M&E concepts and one in ZHAPMoS. All DHAPs, all umbrella organizations, ZAC staff, and 158 HIV implementers were trained in ZHAPMoS, whilst the DHAPs also received training in M&E concepts.

ZAC had a team of eighteen local trainers to undertake the ZHAPMoS and M&E training – this team has now formed the Zanzibar Monitoring and Evaluation Association (ZAMEA); ZAMEA’s mission is to build monitoring and evaluation skills and to promote the recognition of monitoring and evaluation as a profession in Tanzania.

In conducting future capacity building, innovative strategies will have to be devised, as there were observations during the review that “ZAC invites the same people over and over for workshops”.

HIV research: There is a national Research Council in Zanzibar, but it is not functional. No national HIV research agenda exists, and there is a shortage of funds for research to be undertaken. Specifically, research to monitor drug resistance is not currently done. CDC is planning to do size estimation studies of the sizes of CSW, IDU and MSM populations, so as to enable the Government of Zanzibar to answer the ultimate question: “How were the last 100 persons in Zanzibar infected with HIV?”

HIV M&E communications and advocacy: HIV M&E is new in Zanzibar. It is a new profession, and not an establishment post in government. Although civil society organizations have conducted monitoring and evaluation work, there is not a cadre of skilled M&E personnel available. Significant advocacy for monitoring
and evaluation is necessary, and activities for it have therefore been included in the national HIV communications and advocacy plan and accompanying Road Map.

Data dissemination and Information Use: MoHSW has co-ordinated data collection, analysis and publication (dissemination): this has been done at the district level. ZAC has disseminated information through their quarterly newsletter – Jihadhari – through face-to-face meetings, and through other periodic publications and large functions like World AIDS Day Celebrations.

Other M&E systems: The Government of Zanzibar has recently launched its MKUZA monitoring system. All other M&E systems (including the national HIV M&E system) will have provide data to this system. There also needs to be linkages between the National HIV M&E system and the MoHSW HIV M&E processes. The health related HIV strategic information is anticipated to be collected through ZACP and channelled to ZAC as guided in the national HIV and AIDS M&E framework which forms part of implementing the “three-ones” principles. The Population Planning Unit of the MOFEA coordinates a Shehia Register (Community Based Management Information System, or CBMIS) where demographic information about individual household members is supposed to be kept. Each page should contain the demographic information of each household member.

This register has benefited from funds from UNICEF and UNFPA since its establishment. However, at the moment this register is dormant and not updated accordingly because there is no financial support to make it operational. This is mostly due to lack of decentralisation system at the district level. If there was decentralisation, community data like that in the shehia register would be needed by the district planners. The Shehia registers complement ZHAPMoS, because it provides data about the demand for HIV services.

5.4 Specific Challenges and Gaps in 2007

Challenges and gaps are: (a) Linkages with ZACP, HMIS, OCGS and MKUZA monitoring system in terms of data collection requirements, electronic exchange of data, indicator selection, and approval of information products have not yet been harmonized; (b) capacity to develop the QSCR quickly and on time is lacking at the M&E unit; (c) The national HIV M&E system has not yet been operationalised at the district level, primarily due to a lack of funding; (d) There are not enough structured opportunities for different sectors to learn from each other and share information; (e) There are no mechanisms to build M&E capacity through an academic course, thereby making the profession of M&E ‘official’ and a defined career choice and career path; (f) all strategic information (surveys, surveillance and routine data) required in the national HIV operational framework are not being produced and captured in the national HIV database; (g) The national HIV database is not yet operational; (h) data auditing and supervision is not yet taking place; (i) the sizes of MARPs are unknown; (j) the need for the HIS has not been established; (k) A national HIV research strategy is not yet developed, nor an accompanying research agenda. Such a strategy would provide a solid basis for planning and soliciting funds to undertake research; (l) Zanzibar does not have sufficient data on MARPs, and undertaking the Tanzania HIV Indicator Survey at this stage will not be the most cost effective use of resources, which should rather be used to fund additional MARP surveillance; and (m) there is a lack of opportunities for HIV implementers to learn from each other: There are not sufficient opportunities for organizations who implement community-based HIV prevention programmes to learn from each other and to assimilate the research that has been done.

5.5 Achievement of ZNSP and HSSP Objectives Relating to M&E

All objectives are being addressed: the national HIV M&E system has been developed, the second generation surveillance system will be strengthened with the new biological surveillance protocol and the new behavioural surveillance protocol. Capacity in M&E still needs to be built, to cement and ensure that data are used for decision making.
Section 6: RECOMMENDATIONS – WHERE TO FROM HERE?

This section provides a summary list of recommendations for each of the HIV service delivery areas, enabling environment and impact mitigation. The recommendations contained in this Section will be used to develop clear milestones for the national HIV response in the next 24 months.
6.1 Recommendations on HIV Prevention in the Community and at Health Facilities

(1) **Develop a culturally-appropriate condom promotion, procurement, storage, distribution, use, disposal and quality control strategy, and include funding for its implementation in the MTEF.** The condom strategy should be culturally appropriate, educate young people on condom use, instructions on how to use it in Swahili. After the strategy has been approved, MoHSW and the private sector should implement the provisions of the condom strategy with immediate effect.

(2) **Diversify HIV prevention messages, target the implementation of HIV prevention programmes, and develop a mechanism to accredit peer educators.** The main challenge identified in this Joint Review in terms of HIV prevention is that HIV prevention messages are too general and not focused on specific education messages, messages are not communicated using all possible communication channels, and messages do not reach all persons who need it. It is therefore recommended that a national HIV prevention conference should take place which would lead to HIV prevention efforts being more focused, and implementing partners committing to reach specific target groups with specific messages. The conference should include sessions focusing on:

*A: Determining the proportion of infection*
- Modelling of the HIV response in Zanzibar in 10 and 20 years, depending on different prevention strategies chosen
- Presentation of size estimation and behavioural surveillance research
- Estimating the proportion of infection

*B: Sharing experiences in terms of implementing HIV prevention programmes*
- Experiences with programmes for in-school youth (such as AIDS awareness clubs), out-of-school youth, and people with disabilities
- Experiences with programmes to empower women through religious institutions
- Experiences with pre-marital HIV testing and with peer education programme for health care workers in the health care system
- Efforts to reach the hard-to-reach islets and MARPs (hidden and non-hidden MARPs – prisoners, traders, passengers of transportation services, students at study camps, massage parlor girls, persons who tend to funerals, etc)
- Experiences with tested/proven behaviour change interventions from other, similar countries
- How the Great Lakes Initiative on AIDS (GLIA) – a regional institution of which Tanzania is a member state - can assist to support Zanzibar’s mobile populations
- Mechanisms and channels of communication in Zanzibar, with a specific focus on those with special communication needs (e.g. for people with disabilities) in terms of all aspects of the HIV response
- Discussion on communicating about male circumcision and how to communicate about it in Zanzibar
- Experiences from the media in terms of IEC messages

*C: Updating HIV prevention strategies*
- Update the HIV communication and advocacy strategy
- Develop IEC materials focusing on HIV prevention and substance use prevention for specific target audiences

This conference should take place AFTER the results of the current round of biological and behavioural studies of MARPs have been released. It should use QSCR data from ZHAPMoS. The outcomes of the conference should be that (a) the proportion of infection in Zanzibar would have been estimated; (b) the National HIV communications and advocacy strategy would have been updated; and (c) ZAC and ZACP
would have a set of standard IEC materials with targeted, appropriate education messages – specific for each target population.

(3) **Catalyse all sectors to commit to delivering specific messages to specific target audiences using all possible communication channels.** Once the HIV prevention conference has taken place, implementers should commit to reaching specific target audiences with specific messages and using the channels of communication defined at the HIV prevention conference. The umbrella organisations (ABCZ, ZANGOC, TACs, the media and others) should play a coordinating role in mobilizing all organisations to become involved in HIV prevention and commit to fulfilling a specific role.

(4) **After the HIV prevention conference, develop guidelines relating to the new areas of HIV prevention:** (a) guidelines for pre-marital testing for the faith-based society; (b) guidelines for accrediting peer educators and ensuring the quality of peer education programmes; (c) guidelines for an alternative livelihood programme (economic empowerment programme) for the youth; and (d) guidelines for VCT post test clubs.

(5) **Implement an alternative livelihood programmes (economic empowerment programmes) for unemployed youth,** and link the implementation of these to HIV prevention and substance use prevention programmes. These programmes should aim to provide the unemployed youth with skills on how to become involved in income-generating activities and opportunities to access wage employment.

(6) **Establish VCT post test clubs in the community** for all persons who undergo HIV testing to reinforce behaviour change amongst those persons who have HIV negative test results.

(7) **Fast track the implementation of the HIV and substance use prevention programmes defined in the SU-HISP** according to WHO protocols and accompanied by an education package for the community.

(8) **Decentralise the national blood transfusion service for Unguja and Pemba.** Strengthening it would include (a) establishing blood banks at district hospitals, (b) developing a reliable distribution system; (c) developing a test kit reagent procurement system; and (d) developing a national non-financial reward scheme to a targeted group of low risk blood donors.

(9) **Strengthen the PMTCT programme** by (a) developing a comprehensive PMTCT communications strategy; (b) link it to the provision of paediatric ARV treatment; and (c) evaluate the PMTCT programme to assess why the male partners uptake has been so low.

(10) **Promote HBV vaccination** for all health workers, all persons who provide services to MARPs, and all MARPs.

(11) **Roll-out PEP services and universal precautions** to all health facilities in Zanzibar.

### 6.2 Recommendations on HIV Care and Treatment

(12) **Strengthen the health care system for the provision of HIV prevention, care and treatment services to ensure reliable, predicable and sustainable supply of drugs and supplies.** Strengthening the system includes the drug procurement system, infrastructure, and human resources for health - to ensure reliable and predictable supply of STI drugs, OI drugs, condoms and ARVs.

(13) **Promote private-public partnerships** in terms of HIV care and treatment provision.

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29. The guidelines for pre-marital testing should ensure that it is done in an ethically responsible way that will ensure that it is still done voluntarily, confidentially, and that every person will be able to decide for themselves to whom to disclose their HIV status.

30. A comprehensive PMTCT programme would include communication on: (a) the benefits of exclusive breast feeding up to 6 months and other related facts; and (b) including messages on family planning to ensure that pregnant women have access to appropriate information about family planning.
Strengthen the laboratory system in terms of quality assurance, specimen transport, infant diagnosis and drug resistance surveillance.

6.3 Recommendations on HIV Impact Mitigation

Implement a minimum package of HIV impact mitigation services that would be appropriate within the Zanzibari context. Such a minimum package would include (i) the strengthening of services provided to MVCs and improved coordination of MVC activities; and (ii) strengthening PLHIV associations by providing opportunities for them to be involved in HIV prevention and impact mitigation activities, and by providing access to income-generating activities.

6.4 Recommendations on an Enabling Environment for HIV Service Delivery

A: Political Will and Commitment

Strengthen government commitment to coordinate and lead the national response to HIV and AIDS, by implementing the UWAKUZA HIV strategy, by implementing workplace programmes for political party administrative staff; and by including HIV into the General Orders of Government to ensure that HIV be a central part of measuring Principal Secretary and District Commissioners’ performance.

B: Policy, strategies and legal frameworks

Update the ZAC Act and revise / enact all laws and policies defined in the national HIV advocacy and communications strategy what would support the provisions of the national HIV policy.

C: Resource mobilisation

Hold a resource mobilisation conference, subsequent to the HIV prevention conference, to focus and target available HIV resources.

Develop a comprehensive resource mobilisation strategy, that may include: (i) signing a Memorandum of Understanding with development partners to ensure longer term commitment and some predictability of funding and technical support; (ii) alternatives to ZAC managing grants for HIV service delivery; (iii) simplifying funding applications for HIV funding; and (iv) ring-fencing HIV funding within the MTEF, and assign a minimum percentage of funding for HIV.

D: Coordination

Strengthen the districts and shehias to coordinate HIV activities by (i) developing a registration system for CSOs; (ii) developing a system for annual planning of HIV interventions by all sectors and submission of plans to districts; and (iii) formalising the SHACCOMs and DACCOMs within government structures.

Implement the principles of the Joint Assistance Strategy for Tanzania in terms of coordination between and with development partners.

E: Institutional Capacity Development

At Coordination Level

Develop technical assistance plans and operational manuals for ZAC, ZACP, ZAPHA+, ABCZ, ZANGOC, DACCOMs, ZAC Board of Commissioners, the GF-CCM and IFF that will clearly define their operational roles and mandates as institutions responsible for aspects of coordination.

Implement the updated ZAC Scheme of Service as per the approval granted by the ZAC Board of Commissioners.
At Implementation Level

(24) **Develop and implement a structured national HIV capacity building plan and technical assistance plan** with innovative, on the job learning opportunities and a recognition of prior learning system for civil society (e.g. CSOs and umbrella organisations), private sector (e.g. ABCZ), public sector (e.g. TACs), and higher learning institutions to ensure their full participation in the HIV response and mainstreaming within their sectors.

(25) **Formalise HIV capacity building** within the academic institutions and government training institutions, and in conjunction with ZAMEA, so that M&E will be more attractive as a profession and a career path.

**F: Advocacy**

(26) **Review the Communications and Advocacy Strategy** to reflect the lessons from this Joint Review.

(27) **Disseminate all HIV strategies, guidelines and policies** to stakeholders involved in coordinating, monitoring, evaluating, planning, and implementing the HIV response.

(28) **Implement a comprehensive, national community mobilisation campaign.**

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### 6.5 Recommendations on HIV Monitoring and Evaluation

(29) **Strengthen routine monitoring at MoHSW** by (i) developing an M&E strategy for MoHSW’s HIV M&E efforts, and (ii) harmonising MoHSW systems to provide routine data for Quarterly HIV Service Coverage Report every quarter in electronic format.

(30) **Strengthen demand monitoring (monitoring of persons who need HIV impact mitigation services)** by reviving the CBMIS system (i.e. shehia-level registers of vulnerable persons).

(31) **Ensure continued funding for the M&E of the national HIV response** by (i) annually updating the national and district HIV M&E Road Maps and assigning resources to implement them, and (ii) developing HIV M&E budget guidelines for all sectors to enable them to budget for HIV M&E and include it as a separate line item in their budgets.

(32) **Promote data use** by (i) establishing an information and documentation centre to provide easy access to information; and (ii) developing and disseminating information products as mandated by the national HIV M&E system and distribute them.

(33) **Develop and put in place a quality management system for CSOs** through regular supervision, structured feedback and other quality control mechanisms.

(34) **Develop a national HIV research strategy and agenda,** and establish the institutional structures to coordinate research in Zanzibar. This research agenda should include (but not be limited to) this research / syntheses:

i) **Complete size estimation studies and other planned research** such as HIV prevalence and behaviour of other MARPs (not already covered).

ii) **Conduct a national HIV ‘proportion of infection’ workshop** with technical experts to estimate “Where has the last 100 infections come from?” The next review of the HIV response should not take place before this work has been completed.

iii) **Conduct a randomised control trial of a comprehensive harm reduction programme** in Zanzibar, which should include a methadone maintenance programme in a pilot area.
iv) Conduct research into the effectiveness of the current VCT sites and perceptions regarding issuing self test kits for HIV – the effectiveness of current VCT sites in terms of location, cost, the type and level of service provided, and the possibility of issuing self test kits to MARPs and other stakeholders who would like to access them.

Kindly refer to Annex K, where milestones for these objectives have been developed at the Technical Review of the Zanzibar Joint Review..
Section 7: Reference List

Abdulrahman, H. O. 2005. Study to Assess the Impact of CVM HIV and AIDS Programme on District and Shehia Level, 5 July 2005

Advocacy and Gender Project. 2004. Study Report on Knowledge level, attitudes, practices, perceptions and biases of policy level decision makers, community leaders and NGOs on Gender, sexual reproductive health, rights and STIs, HIV and AIDS. Zanzibar, June 2004


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CVM. 2005. Study to Assess the Impact of CVM HIV and AIDS Program on District and Shehia Level, July 2005

Dahoma et al., 2006 [need to insert article name]


Mkapa 2002

Joint Review of the National HIV Response in Zanzibar 2004 to 2007


Joint Review of the National HIV Response in Zanzibar 2004 to 2007

Section 7


Saadat. 1999. KAPB study on fishermen at North “A” district Zanzibar.


THIS Day Tanzania daily newspaper, 10 March 2007


UWAKUZA Strategic Plan - Revised 2005


ANNEX A: JOINT REVIEW DETAILED EVALUATION QUESTIONS

A: What new evidence on the drivers of the epidemic in Zanzibar that have emerged in the past 3 years?

B: Which HIV services\(^{31}\) (those defined in the ZNSP and those not originally defined in the ZNSP) have been delivered by stakeholders from various sectors in the past three years (implementation of the 1st of the Three Ones principles of a comprehensive HIV response)?

C: What has been the coverage of HIV services in Zanzibar (to determine whether the HIV response is of an appropriate scale)?

D: Which, if any, HIV services have been provided to most at risk populations?

E: Has an enabling environment\(^ {32} \) is in existence for implementing the ZNSP and HSSP objectives?

F: How effective has ZAC been in managing the HIV response\(^ {33} \) in all sectors at all levels (2nd of the Three Ones principles of a comprehensive HIV response)?

G: Which resources have been mobilised and utilised by all sectors since the start of the ZNSP, and which resources are still committed for the remainder of the ZNSP implementation period?

H: Are HIV stakeholders are collecting, capturing, storing, processing, presenting, disseminating and using appropriate information about the HIV response, the drivers of the epidemic, and the outcomes of the HIV response (the 3rd of the Three Ones of a comprehensive HIV response)?

I: What have been the challenges and gaps in terms of HIV service delivery, the enabling environment, and M&E of the national response?

Whilst addressing each of these objectives, the following cross cutting issues were taken into account: the focus on most at risk populations (MARPs); access to HIV prevention, treatment and support services by various vulnerable populations (the disabled, mobile and seasonal workers, females, vulnerable children, persons living with HIV (PLHIV)); legal issues; gender issues and the private sector.

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\(^{31}\) ‘HIV services’ are defined as HIV prevention services; HIV care and treatment services; and HIV impact mitigation services.

\(^{32}\) ‘Enabling environment’ is defined as the presence of policies and processes to minimise stigma and discrimination against people living with HIV; appropriate institutional structures; leadership and political commitment; appropriate levels of financial resources; appropriately skilled human resources; and committed and involved partners.

\(^{33}\) ‘Managing the HIV (and AIDS) response’ is defined as planning, resource mobilisation, coordination, implementation, monitoring, reporting and evaluating the HIV response.

<table>
<thead>
<tr>
<th>(c) ENABLING ENVIRONMENT</th>
<th>HIV prevention services (in community and at health facilities)</th>
<th>HIV care and treatment</th>
<th>HIV impact mitigation services</th>
<th>Monitoring and evaluation of HIV services &amp; enabling environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Framework</td>
<td>(d) National level</td>
<td>Zanzibar AIDS Commission (ZAC)</td>
<td>ZAC</td>
<td>ZAC</td>
</tr>
<tr>
<td>Political will</td>
<td>(d) National level</td>
<td>Parliament &amp; political parties</td>
<td>Parliament &amp; political parties</td>
<td>Parliament &amp; political parties</td>
</tr>
<tr>
<td></td>
<td>(d) Sub national levels</td>
<td>Parliament &amp; political parties</td>
<td>Parliament &amp; political parties</td>
<td>Parliament &amp; political parties</td>
</tr>
<tr>
<td>Planning, coordination &amp; management</td>
<td>(d) National level</td>
<td>All sectors</td>
<td>All sectors</td>
<td>All sectors</td>
</tr>
<tr>
<td></td>
<td>(d) Sub national levels</td>
<td>All sectors</td>
<td>All sectors</td>
<td>All sectors</td>
</tr>
<tr>
<td>Resource mobilisation &amp; utilization</td>
<td>(d) National level</td>
<td>All sectors</td>
<td>All sectors</td>
<td>All sectors</td>
</tr>
<tr>
<td></td>
<td>(d) Sub national levels</td>
<td>All sectors</td>
<td>All sectors</td>
<td>All sectors</td>
</tr>
<tr>
<td>Advocacy and communications</td>
<td>(d) National level</td>
<td>All sectors</td>
<td>All sectors</td>
<td>All sectors</td>
</tr>
<tr>
<td></td>
<td>(d) Sub national levels</td>
<td>All sectors</td>
<td>All sectors</td>
<td>All sectors</td>
</tr>
</tbody>
</table>

Source: Joint HIV Response Review Team
ANNEX C: DETAILED DATA ON HIV PREVALENCE OF VCT CLIENTS

Table 28: HIV prevalence amongst male and female VCT clients in Zanzibar between 2001 and 2005

<table>
<thead>
<tr>
<th></th>
<th>2001 - 2002</th>
<th></th>
<th>2004</th>
<th></th>
<th>2005</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number tested</td>
<td>HIV prevalence</td>
<td>Number tested</td>
<td>HIV prevalence</td>
<td>Number tested</td>
<td>HIV prevalence</td>
</tr>
<tr>
<td>Male</td>
<td>100 (pvt clinic only)</td>
<td>18.6%</td>
<td>8626</td>
<td>3.2%</td>
<td>7306</td>
<td>4.1%</td>
</tr>
<tr>
<td>Female</td>
<td>61 (pvt clinic only)</td>
<td>6.1%</td>
<td>4936</td>
<td>7.2%</td>
<td>6026</td>
<td>6.7%</td>
</tr>
<tr>
<td>Sex not mentioned</td>
<td>0</td>
<td>0%</td>
<td>15</td>
<td>6.6%</td>
<td>485</td>
<td>HIV prevalence not recorded</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1568 (all clinics)</td>
<td>10.3%</td>
<td>13577</td>
<td>4.7%</td>
<td>13817</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

Source: ZAC, 2003; ZACP, 2006

Table 28 shows an annual increase in the number of VCT clients, and also that the HIV prevalence of VCT clients is higher than that of the general population. Table 29 presents HIV prevalence data from VCT sites per district.

Table 29: HIV prevalence at VCT sites in all districts of Zanzibar, 2003 to 2005

<table>
<thead>
<tr>
<th>District</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>People Tested</td>
<td>HIV Positive</td>
<td>% Positive</td>
</tr>
<tr>
<td>UNGUJA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>3044</td>
<td>209</td>
<td>6.7</td>
</tr>
<tr>
<td>West</td>
<td>2705</td>
<td>193</td>
<td>7.1</td>
</tr>
<tr>
<td>North 'A'</td>
<td>671</td>
<td>21</td>
<td>3.1</td>
</tr>
<tr>
<td>North 'B'</td>
<td>300</td>
<td>17</td>
<td>5.7</td>
</tr>
<tr>
<td>Central</td>
<td>348</td>
<td>18</td>
<td>5.2</td>
</tr>
<tr>
<td>South</td>
<td>251</td>
<td>22</td>
<td>8.8</td>
</tr>
<tr>
<td>PEMBA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chake Chake</td>
<td>1164</td>
<td>42</td>
<td>3.6</td>
</tr>
<tr>
<td>Micheweni</td>
<td>132</td>
<td>06</td>
<td>4.5</td>
</tr>
<tr>
<td>Mkoani</td>
<td>533</td>
<td>24</td>
<td>4.5</td>
</tr>
<tr>
<td>Wete</td>
<td>633</td>
<td>34</td>
<td>5.4</td>
</tr>
<tr>
<td>Not mentioned</td>
<td>-</td>
<td>07</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10976</td>
<td>593</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Source: ZACP, 2006
ANNEX D: DETAILED DATA ON GENDER IMBALANCES

Tables 30 and 31 contain key gender-related information that impact on women’s vulnerability to HIV. The Tables provide information about women’s decision-making status in society (Table 30) and views about sexual and gender-based violence (Table 31).

Table 30: Responses to Questions about Types of Decisions that Women in Zanzibar Can Make (according to men and women), 2004

<table>
<thead>
<tr>
<th>Type of decision</th>
<th>% women who said “yes”</th>
<th>% of men who said “yes”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own health care</td>
<td>41.2</td>
<td></td>
</tr>
<tr>
<td>Making large purchases</td>
<td>15.6</td>
<td>24.2</td>
</tr>
<tr>
<td>Making daily purchases</td>
<td>17.7</td>
<td>56.2</td>
</tr>
<tr>
<td>Visit to family or friends</td>
<td>36.0</td>
<td>29.4</td>
</tr>
<tr>
<td>What food to cook every day</td>
<td>47.9</td>
<td></td>
</tr>
<tr>
<td>What to do with money she earns</td>
<td>65.0</td>
<td></td>
</tr>
<tr>
<td>How many children to have</td>
<td>62.8</td>
<td></td>
</tr>
</tbody>
</table>

Source: NBS and ORC Macro, 2005

Table 31: Responses to Questions that Reflect Attitudes Towards Wife Beating and Refusal to have Sex in Zanzibar, 2004

<table>
<thead>
<tr>
<th>Type of decision</th>
<th>Unguja</th>
<th>Pemba</th>
<th>Zanzibar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife beating/hitting by husband is acceptable if..</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>…wife burns the food</td>
<td>6.2% F</td>
<td>3.3% M</td>
<td>6.8% F</td>
</tr>
<tr>
<td></td>
<td>22.0% F</td>
<td>21.2% M</td>
<td>21.2% F</td>
</tr>
<tr>
<td>…wife argues with him</td>
<td>26.3% F</td>
<td>21.4% M</td>
<td>26.0% F</td>
</tr>
<tr>
<td></td>
<td>22.4% F</td>
<td>24.3% M</td>
<td>20.6% F</td>
</tr>
<tr>
<td>…wife goes out without telling him</td>
<td>17.7% F</td>
<td>15.1% M</td>
<td>18.0% F</td>
</tr>
<tr>
<td></td>
<td>88.4% F</td>
<td>87.8% M</td>
<td>81.2% F</td>
</tr>
<tr>
<td>Refusal to have sex is ok if</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>… wife knows husband has STI</td>
<td>81.3% F</td>
<td>72.6% M</td>
<td>74.7% F</td>
</tr>
<tr>
<td></td>
<td>88.8% F</td>
<td>85.1% M</td>
<td>86.7% F</td>
</tr>
<tr>
<td>… wife is tired or not in the mood</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: NBS and ORC Macro, 2005

Tables 30 and 31, as well as other data presented in this report, point to the following gender-related factors in Zanzibar that are potential drivers of the epidemic:
- **Multiple sexual partners in polygamous marriages** 18% of men have at least one co-wife – this is not necessarily a gender imbalance, and the only risk for HIV is if one of the partners in a polygamous relationship is unfaithful.

- **Limited decision making power among women.** Table 30 shows that women have some decision-making power, but that there is room for improvement. It also shows that women and men disagree in terms of which areas women should make decisions – e.g. making daily purchases, where only 17.7% of women and 56.2% of men feel that women should make these decisions. Table 31 shows that men and women in Unguja agree on most reasons why wife beating or refusal to have sex is acceptable, but that there are stark differences in Pemba, where 31.7% of men feel that it is acceptable to beat his wife if she refuses to have sex with him, and only 53.5% of men feel that it is in order for a wife to refuse sex if she is tired or not in the mood. Only 41% of women feel they can make decisions about their own health – see Table 30 – and those that can make decisions about their own health care: 36% said that lack of money for treatment was the main reason, whilst 47% stated reasons related to transport.

- **Economic factors** - 45.6% of women were unemployed in the 12 months preceding the survey in 2004, compared to 32.9% of men. Also, 78% of the work that women do in the agricultural sector in Tanzania is unpaid work, whilst 92% of them work for family members.

- **Biological factors** - male circumcision is virtually uniform in Zanzibar. As male circumcision offers 70% biological protection for HIV negative males to become infected with HIV. Male circumcision does not, however, provide any protection for HIV negative women (Hayes, 2007).
At a recent conference it was suggested that HIV prevention for substance users would need to acknowledge the following:

- Countries that have achieved high coverage should provide knowledge and experience to emerging HIV and IDU epidemic countries
- The need to involve all possible stakeholders from the government such as law enforcement authorities, the police, correctional facilities various ministries such as Ministry of Interior and the Ministry of Justice to promote favourable legislation and action that would effectively address HIV among injecting drug users.
- Tension between policies and technical solutions leading to conflicting priorities. The need for continued political advocacy to promote evidence-based interventions.
- The need for legislative reform in many countries; the need for published good practices that could be used as advocacy tools to convince authorities.
- Even if favourable legislation is in place in certain countries, obstacles arise in the application of these laws, especially at regional and local levels, thus hindering the process of scaling towards universal access among injecting drug users.
- Capacity building across sectors, including personnel in police, prisons, law enforcement, policy makers and peer educators and ensure that they can articulate issues relevant to the needs of injecting drug users.
- Gender dimension to reaching injecting drug users with HIV related services. Female injecting drug users have to be reached with services tailored to their needs, with a special emphasis on HIV positive women.
- Detoxification services for drug users should also be linked to other public health services such as primary health care, Prevention of Mother To Child Transmission of HIV (PMTCT) and sexual and reproductive health care services.
- Injecting drug use and HIV related issues in prisons. How could one best to reach inmates with a comprehensive package of services, including HIV testing counselling and care. Female inmates were also recognised as a highly vulnerable group that would need tailored attention and care.
- The role of civil society organisations in reaching most-at-risk populations such as injecting drug users and prisoners and in effectively addressing HIV and related stigma at community level. Civil society actors and community outreach workers need to be empowered through skills building and through technical and financial support.
- The promotion of dialogue and partnerships between governmental authorities, the private sector and civil society in order to effectively address the HIV epidemic among injecting drug users and in prisons and to scale-up national efforts towards reaching universal access.
- Discussion around Methadone, purchasing, minimum and maximum dosages
- The importance of quality control in service provision
## Table 32: Target populations for community-based HIV prevention services in Zanzibar, 2004 - 2007

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Type of prevention intervention currently delivered</th>
<th>Current Implementers and partners for each intervention</th>
<th>Priority intervention as spelled out in the ZNSP for each priority group</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL POPULATION</td>
<td>HIV and AIDS prevention education including awareness creation, counseling, Youth friendly service centers, Premarital testing</td>
<td>Save the Children of UK, FBO, ZAFIDE, ZAYADESA, Ministry of Agriculture, Natural Resources, Environment and Cooperatives</td>
<td>§ Peer education through TOT trainings</td>
</tr>
<tr>
<td>In-school and out-of-school youth between ages of 13 – 24</td>
<td>Promotion of religious focused communication promoting fidelity during Friday prayers, funeral ceremonies and congregations</td>
<td>Interfaith Committee through faith based organization members</td>
<td>§ Behavior Change Communication</td>
</tr>
<tr>
<td>Religious communities</td>
<td>HIV and AIDS prevention education</td>
<td>Commission for Tourism – small scale traders, food vendors e.g Kibanda Ugali ZANGOC members, ZAFIDE</td>
<td>§ Peer education through TOT trainings</td>
</tr>
<tr>
<td>Women Groups</td>
<td>HIV and AIDS seminars to 297 fishermen, livestock keepers, tree growers and farmers</td>
<td>Ministry of Agriculture, Natural Resources, Environment and Cooperatives</td>
<td>§ Behavior Change Communication</td>
</tr>
<tr>
<td>VULNERABLE POPULATIONS</td>
<td>HIV and AIDS seminars to 297 fishermen, livestock keepers, tree growers and farmers</td>
<td>Ministry of Agriculture, Natural Resources, Environment and Cooperatives</td>
<td>§ Peer education through TOT trainings</td>
</tr>
<tr>
<td>Fishermen</td>
<td>HIV and AIDS seminars to 297 fishermen, livestock keepers, tree growers and farmers</td>
<td>Ministry of Agriculture, Natural Resources, Environment and Cooperatives</td>
<td>§ Behavior Change Communication</td>
</tr>
<tr>
<td>Target Population</td>
<td>Type of prevention intervention currently delivered</td>
<td>Current Implementers and partners for each intervention</td>
<td>Priority intervention as spelled out in the ZNSP for each priority group</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Disabled people including physically challenged, blind and deaf people | Sensitization meeting on HIV and AIDS prevention | Association of disabled people  
Zanzibar Association for the Blind (ZANAB)  
Zanzibar Association of people with Disabilities (ZAPPD) | ▪ Promotion of safer sex practices  
▪ Prevention education on HIV and AIDS transmission  
▪ Development of mass media campaigns that enhance knowledge  
▪ Sexual Education and negotiation skills  
▪ Integrate HIV and AIDS in rehabilitation programmes |
| Sex Workers (men and women)               | Condom distribution and peer education               | MDM (not in existence any more)  
Clinton Foundation –  
Zanzibar AIDS Control Program – took over coordination of peer education activities  
Private sector Shamshu pharmacy, a few kiosks, Population Services International | ▪ Focused education on sex and condom negotiation skills and peer education  
▪ STI management and VCT promotion  
▪ Harm reduction and prevention education  
▪ On going qualitative research on them and their clients to gain an understanding of determinant and fueling factors |
| Substance Users                          | Counseling and support  
Capacity building to NGOs and FBOs  
Regular TV and radio programmes on substance use prevention  
School health programme on substance use prevention  
Workplace programmes on substance use prevention  
Community programmes on substance user prevention in general population  
Livelihood skills particularly related to tour guide, provision of milk  
Continuous studies to provide more insight into the situation  
Hospitalization in the psychiatric/mental hospital, hospital food  
Hospitalization and intoxication program | ZAYADESA  
ZIADA  
ZASARNET  
Commission for Tourism  
Dr Dalu Private Hospital (used to be active, now closed)  
Kidongo Chekundu Mental Hospital  
DSAPR, MoHSW | ▪ Introduce friendly rehabilitation centers, vocational training schemes  
▪ Use of peer to implement peer education  
▪ HIV and AIDS education  
▪ Harm reduction education  
▪ STI management including VCT  
▪ Increase number and capacity of CSO working with substance users  
▪ Develop communication programs that educate communities about the problem and help them with how to handle them  
▪ Revisit capacity of government institutions involved in the control of drug abuse |
| Uniformed Personnel                      | AIDS Committees  
Peer education  
STI and VCT clinics | Ministry of Regional Administration and Special Departments  
Bububu military hospital | ▪ Peer education  
▪ Sound education system to reach staff and families  
▪ Put in place user friendly STI management including |
<table>
<thead>
<tr>
<th>Target Population</th>
<th>Type of prevention intervention currently delivered</th>
<th>Current Implementers and partners for each intervention</th>
<th>Priority intervention as spelled out in the ZNSP for each priority group</th>
</tr>
</thead>
</table>
| Clove pickers and social events including Uhuru Torch Rally, Mwaka Kogwa | Koani province has enacted by laws which are now operational, the by laws prohibits young people from attending any evening activities outside family activities including disco, jobless gatherings also know as “maskani” Sensitization meeting | DACCOM (District AIDS Coordinating Committee) Ministry of Trade, Tourism and Investment | ▪ Develop advocacy and behavior change communication before, during and after seasons  
▪ Conduct periodic community based communication campaigns to educate your target audience on how their occupation make them vulnerable to the disease  
▪ Promote condom distribution through community based supply chain |
| Prisoners                             | No intervention                                                                                                     | No intervention                                                                       | No interventions listed                                                  |
| Mobile Traders                        | No intervention                                                                                                     | No intervention                                                                       | ▪ Behaviour change communication programs  
▪ Peer education programs  
▪ Access to condoms  
▪ STI management |
| Passengers, Transportation Services   | No intervention                                                                                                     | No intervention                                                                       | ▪ Design special education programme on HIV for Daladala owners and operators.  
▪ Ensure legal environment on protection of workers and their rights based on ILO recommendations.  
▪ Promote HIV campaigns on Daladala commuters by using various IEC materials (through posters, stickers and spot announcement on cassettes or speakers.)  
▪ Conduct behavioural surveillance for drivers and their assistants/conductors.  
▪ Promote safe sex practices (including access to quality condoms). |

NOTE: GREY shaded areas in the above table indicate those vulnerable populations that have not been targeted through any intervention programme.
## Table 33: PMTCT services delivered in Zanzibar in 2006

<table>
<thead>
<tr>
<th>Beneficiaries and type of service rendered</th>
<th>The PMTCT site performing the services</th>
<th>Mnazi Mmoja</th>
<th>Mwembe Ladu</th>
<th>Chake Chake</th>
<th>Kivunge</th>
<th>Marie Stopes</th>
<th>Wete</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New ANC attendees</td>
<td></td>
<td>2825</td>
<td>2674</td>
<td>1301</td>
<td>857</td>
<td>280</td>
<td>140</td>
<td>8077</td>
</tr>
<tr>
<td><strong>ANC received HIV counseling</strong></td>
<td></td>
<td>2769</td>
<td>2649</td>
<td>1301</td>
<td>857</td>
<td>269</td>
<td>68</td>
<td>7913</td>
</tr>
<tr>
<td><strong>Had HIV test</strong></td>
<td></td>
<td>2769</td>
<td>2649</td>
<td>1301</td>
<td>857</td>
<td>260</td>
<td>68</td>
<td>7904</td>
</tr>
<tr>
<td><strong>Found HIV+</strong></td>
<td></td>
<td>47 (1.7%)</td>
<td>61 (2.3%)</td>
<td>9 (0.07%)</td>
<td>5 (0.58%)</td>
<td>5 (1.9%)</td>
<td>0 (0.0%)</td>
<td>127 (1.6%)</td>
</tr>
<tr>
<td>ANC clients came for delivery &amp; had not tested HIV status</td>
<td></td>
<td>6659</td>
<td>4783</td>
<td>1699</td>
<td>558</td>
<td>85</td>
<td>93</td>
<td>13 877</td>
</tr>
<tr>
<td>Tested for HIV status while in delivery ward</td>
<td></td>
<td>448</td>
<td>416</td>
<td>393</td>
<td>55</td>
<td>2</td>
<td>15</td>
<td>1 329</td>
</tr>
<tr>
<td>Delivering in ward &amp; had test HIV+</td>
<td></td>
<td>17 (3.8%)</td>
<td>10 (2.4%)</td>
<td>2 (0.05%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>29 (0.22%)</td>
</tr>
<tr>
<td>ANC HIV+ clients delivered at hospital</td>
<td></td>
<td>33</td>
<td>17</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td>Mother and baby given Nevirapine</td>
<td></td>
<td>23</td>
<td>12</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>41</td>
</tr>
<tr>
<td>Male spouses tested for HIV</td>
<td></td>
<td>56</td>
<td>113</td>
<td>17</td>
<td>24</td>
<td>16</td>
<td>1</td>
<td>227</td>
</tr>
<tr>
<td>Male spouses tested HIV+</td>
<td></td>
<td>1 (1.8%)</td>
<td>3 (2.7%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>4 (1.8%)</td>
</tr>
</tbody>
</table>

Source: ZACP, 2006
ANNEX H: DESCRIPTION OF SU-HISP

The implementation of SUHISP shall take in consideration the multisectoral nature of the HIV dynamics and the need to closely collaborate various actors and related sub-population groups in Zanzibar. Although the key focus of SUHISP is on MARPs, the plan intends to cover significantly the illicit substance abusers in Zanzibar. SU-HISP is envisaged to complement efforts and key interventions outlined in ZNSP and the health sector strategic plan.

Attention to MARPs: The SU-HISP gives ample attention to emerging population becoming more vulnerable to STI/HIV - the prisoners, youths, CSW and their clients, MSM, young people and children. Equal consideration will be provided to MARPs who use substances (substance users, or SUs). These include general SUs, IDUs, on-the-road CSWs and MSM as well as infected and affected SU in Zanzibar. Providing HIV prevention information, HIV prevention, care and treatment services will continue among the workforce, in-school youth, out of school youth and the general public.

SU-HISP intervention areas: Key goals will be realised through enhanced:

- Institutional capacity development plans.
- Policies and legal reinforcement
- Prevention strategies
- Increased access to care and treatment services.
- Outreach and community based interventions.
- Multisectoral collaboration
- Monitoring and evaluation schemes including research (operational)

Five regional centres are planned to focus on service provision to MARPs.
The greatly increased risk of HIV transmission when formula or baby food is used in addition to breast-feeding has been starkly confirmed in a recent Lancet paper (Coovadia et al., 2007). The risks of HIV transmission by breastfeeding - if used exclusively - were found to be low, around 4% at 6 months. Infants who received formula in addition to breast milk were nearly twice as likely to be infected. **Those who also received solids were nearly 11 times more likely to acquire HIV infection.**

Abundant international experience has demonstrated the protective effect of breastfeeding. Recent studies have shown that the increased mortality in infants receiving formula replacement as part of PMTCT might offset the survival gains from reduced HIV transmission.

The authors calculate that around **250 000 infant infections per year could be averted** if HIV-infected mothers exclusively breastfed for 6 months and then ceased - rather than the more usual 18-24 months of mixed feeding.

A reminder that this new evidence was reflected in a WHO consensus statement, issued late in 2007 which, amongst other recommendations, states: **Exclusive breast-feeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breast-feeding by HIV-infected women is recommended.** (Oelrichs, 2007)
ANNEX J: NEW VCT RESEARCH EVIDENCE

Effect of two types of VCT strategies on HIV incidence

The objective of the study was to investigate HIV incidence during a trial of two voluntary counselling and testing (VCT) strategies. The first type of VCT strategy was an intensive strategy that consisted of “pre-test counselling, risk assessment, testing, results and post-test counselling with risk reduction planning on the same day” (Corbett et al., 2007: 484); whilst in the standard VCT strategy involved pre-test counselling and risk assessment and a pre-paid voucher to attend VCT services at a standalone VCT site. The persons in the standard VCT programme were given a 2-week appointment to discuss their results. In the intensive VCT programme counseling and testing were done on-site and immediately, whilst in the standard VCT programme pre-test counseling, testing itself, and post-test counseling was done over a two-week period and not all at the same location.

The study results indicate that there was no correlation between the type of VCT and HIV incidence – HIV incidence was higher in the group that were exposed to the intensive VCT approach. HIV testing has little effect on risk-taking or incidence of STIs among individual HIV-negative clients. Knowledge of HIV-negative serostatus does not lead to behaviour change (Corbett et al., 2007).

The study clearly showed that although rapid HIV testing at VCT sites might be more acceptable to VCT clients, it may not lead to the same behavioural impact. There are even studies that suggest that learning that one is HIV negative during VCT is followed by higher risk behaviours (Corbett et al, 2007) – which is the opposite of what VCT programmes have been trying to achieve. Research suggest that the contribution from VCT towards HIV prevention comes primarily from identification of HIV-positive clients.

The implication for Zanzibar is immediate: in a context with low HIV prevalence, the majority of VCT clients will be HIV negative. There is not yet conclusive research to show that rapid VCT services have the most potential positive behavioural outcome. More research is needed to maximize VCT benefit and minimize harm.
ANNEX K: MILESTONES – WITH DETAILED DATES

Milestones for the next 30 months of the HIV response in Zanzibar (2007 to 2009)

Definition: What are milestones? The literary definition of a milestone is that it is a “stone post at side of a road to show distances”. Within a programme planning context, a milestone is a “scheduled event signifying the completion of a major deliverable or a set of related deliverables. It is a flag in the workplan to signify some other work has completed. Usually a milestone is used as a programme/project checkpoint to validate how the programme/project is progressing and revalidate work. Milestones are also used as high-level snapshots for management to validate the progress of the programme/project. In many cases there is a decision to be made at a milestone. Milestones can also be described as a significant accomplishment; an intermediate goal, a very important event or a significant point or stage. Within the context of the ZNPS review, milestones are therefore the critically important recommendations that need to be implemented in order to accelerate and move the HIV response forward in a way that addresses the issues that were raised during the midterm review. Therefore, the list of milestones below has been selected from the comprehensive list of recommendations provided in the Joint Review Report.
<table>
<thead>
<tr>
<th>MILESTONE</th>
<th>RELEVANT RECOMMENDATION</th>
<th>GOVERNMENT AGENCY RESPONSIBLE FOR IMPLEMENTATION</th>
<th>PARTNER ORGANIZATIONS</th>
<th>ACHIEVED BY</th>
<th>DEPENDENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV PREVENTION IN THE COMMUNITY AND AT HEALTH FACILITIES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. National HIV prevention conference conducted</td>
<td>Recommendation 2</td>
<td>Zanzibar AIDS Commission</td>
<td>ZACP, CSOs, ABCZ, Ministry of Education, MDAs, Chief Ministers office, development partners</td>
<td>December 2007</td>
<td>Conference is organized</td>
</tr>
<tr>
<td>2. Transport system for the blood transfusion service between national blood bank and district hospitals operational</td>
<td>Recommendation 8</td>
<td>National Blood Transfusion Service</td>
<td>ZACP, ZAC, Development partners</td>
<td>December 2007</td>
<td>Government commits to ring fence funding for drug procurement</td>
</tr>
<tr>
<td>3. Funding for PEP and universal precautions secured up to 2009</td>
<td>Recommendation 11</td>
<td>ZACP</td>
<td>ZAC, MoHSW, MoFEA, development partners</td>
<td>December 2007</td>
<td>Development partners show interest in funding this programme</td>
</tr>
<tr>
<td>4. PMTCT communication strategy launched by MoHSW</td>
<td>Recommendation 9</td>
<td>ZACP</td>
<td>ZAC, DPG AIDS/HEALTH, Private health care providers, PSI, ABCZ, UN, CHAI, PEPFAR, GF</td>
<td>December 2007</td>
<td>Review Guidelines including FP, Retraining Health Staff Consultancy</td>
</tr>
<tr>
<td>5. HIV implementers signed letters of commitment with ZAC to deliver specific HIV education to specific target audiences</td>
<td>Recommendation 3</td>
<td>Zanzibar AIDS Commission</td>
<td>ZACP, CSOs, ABCZ, Ministry of Education, MDAs, Chief Ministers office, development partners</td>
<td>March 2008</td>
<td>Willingness of HIV implementers to sign letters of commitment with ZAC</td>
</tr>
<tr>
<td>6. Funding for an economic empowerment programme for out-of-school youth has been approved</td>
<td>Recommendation 5</td>
<td>ZAC</td>
<td>MoFEA, development partners, Social welfare department (MoHSW)</td>
<td>March 2008</td>
<td>Development partners show interest in funding this programme</td>
</tr>
<tr>
<td>7. Guidelines for VCT post-test clubs approved by MoHSW</td>
<td>Recommendation 4</td>
<td>Ministry of regional admin and special forces</td>
<td>ZACP, DACCOMS and SHACCOMS, Youth clubs and Information Centers, development partners</td>
<td>March 2008</td>
<td>Availability of funding and best practices from within and outside the country</td>
</tr>
<tr>
<td>MILESTONE</td>
<td>RELEVANT RECOMMENDATION</td>
<td>GOVERNMENT AGENCY RESPONSIBLE FOR IMPLEMENTATION</td>
<td>PARTNER ORGANIZATIONS</td>
<td>ACHIEVED BY</td>
<td>DEPENDENCIES</td>
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</tr>
<tr>
<td>8. Condom Strategy approved by parliament</td>
<td>Recommendation 1</td>
<td>Zanzibar AIDS Commission</td>
<td>CSO, IFF, ZACP, DPG AIDS/HEALTH, CSOs, PSI, ABCZ, development partners</td>
<td>June 2008</td>
<td>Consultative processes with faith based groups, ability of top government leaders in the government of the ruling party and main opposition party to agree to not publicly denounce the process</td>
</tr>
<tr>
<td>9. Guidelines for pre-marital HIV testing approved by IFF</td>
<td>Recommendation 4</td>
<td>ZACP</td>
<td>IFF, CSOs, UN agencies, Ministry of Education</td>
<td>June 2008</td>
<td>IFF commits to using a set of guidelines for pre-marital testing</td>
</tr>
<tr>
<td>10. Detoxification centre built and functioning</td>
<td>Recommendation 7</td>
<td>DSAPR</td>
<td>ZACP, ZAIADA, ZAYADESA, development partners, UNODC</td>
<td>June 2008</td>
<td>Legislation have been put in place to support SU-HISP implementation</td>
</tr>
<tr>
<td>HIV CARE AND TREATMENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Health sector HSSP costing report re-evaluated</td>
<td>Recommendation 12</td>
<td>ZACP</td>
<td>DPG/AIDS</td>
<td>September 2007</td>
<td>Same consultancy team available to revise the costing Accurate terms of reference provided for the re-costing exercise</td>
</tr>
<tr>
<td>12. MoU between government and private health care providers signed</td>
<td>Recommendation 13</td>
<td>ZACP</td>
<td>CSOs</td>
<td>March 2008</td>
<td>Private sector health care providers and development partners agree to sign a Memorandum of Understanding</td>
</tr>
<tr>
<td>13. Infant diagnosis facilities for HIV created at laboratory</td>
<td>Recommendation 14</td>
<td>ZACP</td>
<td>Private health care providers, ZAC, development partners, ABCZ</td>
<td>June 2008</td>
<td>Resources available procurement of equipment</td>
</tr>
<tr>
<td>14. Health sector drug and supply procurement system revised to ensure predictable supply of HIV-related drugs and supplies</td>
<td>Recommendation 12</td>
<td>ZACP</td>
<td>Development partners, and CSOs</td>
<td>June 2008</td>
<td>Government commits to ring fence funding for drug procurement and ensure regular supply</td>
</tr>
<tr>
<td>HIV IMPACT MITIGATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Guidelines for a minimum package of HIV impact mitigation services approved by MoHSW</td>
<td>Recommendation 15</td>
<td>Social Welfare department, MoHSW</td>
<td>CSOs, PLHIV associations, development partners</td>
<td>June 2008</td>
<td>Partners agree on impact mitigation package of services</td>
</tr>
<tr>
<td>MILESTONE</td>
<td>RELEVANT RECOMMENDATION</td>
<td>GOVERNMENT AGENCY RESPONSIBLE FOR IMPLEMENTATION</td>
<td>PARTNER ORGANIZATIONS</td>
<td>ACHIEVED BY</td>
<td>DEPENDENCIES</td>
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</tr>
<tr>
<td><strong>16.</strong> Incorporate HIV responsibilities in job descriptions of HIV focal persons at all levels and in all sectors</td>
<td>Recommendation 20, Recommendation 22, Recommendation 25</td>
<td>CMO, umbrella organisations</td>
<td>TACs, ZAC, ZACP, MORASD, Public Service Commission, ABCZ</td>
<td>June 2008</td>
<td>HIV included in general orders of government</td>
</tr>
<tr>
<td><strong>17.</strong> Formalise DACCOMs &amp; SHACCOMs within the decentralisation policy and government structures at the district levels</td>
<td>Recommendation 20</td>
<td>CMO</td>
<td>ZAC, MORASD and MDAs</td>
<td>June 2008</td>
<td>DACCOMs and SHACCOMs execute their roles one formalised</td>
</tr>
<tr>
<td><strong>18.</strong> HIV and AIDS mainstreamed in the Government General Orders</td>
<td>Recommendation 16</td>
<td>CMO</td>
<td>MDAs, ZAC</td>
<td>December 2008</td>
<td>Approval by House of Representatives</td>
</tr>
<tr>
<td><strong>19.</strong> Comprehensive resource mobilisation plan developed</td>
<td>Recommendation 18</td>
<td>ZAC, MoFEA</td>
<td>Public sector, Private sector, CSOs, development partners</td>
<td>December 2008</td>
<td>Development partners willing to commit to resource mobilisation plan</td>
</tr>
<tr>
<td><strong>20.</strong> Relevant HIV-related legislation enacted to enforce the provisions of the national HIV policy</td>
<td>Recommendation 17</td>
<td>CMO, Ministry of Constitutional and Governance Affairs</td>
<td>Public sector, Private sector and CSOs</td>
<td>June 2009</td>
<td>Approval by House of Representatives and communities</td>
</tr>
<tr>
<td><strong>21.</strong> Implement JAST principles as per JAST implementation plan</td>
<td>Recommendation 21</td>
<td>ZAC</td>
<td>Development partners, ZACP, MoFEA</td>
<td>Ongoing</td>
<td>All partners aware of provisions of Joint Assistance Strategy for Tanzania</td>
</tr>
<tr>
<td><strong>22.</strong> System for all HIV implementers to submit annual plans to districts to compile district-level HIV plans institutionalized</td>
<td>Recommendation 20</td>
<td>MORASD</td>
<td>ZAC, CSOs, public sector, private sector, development partners, all umbrella organisations</td>
<td>Designed: December 2007, Operational: June 2008</td>
<td>All HIV implementers adhere to the provisions of the</td>
</tr>
<tr>
<td>MILESTONE</td>
<td>RELEVANT RECOMMENDATION</td>
<td>GOVERNMENT AGENCY RESPONSIBLE FOR IMPLEMENTATION</td>
<td>PARTNER ORGANIZATIONS</td>
<td>ACHIEVED BY</td>
<td>DEPENDENCIES</td>
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</tr>
<tr>
<td>23. Technical assistance plans and operational manuals for ZAC, ZACP, ZAPHA+, ABCZ, ZANGOC, DACCOMs and IFF developed and implemented</td>
<td>Recommendation 22</td>
<td></td>
<td></td>
<td>Developed: March 2008 Implemented: June 2009</td>
<td></td>
</tr>
<tr>
<td>25. Update the communication and advocacy strategy to reflect new developments from the review of the ZNSP</td>
<td>Recommendation 26</td>
<td>Recommendation 27</td>
<td>ZAC</td>
<td>IEC TWG, development partners</td>
<td>December 2007 Same consultant available to finalise the plan</td>
</tr>
<tr>
<td></td>
<td>Recommendation 28</td>
<td></td>
<td>ZAC</td>
<td>Task Force on Advocacy and Communication</td>
<td>June 2008 Community reacts as anticipated to mobilisation campaign</td>
</tr>
<tr>
<td>26. Comprehensive community mobilisation campaign implemented</td>
<td>Recommendation 30</td>
<td>ZAC</td>
<td></td>
<td>MoHSW, HMIS, CSOs, ZACP, OCGS, MDA, MoRASD, Private sector MoHSW, CSOs, ZACP, HMIS, OCGS, MDA, MoRALSD</td>
<td>Developed: March 2008 Operational: June 2008 Enabling environment (capacity, guideline, financial)</td>
</tr>
<tr>
<td>27. Harmonise and link the national HIV M&amp;E system with the MKUZA monitoring system, MoHSW’s routine HIV monitoring systems and CBMIS</td>
<td>Recommendation 31</td>
<td>ZAC</td>
<td>Development partners ZACP, METTHAZ</td>
<td>By December every year</td>
<td>None</td>
</tr>
<tr>
<td>28. Update M&amp;E Road Maps on annual basis</td>
<td>Recommendation 32</td>
<td>ZAC</td>
<td>Development partners</td>
<td>December 2007</td>
<td>Venue for information centre secured</td>
</tr>
<tr>
<td>MILESTONE</td>
<td>RELEVANT RECOMMENDATION</td>
<td>GOVERNMENT AGENCY RESPONSIBLE FOR IMPLEMENTATION</td>
<td>PARTNER ORGANIZATIONS</td>
<td>ACHIEVED BY</td>
<td>DEPENDENCIES</td>
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</tr>
<tr>
<td>30. In consultation with stakeholders, plan, coordinate HIV and AIDS research and studies to support planning and informed-decision making</td>
<td>Recommendation 34</td>
<td>Chief Ministers Office</td>
<td>Higher Learning Institutions, MoHSW, CSOs, ZAC, ZACP, OCGS, MDA, Poverty Monitoring TWG (MKUZA), DP</td>
<td>2007-2009</td>
<td>Community members willingness to participate. Availability of funds</td>
</tr>
</tbody>
</table>