



THE REVOLUTIONARY GOVERNMENT OF ZANZIBAR

ZANZIBAR NATIONAL HIV STRATEGIC PLAN II

(ZNSP-II) 2011 – 2016



**ZANZIBAR NATIONAL
HIV STRATEGIC PLAN
(ZNSP-II) 2011 – 2016**

July 2011

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ACRONYMS

ABC	Abstinence, Be faithful and Condom Use.
ABCZ	AIDS Business Coalition for Zanzibar
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante- Natal Care
AO	AIDS Orphans
ARV	Anti-Retroviral Therapy
ASAP	AIDS Strategy and Action Planning
BCC	Behavioural Change Communication
CBO	Community Based Organization
CBD	Community Based Distributors
CHBC	Community Home based Care
CRC	Convention on the Rights of Children
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CM	Chief Minister
CMO	Chief Minister's Office
CSO	Community Service Organisation
CSW	Commercial Sex Worker
CTC	Care and Treatment Clinics
DACCOM	District AIDS Coordinating Committee
DTC	Diagnostic Testing and Counselling
DPGA	Development Partner Group on AIDS
DHMT	District Health Management Team
EID	Early Infant Diagnosis
FBO	Faith Based Organizations
FDC	Fixed Dose Combination
FHHD	Female Headed Household
FP	Family Planning
FSW	Female Sex Worker
GBV	Gender Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB and Malaria
HAART	High Active Anti-Retroviral Therapy
HCT	HIV Counselling and Testing
HTC	HIV Testing and Counselling
HCW	Health Care Worker

HF	Health Facility
HIV	Human Immunodeficiency Virus
HBC	Home Based Care
HBV	Hepatitis B Virus
HCV	Hepatitis C virus
IBBSS	Integrated Behavioural and Biological surveillance surveys
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IEO	Institute of Education for Offenders
ILO	International Labour Organization
IMC	Inter-Ministerial-Committee
JAST	Joint Assistance Strategy for Tanzania
KAP	Knowledge, Attitude and Practice
LPSE	Life Planning Skills education
MARPs	Most at Risk Populations
MCH	Maternal and Child Health
MCHA	Maternal and Child Health Aiders
MCP	Multiple Concurrent Partnership
MDG	Millennium Development Goals
MDA	Ministries, Departments and Agencies
M&E	Monitoring and Evaluation
MEES	Moral Ethics and Environmental Studies
MKUZA	Mkakati wa Kukuza Uchumi Zanzibar
MOHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
MTP	Medium-Term Plan
MoEVT	Ministry of Education, and Vocational Training
MoFEA	Ministry of Finance and Economic Affairs
MoRASD	Ministry of Regional Administration and Special Departments
MoYEWCD	Ministry of Youth, Employment, Women and Children Development
MALE	Ministry of Agriculture, Livestock and Agriculture
MSM	Men having Sex with Men
NGO	Non Governmental Organization
OI	Opportunistic Infection
IPT	Isoniazid Prophylaxis Therapy
OVI	Objectively Verifiable Indicators

OTC	Over The counter
PEPFAR	President Emergency Plan for AIDS Relief
PEP	Post Exposure Prophylaxis
PF	Performance Framework
PCR	Polymerase Chain Reaction
PER	Public Expenditure Review
PLHIV	People Living with HIV
PPP	Public-Private Partnership
PRSP	Poverty Reduction Strategy Paper
PSM	Procurement and supply Chain Management
PMTCT	Prevention of Mother To Child Transmission
QA	Quality Assurance
RGoZ	Revolutionary Government of Zanzibar
SHACCOM	Shehia AIDS Coordinating Committee
SRH	Sexual Reproductive Health
STD	Sexual Transmitted Diseases
STI	Sexual Transmitted Infection
SU	Substance Use
SUHISP	Substance Use and HIV Strategic Plan
TAC	Technical AIDS Committee
TB	Tuberculosis
TBA	Traditional Birth Attendant
TBE	To be estimated
TH	Traditional Healer
THMIS	Tanzania HIV and Malaria Indicator Survey
TWG	Technical Working Groups
TOR	Terms of reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nation Children Fund
UNGASS	United Nation General Assembly Special Session.
UWAKUZA	House of Representatives' Coalition on HIV and AIDS in Zanzibar
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YFF	Youth Friendly Facilities
ZAC	Zanzibar AIDS Commission

ZACP	Zanzibar AIDS Control Programme
ZANGOC	Zanzibar Non-Governmental Organization Cluster
ZAIDA	Zanzibar against AIDS Infection and Drug Abuse
ZAPHA+	Zanzibar Association of People Living with HIV/AIDS
ZCCM	Zanzibar Country Coordinating Mechanisms
ZGFCCM	Zanzibar Global Fund Country Coordinating Mechanisms
ZNSP	Zanzibar National HIV/AIDS Strategic Plan
ZPRP	Zanzibar Poverty Reduction Plan

Foreword

The preparation of the Zanzibar National Multisectoral Strategic Plan (ZNSP II) covering the period of 2011/2015 is the culmination of profound efforts invested by the Zanzibar AIDS Commission (ZAC) in close collaboration with Development partners, implementing partners, and the Zanzibari community to deliver a better framework for a strengthened national HIV response.

This collaborative and supportive approach augments an increasing awareness among all stakeholders that the challenges of HIV could only be successfully addressed by working together towards a common goal. It is my strong conviction that the participation by individuals from all sectors, and representing a wide range of organisations, will ensure dynamic national action that yields desirable results in HIV interventions in Zanzibar.

Despite the fact that Zanzibar has been documenting a lower HIV prevalence in the general population of < 1% (THMIS -2007/8 & DHS 2010) with an increased HIV awareness and knowledge in the general population, we still face challenges in mitigating new HIV infection among the key population. Results from multitude of studies among key populations have documented numerous fold levels of HIV and accompanying Sexual Transmitted Infections (STI) within these sub-populations. These noted levels of infections are unacceptably high. We must all double our efforts in HIV prevention to turn off the tap of new infections. I am happy to note that ZNSP II will focus attention on the prevention of new infections among key populations and community at large, while at the same time providing care and support as well as create enabling environment for people living with HIV or AIDS in Zanzibar.

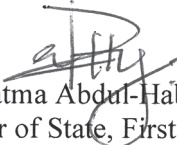
The ZNSP II aims at ensuring Universal Access targets for quality integrated services at all levels to prevent new HIV infections, reduce HIV-related illnesses and deaths, and mitigate the effects of the epidemic on households and communities in Zanzibar. This plan will deliver on Vision 2020, MKUZA as well as catalysing on the process to realise the targets set by the United Nations General Assembly for scaling up HIV prevention, treatment, care and support, and mitigation of its socio-economic impacts. This Strategic Plan will also enable Zanzibar to achieve Millennium Development Goal (MDG) 6.

The Strategic Plan, which will guide our HIV interventions over the next five years, is an expression of our commitment and determination to face HIV and AIDS not

only as a medical and health, but also as a cultural, social, economic developmental challenge as a whole. HIV and AIDS challenges affect all sectors of our society and to every Zanzibari family. ZNSP II shall address the complexities of our sexuality, our relationships, our culture, beliefs and attitudes that influence the transmission of new infections, our reactions to infection and illness, whether and how we support, stigmatise and discriminate against each other. The ZNSP II is therefore, about us, and is for us in all settings as it underpins and addresses our risk behaviours. Let us now, and in the years ahead, join together to ensure that the plan is translated into concrete, focused and sustained actions that bear the expected results. We can do it, and in so doing we can achieve the global call of zero new infection, zero discrimination and zero HIV related death.

In conclusion, I would like to thank all stakeholders involved in making ZNSP II a reality. I also wish to recognise and thank all development partners whose technical and financial support enabled Zanzibar to have in place this comprehensive ZNSP II.

Zanzibar
September, 2011


Hon. Fatma Abdul-Habib Fereji
Minister of State, First Vice President Office

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The development of the Zanzibar National HIV Strategic Plan 2011-2016 was the result of the combined effort and support of various individuals, organisations and communities. It is difficult to acknowledge all, but some deserve special mention.

The Zanzibar AIDS Commission (ZAC) would like to acknowledge the Steering Committee and the Technical Working Groups that guided the whole process of developing the ZNSP-II; and the ZAC Commissioners who also made very valuable contributions. In addition, ZAC would like to thank the team that conducted the *Gap Analysis of the Zanzibar HIV Response Initiatives* (2009), and the participants who attended the consensus building workshops, for providing their input that informed the strategies, outputs, outcomes and impact results of the ZNSP-II.

The Commission is also grateful to the consultants who supported the development of ZNSP-II. In particular special thanks go to the following: F. Steven Chizimbi (International team leader), M.J.U. Dahoma (National team leader), Diggos Amran (Lead, Care and treatment component), Dolar Vasani (Lead, HIV prevention component), Rashid Khamis (Lead, Impact mitigation component), and Peter Bujari (Lead, Enabling environment component).

Finally, special thanks go to the Development Partners who supported the process, especially the UN Joint team, the bilateral agencies, and ASAP for providing technical and strategic support for the successful development of the ZNSP-II.

EXECUTIVE SUMMARY

The Zanzibar National HIV Strategic Plan 2011-2016 (ZNSP-II) has been formulated to guide the national HIV response and builds on the efforts and achievements of the ZNSP-I (2005-2009). The ZNSP-II aligns the national HIV response with the *Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP)*, popularly known by its Swahili acronym as *MKUZA*. The ZNSP-II was developed through a consultative process at various levels, including: i) the *Joint Review of the National HIV Response in Zanzibar*; ii) the *Gap Analysis of the Zanzibar HIV Response Initiatives* (2009); iii) and the thorough review of relevant HIV related source documents and reports. The development of ZNSP-II also benefited from the broad participation of implementing partners, communities infected and affected by the epidemic, and development partners.

In Zanzibar, the HIV prevalence among adults aged 15 – 49 years is estimated to be about 0.6 percent (THIMS, 2008). There are about 7,200 people living with HIV (PLHIV) in Zanzibar. Like other countries in the sub-region, Zanzibar is currently experiencing a mixed epidemic characterised by: i) low prevalence in the general population (driven by heterosexual HIV transmission); and ii) a concentrated epidemic driven by the key populations (especially most-at-risk populations - MARPs) and who often share some overlapping risk factors (risk sexual behaviour and drug abuse). The key populations in Zanzibar include: injecting drug users (IDUs), female sex workers (FSWs), students in the Institute of Education for Offenders (correctional facilities), and men having sex with men (MSMs). The HIV prevalence among key populations in Zanzibar is higher than in the general population

The national response has made great strides since 2005 in the fight against the HIV epidemic in Zanzibar. The implementation of the first national HIV strategic plan, ZNSP-I 2004/5 – 2008/9, was based on the ‘Three Ones’ and other guiding principles. This resulted in tremendous scale-up of HIV testing and counselling (HTC) and antiretroviral therapy (ART). There were 58,921 people who got HIV tested in Zanzibar in 2010 compared to 13,075 in 2005; there were 2,498 PLHIV on treatment in 2010 compared to 186 in 2005 (ZACP, Closeout report, 2010). As at December 2010, a total of 4,908 PLHIV were enrolled into care.

The current HCT coverage in Zanzibar is about 39% for men and 47.9% for women (TDHS, 2010). The ART coverage is about 64.2% in Zanzibar (ZACP, Closeout report, 2010). Mainstreaming of HIV in the public sectors increased from 0% in 2004 to

100% in 2009. The private sector response is however lagging behind.

The goal of ZNSP-II is to: i) prevent the spread of HIV in Zanzibar; ii) to mitigate the associated ill health (morbidity), socio-economic and psychosocial impact of the HIV epidemic on individuals, their families and communities, the key populations in Zanzibar and the whole nation; and iii) provide access to care and treatment for all eligible PLHIV. The Zanzibar National HIV Strategic plan 2011-2016 has five priority areas as listed below:

- Prevention of new infections;
- Treatment, care and support of the PLHIV;
- Mitigation of socio-economic impact of the epidemic;
- Creation of an Enabling environment; and
- Research, monitoring and evaluation.

This strategic plan presents under each priority area: key issues to be addressed during the period 2011-2016; the strategies to effectively address them; the expected outputs, outcomes, and the impact result. An Annual Operational Plan will be developed each year to support the successful implementation of the ZNSP-II. Each year, a thorough review of the implementation of the last Annual Operational Plan will be undertaken to inform the development of the next. This will allow the national HIV programme to document and use best practices and lessons learnt in the fight against the HIV epidemic in Zanzibar.

1 CHAPTER ONE

1.0 BACKGROUND AND CONTEXT

1.1 Rationale for the Development of ZNSP-II

In 2003 the Revolutionary Government of Zanzibar developed, through a nationwide consultative process, the first comprehensive National HIV Strategic Plan 2004/5–2008/9 (ZNSP-I). The ZNSP-I brought the efforts of various stakeholders in the national HIV response into convergence for better synergy and success. It was implemented from 2004 to 2009. And to build on the gains realized, the Zanzibar National Strategic Plan 2011–2016 (ZNSP-II), was developed in 2010. This is expected to continue to drive and align all stakeholders and HIV interventions for the next five years in our quest to achieve the set national objectives. ZNSP-II seeks to address the identified gaps and emerging issues, and to leverage best practices and lessons learnt during the implementation of the ZNSP-I.

Two major reviews of the ZNSP-I (2004/5–2008/9), and which served as the foundation for the development of the ZNSP-II, are: (a) *Joint Review of the National HIV response in Zanzibar* [2004-07]; and (b) *Gap Analysis of the Zanzibar HIV and AIDS Response Initiatives* (2009).

The findings of these surveys and other relevant source documents helped define the current HIV context in Zanzibar and the national response, and especially the key achievements and challenges documented during the implementation of ZNSP-I. The ZNSP-I highlighted the need to address the following key issues under ZNSP-II:

- a. Alignment of all institutional arrangements among various stakeholders in the national HIV response (including ZAC, development partners, government and other stakeholders) with the Three Ones Principle and in scaling up HIV mainstreaming to achieve both MKUZA targets and the Millennium Development Goals;
- b. Greatly shifting the strategic focus of the national HIV response from the general population to address Key Populations (most-at-risk populations - MARPs), who are now widely recognized as the key drivers of the epidemic in the country and general population;
- c. Incorporate new policies and guidelines that have been developed in the last five years to support the national HIV response;
- d. Translate the high levels of awareness about HIV and AIDS among Zanzibaris into behaviour change that reduces new infections;

- e. Enhance research, monitoring and evaluation of the national HIV programme activities to document actual impact on communities;
- f. Scale up adoption and use of best practices in the national HIV response;
- g. Compliance with standards on rights-based and gender sensitive approaches to implement elements of the national HIV response/programme.

1.2 The ZNSP-II Formulation Process

A participatory and inclusive process was followed during the development of the Zanzibar National HIV Strategic Plan 2011-2016 (ZNSP-II); and this approach brought in the valued contributions of all relevant stakeholders involved in the national HIV response. ZAC facilitated the formation of a multi-disciplinary Steering Committee (SC), which provided the overall guidance during the development of ZNSP-II. In addition, ZAC recruited a team of six consultants to review available data and to facilitate drafting of the Strategic Plan. The core team included: i) one international consultant as team leader; ii) one national lead consultant; and iii) four national consultants based on specific thematic areas of the HIV response.

The Steering Committee approved the Terms of References (TORs) to guide the process, and reviewed the Inception Report prepared by consultants. A one-day workshop was organised to bring together the Technical Working Groups (TWG) of the four HIV thematic areas to discuss and agree on the tools to be used to collect data. The approved tools were then used to collect data as appropriate to inform the development of the ZNSP-II. A broad cross-section of respondents were interviewed in Zanzibar including at the community, district, and national levels. The criteria used to select key respondents are as below:

- Patterns of HIV prevalence in the general population, incidence and/or the relative risk factors among the various groups;
- Need for equity in representation of groups based on gender, age and vulnerability;
- People living with HIV (PLHIV) and the affected families;
- Key populations (including most-at-risk populations - MARPs);
- Regional representation;
- Need to include the key stakeholders involved in the national HIV response

The consulting team acquired, processed, analysed, and triangulated as necessary the findings to support and guide the drafting of ZNSP-II. The draft ZNSP-II was

reviewed by Technical Working Groups, the Steering Committee as well as by a select group of peer reviewers. To ensure ownership of the ZNSP-II, the document was shared with the ZAC Commissioners, and also presented at a stakeholders' workshop which brought together the key public sector and the non-state actors.

1.3 The Policy and Planning Environment

1.3.1 Vision 2020¹ and MKUZA

In an effort to transform her economy to a market driven one, the Government of Zanzibar formulated **Vision 2020**, a long-term *development plan* in 1999. This is intended to support the realization of sustainable social and economic development with the objective of eradicating abject poverty and bridging the income gap among various social groups and geographical zones. Vision 2020 defines clearly the national goals, policies and strategies that guide both the public and private sectors to act and achieve the national development targets by the year 2020.

The *Zanzibar Poverty Reduction Plan (ZPRP)*, set the stage for the implementation of Vision 2020 from 2002 to 2005. This focused on reducing the income gaps and poverty; and also improving human capacities, survival and the social well being of the people. As a follow-on to ZPRP, the *Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP)* was developed to broaden growth, and enhance both equity and good governance.

The earlier versions of the ZPRP considered the HIV epidemic as an important issue albeit under the health sector goals and strategies. The *Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP)* adequately mainstreamed HIV into the development agenda, including targeting key populations (MARPs) and other vulnerable groups. This change in focus has been made, in part, because the Government recognises HIV as a threat to both the national economic and social development. Available data (anecdotal as well as from basic assessment²) have shown that HIV related disease burden is undermining household incomes and slowly eroding the national economy³ in Zanzibar. It is envisaged that ZSGRP will facilitate resource mobilization and support its equitable allocation to finance the national HIV response.

1 Vision 2020: The National Long term Development Perspective for Zanzibar

2 The AIDS orphan study ZACP-2002.

3 Comments from Key informal interviews and FGD (anecdotal)-2009

1.3.2. The National HIV Policy

In 2005, Zanzibar developed its national HIV policy and which serves as an important milestone in the fight against the HIV epidemic in the country. It does incorporate most of the current international policy principles and lays down the administrative and legal framework for all programmes and interventions which are to: “Prevent new HIV infections in the population; treat, care for, and support those who are infected; and mitigate the impact of HIV epidemic on the social and economic status of individuals, families, and communities, and; enhance the institutional/ key implementers’ capacity to develop and implement HIV interventions that are sensitive to/respect gender and the human rights of all”. To date, Zanzibar has had no specific HIV law to protect the infected and non-infected populations.

1.3.3. The Health Sector Policy and the National HIV Strategic Plan

The overall goal of the national health policy is to raise the health status of all Zanzibaris by: i) reducing incidence of disease/illness; ii) prolonging life expectancy; and iii) developing a sound service delivery system capable of promoting health; preventing, reducing and curing disease; protecting life and fostering the general well-being of all citizens; and raising economic productivity. In addition, the national health policy and the National HIV Strategic Plan continue to provide the general operational guidance on HIV prevention; treatment, care and support; and impact mitigation. The Zanzibar health sector policy and the ended National HIV Strategic Plan 2004/5 – 2008/9 (ZNSP-I) were aimed at improving access to quality health care services for those infected and affected in the country.

1.4 The HIV situation in Zanzibar

The HIV pandemic has not spared any continent and/or region of the world. Sub-Saharan countries have been the hardest hit, resulting in significantly higher negative outcomes including in ill-health, deaths and reduced economic productivity. Generally, the United Republic of Tanzania and Zanzibar have not been spared either from the challenges and effects of the HIV epidemic. Each part of the Republic has witnessed and documented variations in the character and pattern of the HIV epidemic. The HIV epidemic in Mainland Tanzania is of the generalised type, largely driven by heterosexual transmission. Based on HIV surveillance surveys both at the national and ANC service level, and on subsequent assessment of some sub-populations, the HIV epidemic in Zanzibar has signs of being the concentrated type.

Concentrated HIV epidemics are largely driven by MARPs. In-depth analysis of other diseases with a similar transmission profile, such as Hepatitis C, is suggestive of the fact that Zanzibar is not yet experiencing a mature concentrated HIV epidemic. In order to fully characterize the HIV epidemic in Zanzibar to help in better planning and effective implementation of interventions, there is need to undertake an in-depth assessment of risk factors or drivers of the HIV epidemic in the country. This could be done through a national mode of HIV transmission study.

In 1986, the Isle of Zanzibar documented the index case of AIDS at Mnazi Mmoja Hospital. In the wake of the index case, the country has continued to witness growth in the cumulative number of PLHIV. Initial surveillance reports suggested the potential factors driving the epidemic in Zanzibar as being similar to those witnessed in countries/areas with a generalised HIV epidemic⁴. Hence, heterosexual HIV transmission was initially predominantly singled out as the sole mode of transmission on the Isles. Over the last fifteen years, the HIV epidemic has spread to all districts in Zanzibar but at unequal pace, level and magnitude. With both a limited institutionalised surveillance system and evidence characterizing the epidemic as generalized, initially the efforts made to control the epidemic were targeted at addressing primarily the risk of heterosexual transmission.

In 2002, stakeholders involved in the national response queried the quality and validity of data collected on the HIV epidemic in Zanzibar. In response to this, a validation survey was carried out in 2002, and the results put the national HIV prevalence at below one percent. The survey also showed indications that the epidemic in Zanzibar may be of the concentrated type. This led to a revision of the national HIV surveillance protocol relevant was gathered in future to help more accurately define the prevailing epidemic and response strategies in Zanzibar. Today, key nationwide surveys, i) the *Integrated Behavioural* and ii) the *Biological Surveillance Surveys (IBSS)* have been institutionalised in Zanzibar; and they seek to monitor HIV/STIs in the general population as well as among some of the identified key populations.

1.4.1. HIV infection patterns in the general population (Zanzibar)

Two population based surveys namely i) *HIV validation survey*, and ii) *Tanzania HIV/Malaria Indicator Survey*⁵ (*THMIS2*) have put the HIV prevalence in Zanzibar at 0.6 percent in the sexually active general population. The estimated number of people living with HIV (PLHIV) in Zanzibar is 7,200. The HIV epidemic in Zanzibar

4 ZACP Surveillance reports 1-3; the validation survey-2003

5 Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08

varies by sex of the individual and Island of residence. HIV prevalence is higher among women (0.7%) compared to men (0.5%) and higher in Unguja (0.8%) compared to Pemba Island (0.3 %). Also among young Zanzibaris aged 15-24 years and whose HIV prevalence is estimated at 0.2 percent, there are 3 females who are infected for every male (0.3% Vs 0.1% respectively). There are in general inherent limitations in getting data on concentrated epidemics among the key populations and this often makes it difficult to understand the actual context. To try to get the necessary data and understand the HIV context among key populations in Zanzibar, additional surveillance methods (such as *Respondent Driven Sampling Techniques-RDS* and *Snowball* sampling methods) have been applied.

ANC surveillance in Zanzibar

The ante-natal clinic (ANC) data, from 1999 to 2008, indicates that the HIV prevalence in Zanzibar on average is below one percent (1%) as shown in the table below:

Table 01: Sentinel Surveillance Results for Four Years.

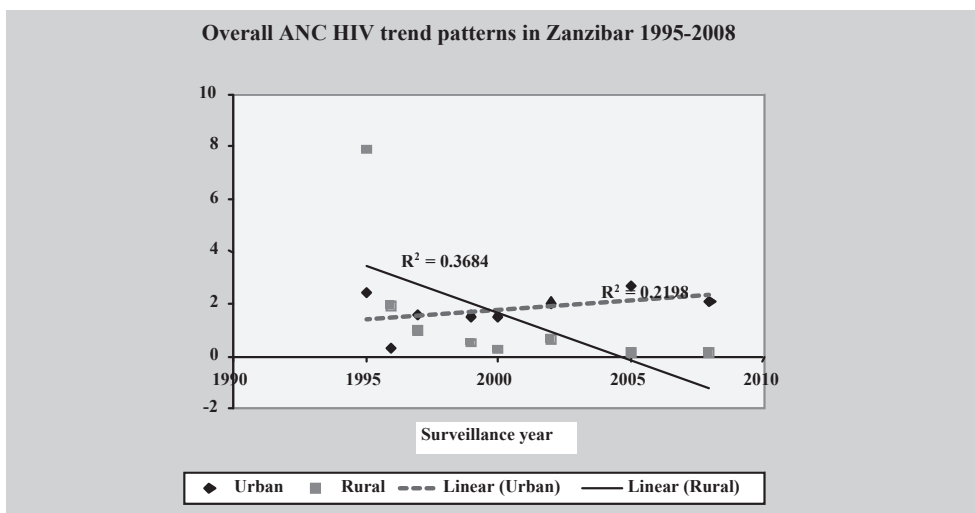
Year	Tested	Positive	Percent
1999	1400	10	0.7
2002	1376	14	1.0
2005	2988	26	0.87
2008	5983	34	0.6

Source: Strategic Information Unit-ZACP, MoHSW-2009

Findings from the *HIV validation survey (2002)* concluded that the ANC surveillance can be used as a proxy indicator of prevalence in the general population. While acknowledging the limitations inherent using such resultant data, ANC survey findings have been used to model patterns of the epidemic in the general population. The major findings of the ANC surveillance conducted in 2008 were that the HIV prevalence:

- a. Among ANC attendees from 1995-2008 was less than 1%
- b. Is higher in Unguja compared to Pemba Island (0.9 percent Vs 0.1 percent, respectively), with an urban-rural predilection of 0.6 and 0.4 percent, respectively.
- c. Is about 0.8% amongst those in the 25-34 year age bracket, and about 0.5 percent among the 15-24 year olds in Zanzibar. The HIV prevalence tapers off after the age 34 years.

- d. Among divorced women (10%) is relatively high compared to both unmarried singles (3.7%) and those who are married (0.5%) respectively.
- e. Is higher among women with primary education only (0.8%) as compared to those with secondary education (0.5%).
- f. Is reportedly higher in some regions than others: Urban-West and the South Region have relatively high HIV prevalence compared to other regions on the islands (>1% Vs < 1%).
- g. Had slightly fallen as well as incidence in the rural areas. However, this was balanced out by a slight increase in the urban areas as highlighted in the figure below:



Source: Strategic Information Unit-ZACP, MoHSW, 2009

1.4.2 HIV prevalence among vulnerable and Key Populations

Monitoring patterns of HIV infection and risk factors among key populations started in 2005. The first survey targeted at the key populations was done in 2005 (on SU/IDUs) using a snowball sampling technique to determine the sexual and drug related risk behaviours. The survey results showed significant risk behaviours among key populations in Zanzibar⁶ and that their HIV prevalence was higher than that in the general population. The HIV prevalence was 16.0 percent among intravenous drug users (IDUs), 12.3 percent among men having-sex-with men (MSMs) and 10.8 percent among female sex workers (FSWs). While some sub-groups among the key populations can be characterized by their unique risk behaviours, they are not

⁶ ZACP – Substance Abuse Report: 2006

mutually exclusive. There are considerable overlaps in transmission risk factors. For instance, among MSMs, about 13.9 percent of the respondents reported injecting drugs during the three months preceding the survey and 77.5 percent having transactional sex in the prior year. Although only about 2.8 percent of female sex workers reported using injection drugs, a larger proportion of them (10.9 -17.6%) suspected their sex partners were using injection drugs⁷.

There exists cross-over (bridging) potential for HIV transmission from the key populations into the general population in Zanzibar. This was highlighted by the *Integrated Behavioural and Biological Surveillance Survey (IBBSS, 2007)* and established that: i) nearly three-quarters of MSMs (71.2%) also had female sex partners in the previous year; ii) half of FSWs (48.9%) had a steady non-paying partner; iii) more than half of IDUs (52.8%) had unprotected sex in the month preceding the study; and iv) both injecting drug use and sexual risk behaviours are not mutually exclusive.

Transactional sex and sharing of clients among sex workers is also common. The incidence of STIs among the key populations (especially MARPs) is high compared to the general population in Zanzibar. Stigma and physical abuse is commonly experienced by key populations as highlighted in the table below:

Table 02: Summary of the key findings of the survey on risk behaviours and STI infection patterns among key populations in Zanzibar

Observation	Injecting Drug Users (IDUs)	Men Having Sex with Men (MSM)	Female Sex Workers (FSWs)	Correctional Facility Students (CFS -“prisoners”)
Risk behaviours				
Substance use	-	60.3%	9.6%	46%
Injecting drugs	-	13.9%	2.8%	6%
Needle sharing	53.8%	60% of MSM who are IDUs		40% of IDUs
Flashblood	3.4%	-	-	22% of IDUs
Multiple sex partners (two or more)	63.0%	47.8%	Median – 3 clients last day of work	
Condom use	<30%	<50%	55.7%	Not mentioned

⁷ MARPs Study: RDS Methodology - Zanzibar AIDS Control Programme (2007-08)

Transmission potential (to the general population)	-Low condom use. - Sexual relationship with a paying partner	-71.2% are bisexual. -13.9% are IDUs -29% were married	Casual non-paying partner-24%.	
Transactional sex	20.7%	77.5%	100%	1.6%
Violence & stigma				
Physical abuse	57.1%	35.2%	37.2%	1.3% (rape)
Police harassment	32.6%	25%	2%	
Abandonment	60.3%	-	-	-
STIs among /				
HIV prevalence	16.0%	12.3%	10.8%	2.8%
Co-infection with other STDs	Syphilis - 0.3% HBV- 6.5% HCV- 26.9%	Syphilis - 0.2% HBV- 4.6% HCV- 14.7%	Syphilis -1.3% HBV- 5.1% HCV- 1.9%	Syphilis - 3.8% HBV- 7.1% HCV- 4.8%

Source: Zanzibar AIDS Control Programme (ZACP-2009)

1.4.2.1 Students at the Institute of Education for Offenders (IEO)

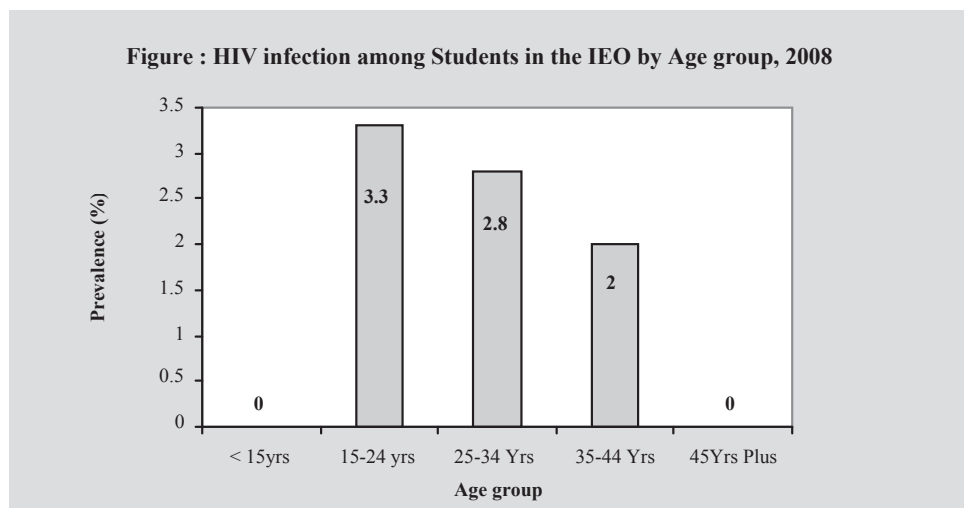
Nearly half (47.6%) of all students at the Institute of Education for Offenders in Zanzibar are aged between 25 to 34 years, and the majority of them are single (40.8%). Most of these students have primary education (51.9%) and about a quarter of them have been sentenced more than once (2-4 times). Risk behaviour is prevalent among students at these Institute of Education for Offenders including anal sex. About 23 percent have reported to have had sex with their male counterparts. The practice of MSMs is common among the young inmates compared to the older ones. The inmates serving longer sentences have a greater risk of engaging in same sex relationships compared to those serving shorter sentences.

Incidences of sexual assault among students at the Institute of Education for Offenders have also been reported (1.3%). The high drug risk behaviour among students in the Institute includes syringe sharing (40%) as well as *Flashblood* practises (22%) among those identifying themselves as IDUs⁸. The incidence and prevalence of STIs, and substance abuse among students at these facilities are estimated to be high: HIV, 2.8 percent; Hepatitis B, 7.1 percent; Hepatitis C, 4.8 percent; and Syphilis, 3.8 percent⁹. The pattern of HIV infection and prevalence among students at the

⁸ Light behind Bars: Addressing the HIV & AIDS challenges in all settings in Zanzibar (A prison study report; ZACP, 2008)

⁹ Ibid.

Institute of Education for Offenders differs greatly from that in the general public. The epidemic peaks at the age between 15 and 24 years as shown in figure below:



1.4.2.2 The HIV transmission bridge potential

The risk of HIV transmission from high risk groups, including key populations, to the general population is increased by the following factors:

- i. Higher HIV prevalence among students in IEO due to increased risky behaviour.
- ii. Notably a higher HIV prevalence among cohabiting partners (9.7 percent) and married partners (3.3 percent).
- iii. Recent history of STIs which predisposes the risk of HIV infection. The HIV prevalence among those with a recent history of STIs and those with a past history of them is 14.3% Vs 8.3%, respectively; and this is statistically significant.
- iv. High HIV prevalence among students at the Institute of Education for Offenders who are IDUs (at 4 percent).

Despite the above observations, Zanzibar has not established the proportional contribution of each of these risk factors to the HIV epidemic. Some of the areas that require further research include HIV infections among sexual partners, infection patterns among clients of sex workers and/ or partners of MSMs. In the absence of a *Modes of Transmission (MOT)* study, Zanzibar needs to monitor both the general as well as the specific key populations, and use the gathered evidence to clearly define the nature and underlying factors that drive and fuel up the HIV epidemic in the country.

1.5 HIV related mortality in Zanzibar

Data on AIDS related deaths in Zanzibar is very scanty and unreliable, and could lead to under or overstatement of the real situation. That said, from 2005 to 2008, a total of 161 deaths were recorded among PLHIV receiving care and treatment services. This translates to approximately 4.35 percent of reported AIDS related mortality in the past 4 years (cumulative). Similarly, there is scanty data on HIV related morbidity and/ or mortality among key populations in Zanzibar. About 45 percent of participants in a *HIV and Substance Abuse KAP study by ZACP (2005)* cited: HIV/SU associated deaths at 43.3%; advanced HIV disease at 0.2 percent; and 14 percent due to HIV and TB co-infection among substance abusers in Zanzibar. There is currently no similar data/information available on other sub-populations in Zanzibar. Further, the HIV epidemic has also been compounded by the existence of dual or triple co-infections especially among key populations (IDUs, FSWs, MSMs & students at Institute of Education for Offenders).

1.6 Determinants of HIV transmission in Zanzibar

Zanzibar has not yet undertaken a *Modes of Transmission (MoT)* study. Based on limited programme data and evidence from neighboring countries sharing a similar HIV context, it can be reliably predicted that the following may be the key drivers of the HIV epidemic in Zanzibar:

- ***Unequal gender relations and gender based violence***

There is gender unevenness in its various forms and levels in Zanzibar. And in particular, the lack of parity in gender relations makes it difficult for women to negotiate for safe sex with their male partners. Men have been socialized to have, and exercise enormous power in seeking and/or forcing women to have sex with them including in union/partnerships. Inability to negotiate for sex and safe sex practices increases the vulnerability and risk of women in Zanzibar to HIV infection.

- ***High Risk behaviors (sexual and drug related behaviours) among Key Populations***

There is high HIV and other STI prevalence among key populations (MSMs, FSWs and IDUs) because of their higher risk behaviour (including unsafe sex and drug abuse practices) compared to the general population. Various studies conducted among key populations in Zanzibar have documented high sexual and

drug related risk behavior. These include the following in the recognized sub-groups¹⁰:

- **IDUs:** About 53.8 percent of IDUs reported injecting themselves with a previously used needle in the month preceding the study, and 63.0 percent reported having two or more partners while between 66.7 to 73.4% of respondents reported “never” using condoms during sexual intercourse.
- **MSM:** Transactional sex was common with multiple partners, and the median number was three, and one for male and female partners respectively in the month preceding the survey. In addition, between 63.3 to 77.2 percent of respondents reported never using a condom while having intercourse with non regular sexual partners. Furthermore, about 13.9 percent of respondents reported injection drug use.
- **FSWs:** About fifty eight percent (58%) of the female sex workers reported using condoms the last time they had sex. The most common reason given for not using a condom was their partners’ objection to it (42.5%).

On the other hand about 6.2% of women and 11.9% of men in the general population in Zanzibar (THMIS 2008) admitted having been involved in unsafe sexual intercourse including;

- ***High risk behaviors (sexual and drug related behaviours) among Students in Institute of Education for Offenders***

High risk behaviors are common among students in the Institute of Education for Offenders. These behaviours include having unprotected sex, sexual assault, group sex, the sharing of injecting paraphernalia/needles and flash blood practices. These do aggravate the vulnerability and risk of HIV infection of the student at the Institute. Attendants also at the Institute of Education for Offenders are at risk of HIV infection.

- ***Stigma and Discrimination towards Key Populations and PLHIV***

There is high level of stigma directed at key populations in the country (50.2% of the MSMs, 37.2% of the FSWs, 70% of the IDUs reported being

¹⁰ Integrated behavioural and Biological Surveillance surveys for MARPs-2008 (ZACP)

beaten by family members and/or not being respected by the community). Stigma and discrimination directed at PLHIV does significantly hamper their ability to access most of the HIV related services provided (prevention, care, treatment and support). The negative attitudes of some service providers too do contribute to inability of individuals among the key populations not being able to access services.

- ***Poverty and transactional sex***

Transactional sex (sex in exchange for something of value) is common among all recognized key populations in Zanzibar. It is evident that transactional sex is prevalent among IDUs (16.5%) and MSMs (68.4% paid and 77.5% were paid for sex) in the year preceding the survey (THMIS II, 2008). In addition, there is growing evidence of the existence of multiple sexual relationships in the general population that might, if unabated, fuel the epidemic. Trans-generational sex, which had limited documented evidence earlier, is now estimated to be about 9.7% in Zanzibar (THMIS II, 2008).

- ***Mismatch between high levels of HIV related knowledge among Zanzibaris and high risk sexual behaviour***

The THMIS II documented high levels of HIV awareness in the population in Unguja and Pemba Islands. HIV related awareness level among men and women in Zanzibar is about 99 percent. Despite this level of awareness, less than 50 percent of both men and women in Zanzibar knew that condoms are HIV prevention intervention/commodity while only 32.9 percent of men and 20.3 percent of women claimed to have used a condom in the last high risk sexual encounter. Non consistent and incorrect use of condoms by those engaged in risk sex behaviour might fuel the epidemic in Zanzibar.

There is now evidence that young women in Zanzibar are getting exposed to sex at an early age, and those involved are often oblivious of the dangers that this poses to them; especially the risk of HIV infection. About 6 to 13 percent of young people aged 15-24 years have had pre-marital sex, and which in most instances, is unprotected. This pre-disposes these young people to higher risks of contracting STDs including HIV and hepatitis B. Similarly, unprotected sex among married couples who have multiple concurrent sexual partnerships poses challenges to HIV prevention efforts in Zanzibar.

- ***High mobility and migration***

Migration and emigration are both common in Zanzibar. This largely involves movement of business people, migrant workers (pre-dominantly hoteliers), tourists and key populations (all MARPs are highly mobile). Prevailing circumstances might limit the ability of these individuals to protect themselves and some might even, as a survival strategy, participate in high-risk sexual activities. Access to quality health services by these individuals is also quite limited.

1.7 The Socio-economic Impact of HIV in Zanzibar

As is the case in other neighbouring Sub-Saharan African countries, the HIV epidemic has had a negative impact on Zanzibar. To reduce the impact of HIV on the country and its people, Zanzibar has designed and implemented effective strategies under the now ended ZNSP-I. Many challenges however remain due to the nature and type of the epidemic in Zanzibar, and in part, as a result of limited reliable data. Few assessments have been done to establish the impact of HIV epidemic on Zanzibar, and especially on the household and at the national level. The Government of Zanzibar (GoZ) has this notwithstanding, acknowledged effects the HIV epidemic has had on the economy, and made it a key issue in the *Zanzibar Strategy for Growth and Reduction of Poverty* document. Though data remains limited, it can be reliably estimated that presently, the greatest impact of the HIV epidemic is at the micro-economic level (households). Household incomes have declined for those infected and affected due to ill-health related absenteeism from work by the PHIV or the relative who has to stay at home provide to the infected individual. Further, the cost of caring for the PLHIV and the orphans reduces the family's ability to procure goods and services.

2 CHAPTER TWO

2.0 HIGHLIGHTS OF THE ZANZIBAR NATIONAL HIV STRATEGIC PLAN 2005-2009

2.1 Abridged Background of the ZNSP-1

The Revolutionary Government of Zanzibar developed the first Zanzibar National HIV Strategic Plan in 2003. The Zanzibar National HIV Strategic Plan 2004/5-2008/9 (ZNSP-I) provided guidance to ensure a multi-sectoral response to the HIV epidemic in the country i.e. at the national, district, and community level with all contributing. This chapter summarizes the achievements and challenges identified during the implementation of ZNSP-I.

2.2 Summary Results of the Implementation of ZNSP-I

The key achievements, gaps and challenges documented during the implementation of the ZNSP-I are highlighted hereunder:

2.2.1 Overview of the HIV situation (epidemiology and mapping) in Zanzibar

A review of the results of the implementation of ZNSP-I that ended in June 2009 and the overall national HIV response brings out the following attendant achievements and challenges in Zanzibar:

Achievements

Surveys and surveillance data have reliably shown that the implementation of the ZNSP-1 has enabled Zanzibar to maintain the national HIV prevalence among the general population at less than one percent from 1995 to-date. Throughout the 2002-2008 period, HIV prevalence among the general population remained around 0.6 percent. However, *provider initiated HIV testing and counselling* (PITC) data has put the HIV prevalence at 4.7 percent among those seeking services at the health facilities. Data routinely gathered between January and September 2009 at the TB service delivery sites indicated that HIV prevalence among TB clients was 14.06 percent¹¹. In-depth trend analysis on surveillance data has shown some variation in prevalence between the urban and rural populations.

11 ZTLP- Quarterly progress report: 2009

To improve the quality of data for planning, the country shifted from the use of anonymous unlinked to linked surveillance system to monitor HIV infections among pregnant women attending ANC clinics and accessing PMTCT¹². The numbers of ANC surveillance sites were scaled up from eight to twenty by end 2009; and these are also linked to HIV care and treatment centres. The HIV programme has also started monitoring incidence and prevalence in key sub-populations in Zanzibar. The gathered data has helped in the characterization of these key sub-populations (key populations) as high risk, due to both higher HIV and/or STIs prevalence as well as high risk behaviours (sexual and drug abuse) compared to the general population. In addition, gender-related risk factors have also been explored and documented.

Challenges

The key challenges that remain to be addressed include: estimating HIV incidence in Zanzibar, and the contribution of each of the known risk factors in the overall spread of the epidemic. The absence of *Modes of Transmission Study* (MoTS) has created a major challenge in clearly defining the key drivers of the epidemic. In addition, lack of size estimation of the key populations has hampered better planning and implementation of well targeted activities.

2.2.2 HIV Prevention Interventions

2.2.2.1 General prevention

Achievements

There is overwhelming evidence that awareness at all levels in the general population is high. Workplace prevention programmes have been established. Prevention efforts by both state and non-state actors have been initiated in many parts of the country. Further, there is significant reduction in self and social stigma as indicated by increased uptake of HIV testing among Zanzibaris, and improved access to HIV services. The number of individuals who sought HIV testing services grew by 45.5% (the number rose from 13,577 in 2005 to 43,440 in 2010); the number accessing PMTCT grew by 68% (from 5.6% in 2005 to 74% in 2010). In 2008, a total of 34,152 pregnant women were counselled and tested for HIV, and 337 of them testing positive. A total of 125 exposed infants, delivered by mothers on PMTCT, were tested for HIV and 10 percent of them were found to be HIV infected. It can be deduced from this data that the PMTCT intervention in Zanzibar does reduce vertical transmission by 90 percent.

¹² ZACP: report on HIV Sentinel Surveillance for Pregnant women using a PMTCT approach in Zanzibar-2008.

Strategies to mainstream HIV interventions have also been institutionalised in the public sector and institutions of higher learning. No government institutions had launched a workplace HIV strategic plan in 2004 but by end 2009, about thirteen sector specific policies had been developed. Curricula for tertiary level and secondary schools have incorporated HIV related issues; and in addition, many HIV health clubs have been started to serve students as appropriate. Today, the Zanzibar community is also better informed about key populations and the drivers of the epidemic in the country.

Challenges

The majority of interventions have targeted the general population, and mostly with a greater inclination on the urban and semi-urban populations. Generally speaking, some of the strategies have been the ‘one-size’ fits all type. This did reduce the effectiveness of the HIV prevention strategy/intervention in the country. Furthermore, the HIV prevention interventions were more targeted at the rural population than the urban and semi-urban populations. The HIV related knowledge levels in the country varied and had no correlation with positive behaviour change or risk reduction (THMIS, 2008). Workplace interventions have been predominantly established in the public sector, and that their sustainability is questionable because they are largely dependent on external financial support. The Business Coalition in Zanzibar (ABCZ) is not fully functional to support HIV mainstreaming in the private sector. The general public remains not fully aware of the implications of gender inequalities and the inherent potential to fuel the HIV epidemic.

2.2.2.2 HIV related Advocacy

Achievements

Zanzibar has acknowledged the HIV epidemic as a priority and considered it a national developmental issue. The National Strategy for Economic Growth and Poverty Reduction, MKUZA, has therefore included HIV as a core issue to be addressed during its implementation. In the fulfilment of the country’s commitment to MKUZA, Zanzibar has shown high level political commitment to fighting against the HIV epidemic. During the ZNSP-I plan period, a national anti-stigma campaign was launched by Her Excellency, the then First Lady of Zanzibar, Mama Shadya Karume, in her capacity as the HIV Goodwill Ambassador. Platforms such as the World AIDS Days, “Uhuru” torch rallies, and other national and cultural events (ZIFF, Mwaka Kogwa etc) have been successfully used to drive advocacy and anti-stigma campaign in Zanzibar.

Challenges

Limited resources allocated for advocacy campaigns remain a major challenge in the country's quest to reach targeted populations in a sustainable manner. Approaches used as part of the advocacy campaigns are those targeting non-contentious issues namely abstinence and being faithful to uninfected sexual partners, and very limited on condoms and/or key populations. Inadequate advocacy materials were developed as part of the condom promotion and appropriate use strategy to reduce the risk of HIV infection/transmission and/or unintended pregnancies. Advocacy targeted at key populations is largely geared towards mitigating both substance abuse and injecting drug use. Currently there is no coherent and specific national strategy to address the issues of key populations to help them reduce their own risk of HIV infection and/or transmission.

2.22.3 Community HIV Prevention Interventions

Achievements

Capacity enhancement and sensitization programmes for faith-based leaders have been institutionalised in Zanzibar, resulting in the cascading of appropriate HIV messages to encourage behaviour change and improved access to available services. More specifically, these programmes include those meant encourage individuals and communities to embrace HIV prevention, and the correct and consistent use of condoms when in discordant relationships, etc. Communities in Zanzibar have adopted pre-marital counselling and testing as a key eligibility criterion for those seeking to get married. The out-of-school youths in Zanzibar have been regularly targeted with culturally sensitive interventions/approaches including via folk media, entertainment and music groups. A total of two HIV programmes at Shehia administrative level were initiated in 2009.

Over the ZNSP-I implementation period, Zanzibar witnessed increased societal openness about the contentious issues including the promotion, distribution and appropriate use of condoms to reduce one's own risk of HIV infection/transmission and/or unintended pregnancies.

Challenges

The achievements noted above have not been without challenges, including the absence of a comprehensive community capacity enhancement strategy. Currently, most of the interventions targeted at the community are ad hoc. Moreover, the country does not have a formal catalytic platform to engage and encourage the faith-based organization leaders to discuss contentious issues such as condom promotion and distribution. The current out-of-school- youth BCC interventions programmes

area little superficial and limited to awareness creation. The societal enforcement of pre-marital HIV testing requirement has had a negative bearing on the rights of the individual, and especially if testing is neither voluntary nor confidential or ethical. When in-laws take action based on the sero-status of the bride or groom, it is against the policy and principles of HIV testing in general. High HIV related stigma in the community has continued to impede HIV prevention and service provision. The greater engagement and involvement of PLHIV in the national HIV response as part prevention with positives remains an important missed opportunity.

2.2.2.4 The Most at Risk Populations (Key Populations)

Achievements

Implementation of the ZNSP-I acknowledged the existence of key populations, and therefore their needs were incorporated into the key national documents and the necessary resources committed to address them. To effectively reach the key populations, peer educators were identified, trained and supported to undertake specific activities including HIV counselling and testing services. *Moonlight Outreach Educational Campaigns* and *HCT* in night clubs and bars in Zanzibar are one of the approaches to ensure individuals in the key population know their status. Zanzibar developed and launched the *Integrated HIV and Substance Abuse Strategic Plan*¹³ during the ZNSP-I period. The substance abuse recovery programme was initiated on a small scale, with the programme elements being the *twelve step recovery method* as well as a *Sober House*. Zanzibar is now undertaking the construction of the first detoxification and rehabilitation centre. IEC materials and education programmes targeted at key populations were developed and implemented using both the electronic and paper-based media.

Challenges

Operational research and most of the initiated interventions targeted at key populations remain small scale and predominantly urban based. Access to health services by the key populations in Zanzibar remains limited, and in particular HIV and reproductive health related services including male and female condoms and water-based lubricants. Levels of stigma and homophobia towards the key populations in Zanzibar are high and a barrier to greater access to services. Lack of adequate numbers of service providers with appropriate skills to address the unique needs and expectations of key populations remains an important issue begging for urgent attention in Zanzibar; currently, only a few but non-experienced civil society organizations are catering for the needs of this important group in the country.

13 Zanzibar Substance Abuse-HIV & AIDS Strategic Plan (2007-2011) – SUHISP.

2.2.2.5 Information, Education and Communication (IEC) and Behavioural Change Communication

Achievements

The implementation of the ZNSP-I resulted in the development and dissemination of many IEC and BCC messages aimed at changing unsafe sexual behaviour, stigma reduction and addressing other HIV related issues. The public radio and television (TVZ) in Zanzibar were greatly engaged and remain committed to conveying HIV related messages as part of their contribution to the national response. Billboards with enduring HIV messages were put up, and can be found around the street corners and road network throughout the country.

Challenges

The majority of the expressed or aired HIV related messages are too general and targeted at addressing a generalised epidemic. They are a ‘*one size fits all*’ and this approach needs to change to more effectively address the now evident character of a mixed epidemic in Zanzibar. The documentation of the prevailing HIV related myths and misconceptions remains limited in Zanzibar, and this has impacted the effective success of IEC/BCC approaches used to reach hidden (“the underground”) key populations. The engagement of mobile cinemas, mobile phone, drama and television to pass on the epidemic also remains limited in the country. Monitoring of outcomes and/or the effect of advocacy materials is not fully institutionalized in Zanzibar and this hampers data gathering necessary to improve the development and implementation of evidence informed strategies. Further, not messages addressing gender unevenness in relation to HIV infection/transmission and outcomes were developed and implemented during the ZNSP-I.

2.2.2.6: Condom Programming in Zanzibar

Achievements

The availability and accessibility of both male and female condoms improved significantly by the end of ZNSP-I. These are now more readily available in health facilities, private pharmacies and “silent kiosks” in Zanzibar. Condom distribution in the evenings and late in the night is now done through an enduring partnership between the national programme on one hand and taxi drivers, sex workers and bar attendants on the other. Sectoral TACs do play a key role in ensuring condoms are available to the workforce, albeit to a limited level. Key populations’ own peer educators, PLHIV, and CSOs have also scaled-up the number of outlets providing prompting messages and distributing condoms in Zanzibar. The uniformed services, especially the military, routinely provided condoms too to staffs as part of their

workplace HIV intervention. In line with the national condom promotion strategy, the messages carried by/on the electronic (radio and TV) and print media from the neighbouring Tanzania mainland is widely received on the Isles. Zanzibar also conducted a condom needs assessment during the implementation of the ZNSP-I to guide effective condom programming.

Challenges

Although use of condoms is a scientifically proven intervention to reduce risk of HIV/STIs acquisition/transmission and/or unintended pregnancies, their promotion and use in Zanzibar is still a taboo. Universal access to condoms in Zanzibar is affected by strong cultural and religious barriers, and which have restricted open discussions about their widespread distribution and use. Erratic supply of the condoms is common due to their classification as a medical commodity to be available only through the pharmacies. This classification works against efforts to promote more universal access and use of condoms as HIV prevention intervention. Access to female condoms remains very limited, and therefore too, their wide use. Myths associated with condoms are very common, and condoms are sometimes even mythically associated with unpleasant outcomes including STD symptoms; for instance, one female sex worker in Pemba associated an STD related abdominal pain with use of condom lubricants¹⁴. Gender inequalities have a big bearing on who decides on condom use during sexual intercourse, with men clients in most partnerships having the last say in condom negotiation during sexual intercourse.

2.2.2.7 Health facility based HIV Prevention Interventions

Achievements

Zanzibar has greatly strengthened its health facility based HIV counselling and testing services in line with the nature and pattern of the epidemic. HIV counselling and testing services have been scaled up and the quality of services is regularly monitored. The national HTC guidelines have been developed including the national VCT guidelines. The guidelines have been used to support all testing opportunities including via PMTCT. Many service providers were trained during the ZNSP-I to provide counselling and testing services at various levels of the health care system in the country. Service monitoring is routinely performed to ensure quality HTC is being provided to those seeking to know their correct status. HCT services to the hidden and other hard to reach populations (including key populations) have been institutionalised in the form of outreach or satellite services. The National Blood

¹⁴ Findings from Focal group Discussion with FSWs during ZNSP-II formulation in Pemba-2009

Transfusion centre was strengthened during ZNSP-I and now ensures access to quality safe blood through routine HIV testing and monitoring of all blood borne infections such as syphilis, hepatitis B and C. In addition, post exposure prophylaxis programme was initiated and is now provided to those who get accidental exposure to potentially HIV infected materials; this service is however currently only available in the urban settings.

Challenges

The ongoing practice of community driven pre-marital HIV testing as a key criterion for marriage is not voluntary and the results are often not confidential. Limited public knowledge of the need to respect of rights of an individual remains a key concern to the national programme. The decisions taken based on the results of such HIV tests could have huge implications on greater uptake of counselling and testing in general. This is especially so, when the eventual breach of confidentiality is associated with service providers at the VCT centres involved in the practice. An additional challenge is the timing of these pre-marital testing; they are mostly done as a last minute event.

HTC services are not widely accessible in the rural areas. Most of the sites providing counselling and testing services are in urban and peri-urban settings in Zanzibar. Limited space in most VCT centres and both the shortage and uneven distribution of qualified staffs remain a key concern to the national HIV programme. Noteworthy also are the challenges standing in the way of providing universal access to PMTCT services, including the limited number of facilities offering these services, the high number of women who deliver at home without skilled attendance, the low levels of male involvement, and the lack of comprehensive post-natal follow-up interventions. In addition to the above, information on strategies for positive prevention for discordant couples and PEP are limited because only a handful of facilities can provided them in the country. Operational costs for these services remain high, and mostly are covered by donor funds, and therefore the sustainability of the initiated services remains a key issue.

2.2.2.8 Stigma and Discrimination

Achievements

The last five years of the response have resulted in greater investment by various stakeholders to mitigate key factors that fuel and maintain HIV related stigma and discrimination in Zanzibar. The concerted efforts and educational campaigns on behavioural change throughout the country have shown preliminary changes in perceptions, and especially in both urban areas and at the workplaces. Zanzibar,

through the ZAPHA+ and in collaboration with development partners, is undertaking a study/index assessment that will shed more light on the extent/degree of HIV related stigma and discrimination in the country to inform future planning.

Challenges

Key stigma and discrimination related challenges in Zanzibar include negative attitudes among health care workers that hamper accessibility and utilisation of existing services by key populations (MARPs and PLHIV); homophobia and unfriendly environment at service delivery points which affects service utilisation (and accessibility) by key populations including MSMs, SWs and IDUs. Internal (self) stigma also remains a major challenge to PLHIV as well as MARPs. Discriminative laws, and both unhelpful policies and regulatory frameworks have had a negative bearing on some of the key sub-populations limiting their access to services, or if they do access them, these services are mostly of inadequate quality.

2.2.3 Care, Treatment and Support

2.2.3.1 HIV care

Achievements

The health sector has established HIV care and treatment centres on both the Island of Unguja and Pemba, covering four of the country's five regions. Renovation health facilities and procurement of basic equipment for these sites was done during ZNSP-I. Access to crucial laboratory machines such as FACs count machine (for CD4+cell monitoring), biochemistry and haematological analysers have been strengthened and institutionalised. It is estimated that there are about 7,200 people living with HIV (adults and children) in Zanzibar¹⁵; and all are targeted with risk reduction, care, and treatment services. Currently 3,699 PLHIV are enrolled for care services centres out of the targeted 5,760 (80%)¹⁶. This represents coverage of about 64.2 percent of all PLHIV who need care.

The Mnazi Mmoja Hospital has been incorporated into the national, regional and international quality assurance schemes. A capacity enhancement programme was developed and implemented to improve comprehensive care and ART services in fulfilment of the establishment of comprehensive treatment centres (CTCs) throughout the country. Staff retraining and supportive supervision has also been undertaken periodically and institutionalized.

¹⁵ ZACP-Surveillance report.

¹⁶ ZACP- CTC quarterly progress report: 2009

Challenges

Infrastructure related issues such as space and aging and dilapidated facilities are among the key challenges affecting service delivery and access to quality care and treatment in Zanzibar. Moreover, inadequate number and inequitable distribution of qualified staff undermines the achievement of the objectives set to ensure universal access to care and treatment by all those who need them. Donor-driven vertical interventions remain a challenge to the establishment of integrated and comprehensive services that go beyond the HIV service centres. Based on current epidemiological patterns, comprehensive treatment centres (CTCs) have not been fully decentralised to cover all districts in the country. The placement of the CTCs is driven more by set targets. Monitoring paediatric HIV is a real challenge as there is limited deployed PCR capacity to undertake *early infant diagnosis* (EID). Currently, there is also no laboratory in Zanzibar with the capability to undertake ART resistance monitoring.

2.2.3.2 HIV treatment related Commodity Security

Achievements

During the ZNSP-I, Zanzibar developed and operationalized a national HIV procurement plan. In line with this plan, procurement and supply chain management officers were recruited and stationed at the CMS-MoH. This has resulted in the strengthening of the procurement and supply chain system for ARVs and OIs treatment drugs in the country. Key procurement and managerial staffs have been trained on the procurement process including demand forecasting.

Challenges

In spite of the achievement highlighted above, the current PSM performance remains sub-optimal. This is mainly due to the inadequate number and poor retention of skilled procurement officers, and the unpredictability of availability of funding for planned procurement.

2.2.3.3 Paediatric HIV Management

Achievements

During the last five years of ZNSP-I implementation, Zanzibar witnessed an uptick in paediatric HIV management. Notable achievements in this include the roll out of a paediatric diagnosis system based dry blood spot samples being transported to Mainland Tanzania for testing. The results are used as a surrogate indicator of the

success/ outcome of the PMTCT services in Zanzibar¹⁷. To ensure quality paediatric HIV management is provided, key staffs have been trained on comprehensive paediatric management and the relevant treatment guideline provided to health providers. In collaboration with development partners, appropriate and adequate quantities of the paediatric ARV formulations have been procured and availed to all CTCs in Zanzibar.

Challenges

The key notable challenge in the providing ART to children is the absence of adequate early infant diagnosis (EID) infrastructure in Zanzibar, and this limits the proper estimation of vertical HIV transmission and effectiveness of the PMTCT intervention. In addition, there are a limited number of health facilities, and health providers with the necessary capacity/skills to provide comprehensive and user-friendly paediatric services in Zanzibar.

2.2.3.4 Treatment Monitoring

Achievements

Zanzibar, through both ZAC and ZACP, developed a costed monitoring and evaluation framework that guided all key monitoring and evaluation activities under the ZNSP-I. Various M&E related training sessions based on need, were undertaken especially for key staffs. The national M&E system does cover, to some extent now, both the services provided at the health facility and in community settings in the country. During implementation of the ZNSP-I, a treatment defaulter tracing and adherence system was developed; this is used by comprehensive treatment centres (CTCs) to bring back to defaulting PLHIV back to treatment.

Challenges

Insufficient referral and monitoring systems for home based care, comprehensive treatment centres and voluntary counselling and testing remain a key challenge in Zanzibar. Community systems are not fully linked to the central M&E system, resulting in delayed reporting. The wide use of paper-based field data collection tools and very limited adoption of PDA contributes to delayed uploading and analysis of collected data. In addition, the surveillance officers in Zanzibar are not sufficiently provided with transport and computers to carry out their role and responsibility in support of acquiring relevant strategic information for planning.

¹⁷ ZACP- PMTCT report, 2009

2.2.3.5 Management of Opportunistic Infections (OI) & STIs

Achievements

During the ZNSP-I period, the STIs management services were made part of the routine service package at all health facilities. The service providers at these facility were trained on syndromic management of STIs during the early phase of ZNSP-I implementation. The STIs management is currently done as part of a comprehensive service package which includes HIV and Reproductive Health interventions. Specific STIs treatment service packages targeting key populations (MARPs) were initiated in Zanzibar.

Challenges

Effective STIs management is a crucial part of HIV prevention. There are however a limited number of health facilities provided comprehensive STIs management services in the country. The attitudes of the health providers projected to/at the key populations is a significant barrier to access to these services. The STIs management services are largely available at fixed health facilities and therefore outreach services especially targeted at the key populations in the country remains limited. The STIs training manual currently in use has limited options to address specific needs of the key populations, and in addition, not all service providers have been trained on how to offer quality friendly-services to them.

2.2.3.6 Co-infections Management

Achievements

During the implementation of ZNSP-I, management of co-infections (HIV and TB) was taken to the next level. The services provided were broadened with the development of operational plan, with support from CDC, to include Hepatitis B and C Virus. A national policy on HIV-TB collaborative activities was developed and launched during the plan period. Integrated HIV-TB services were initiated and are now available in some clinics in Zanzibar.

Challenges

Although the HIV/TB policy document exists, it has not been fully owned by all health care workers. The knowledge and capacity of providers to diagnose and manage Hepatitis and HIV co-infections remain limited. The necessary infrastructure required to effectively diagnose and manage Hepatitis infections remains limited too. Moreover, the majority of health providers are not vaccinated against Hepatitis B in Zanzibar.

2.2.3.7 Home Based Care (HBC) Services:

Achievements

Home-based care services have been scaled up throughout Zanzibar, and both health care workers and community workers were trained on the home-based care strategy. Basic field HBC kits and bicycles were and continue to be regularly provided to those implementing planned home-based care activities in the country. The national HBC guidelines have been developed, printed and distributed. Treatment defaulters and those who are bed-ridden are visited as part of outreach services. Civil society organizations, including the Zanzibar Association of People Living with HIV and AIDS- ZAPHA+, have been fully engaged, trained and supported to carry out these activities. Home-based care services are now linked to HIV care and treatment clinics (comprehensive treatment centres) as well as to other health related services such as PMTCT. Nutritional/ food supplements are now available on prescription for eligible PLHIV and are provided as part of the home-based care services.

Challenges

Lack of ownership of home-based care activities at district level, and the limited motivational incentives provided to those implementing them are a challenge to effective and sustainable outcomes. High staff turnover too remains a common challenge, and further, the home-based care strategy/interventions in are not comprehensive enough to address all the community needs and expectations. In addition, home-based care services in Zanzibar are not fully integrated into role of the civil society organizations as part of the national HIV response.

2.2.3.8 Nutritional Support

Achievements

The ZNSP-I identified the need to provide nutritional support to PLHIV who are accessing ART services to improve outcomes. Based on this, a nutritional needs assessment was done in collaboration with development partners (CHAI and WFP), and the results of the survey used to develop an eligibility criterion for PLHIV who need to get nutritional supplements. The two nutritional intervention approaches implemented include: i) food by prescription, and ii) household food support. Because of limited resources and to ensure the intervention is sustainable over the longer term, Zanzibar currently undertakes the former for PLHIV based on the set eligibility criteria.

Challenges

Some in society are questioning the merits of using chronic diseases as a basis for proving food support to anyone in Zanzibar. In fact, communities are questioning the legitimacy of providing food support only to PLHIV while similar needs do exist for those with other chronic diseases such as cancer and tuberculosis. Further, the eligibility criterion set for PLHIV to access food support remains a challenge because it was not based on a mean tested score, but instead on the clinical manifestation of the HIV disease. The sustainability of food support too is debatable, as this intervention is very reliant on donor funding.

1.1.3 Creating an Enabling Environment

2.2.4.1 Administrative structure and performance

Achievements

To scale up and mainstream HIV interventions during the ZNSP-I implementation, the lower level government administrative structures were assessed, mobilised and their capacity enhanced. Apart from strengthening the DACCOMS and SHACCOMs, civil society organizations including community-based organisations and structures were also targeted. Funding to support these community-based organizations to implement HIV programme activities was channelled through TASAF. Both technical and financial support is also being provided to district level response initiatives in Zanzibar. The role and capacity of civil society organizations involved in the HIV response were enhanced, and they are now represented in the decision making processes including on matters touching on financing and programme implementation. The civil society organizations in Zanzibar are therefore members of the Country Coordinating Mechanism of the Global Fund (CCM) and the ZAC Board.

Challenges

Retention of trained institutional staff is a major challenge and this does affect the performance of both state and non-state institutions. High staff turnover and mobility within and between the civil society organizations is a major hindrance to institutional capacity and sustainability. Institutional capacity needed for non-government actors to mobilise financial resources, is another major challenge facing the HIV response in Zanzibar. The nature and legality of some of the civil society organizations and their structures do limit them in their quest to solicit and/or mobilise required resources to fund planned activities. Further, the number and

skills of staffs at most of them remains a challenge and especially to their long term survival and sustainability.

1.1.3.1 HIV related Policy and legal Environment

Achievements

The national coordinating body (Zanzibar AIDS Commission-ZAC) was established during ZNSP-I was established through an Act of the House of Representatives. In pursuance of its mandate, ZAC developed the national HIV policy which provides stewardship on all HIV related matters in the country. As part of national policy, Zanzibar allocates five percent of its national annual budget to financing the HIV response to ensure the sustainable mainstreaming of HIV interventions at sectoral level. There is high level commitment by government, the workers' unions, implementers and other stakeholders in Zanzibar. Laws on human rights and substance abuse have been enacted and/or ratified based on the international standard, and these have laid the foundation for the provision of detoxification and rehabilitation services to identified individuals in the country.

Challenges

During the implementation of ZNSP-I, inadequate number and access to condoms was a challenge due to their classification as a medical or pharmacy only product. This classification heavily limited condom accessibility and negatively affected condom programming. There is also limited willingness in Zanzibar to develop and/or strengthen the policy framework/guidelines to address the conduct and negative attitudes of providers towards the key populations when they seek services at the health facilities. In addition, the funds allocated for HIV activities by the Government of Zanzibar are not ring-fenced, and are therefore easily re-allocated to non-HIV related activities.

2.2.4.3 Institutionalisation and Operationalisation of ZNSP-I

Achievements

The ZNSP-I and the national HIV response were institutionalised in the country, in part, because of the development of key guiding documents and tools as well as the promotion and/or existence of a conducive/enabling environment. This includes the presence of a proactive ZAC Board and the nomination of the HIV Goodwill Ambassador. During the implementation of the ZNSP-I the national HIV Monitoring and Evaluation Framework, its integrated monitoring body (METHAZ),

and the Interfaith Umbrella Association were formed and institutionalized. The ZAC, DACCOMS and SHACCOMs, and the ZAC sub-office in Pemba were strengthened to effectively support the implementation of ZNSP-I. Further, the multi-sectoral approach to the national HIV response was also strengthened to ensure all are contributing to the achievement of objectives set in ZNSP-I. Not-state actors, such as the Zanzibar Business Coalition and UWAKUZA, are fully involved in the national HIV response.

Challenges

One of the key challenges that stood in the way of the effective institutionalization of the ZNSP-I was limited internal funding for more sustainable national HIV response. Greater country ownership of the HIV response is a strategic imperative. Further, the national HIV M&E framework was never fully understood by all key stakeholders (especially implementers); and this affected the timely and accurate reporting by some of those involved in the national HIV response. In addition, the number, skills and retention of human resources in the health system was a great challenge to the effective institutionalisation of ZNSP-I.

2.2.5 Impact Mitigation

Achievements

The most vulnerable communities and as well as old people, orphans and people with disability were supported by the Government of Zanzibar as part of the national HIV response. To ensure success, and sustainability, the government did also encourage and involve the civil society organizations in the implementation of HIV impact mitigation activities. And further, more enduring partnerships have been forged between the Government and the development partners to develop strategies to provide support to key populations and PLHIV groups to make their contribution to the fight against the HIV epidemic in Zanzibar. In particular, collaborative efforts have been made to enhance the capacity of ZAPHA+ (a PLHIV support group) to develop impact mitigation strategies to alleviate the burden brought onto its membership and the community by the epidemic. Some of the interventions supported include: community outreach services, adult education and training for ZAPHA+ members. The training modules developed and implemented for the PLHIV support groups include: i) English language lessons; ii) starting and managing small businesses; and on iii) resource mobilisation. Micro-finance/soft loans have also been provided to ZAPHA+ members to start income generating activities, including animal rearing, soap making, clothes making, and backyard horticulture.

Challenges

HIV related stigma and discrimination remain a challenge in Zanzibar. Therefore, most of the interventions mentioned above have largely been implemented in urban settings. There is still inadequate coordination, collaboration, partnership building and networking in the design and/or implementation of strategies and/ or policies to reduce impact of the epidemic on the Zanzibari society. What constitutes the minimum package of services per household in the country in relation to impact mitigation remains poorly defined and this affects resources mobilization and allocation. Further, the key populations in Zanzibar have not yet been fully engaged and involved in the effective implementation of the impact mitigation strategies.

2.2.6 Monitoring, Evaluation and Research

Achievements

As part of the ZNSP-I, the national M&E framework and data collection tools were developed. The M&E indicators developed to support implementation of the plan were aligned with the set objectives and also both UNGASS and MDG indicators. Information channels and the flow of data were well characterized during the plan period, and also the monitoring and evaluation related activities decentralised. The implementation of the ZNSP-I, appreciable investments were made resulting in the development of monitoring and evaluation structures, and the training and retention of requisite human resources to facilitate the operationalisation of national M&E framework. Basic programme performance monitoring related capacity building was done at various levels of the national response. Zanzibar did participate in the *Tanzania HIV and Malaria indicator survey (THMIS)*, and did other surveys including: i) Study on HIV and tourism; ii) Gender mitigating factors; and iii) The prevalence of STIs among students in the Institute of Education for Offenders.

Challenges

The current M&E system focuses more on routine data collection and functions, and therefore does not respond well to an evolving and non-generalized epidemic. While the system can support some measure of epidemic modelling, it is not very responsive to a mixed epidemic. Further, the national HIV monitoring and evaluation system is neither fully integrated nor harmonised with other complementary planning and monitoring systems. The national monitoring and evaluation is largely dependent on external funding and its activities would be constrained if this support was curtailed. The lower level health facilities in the country do not have adequate capacity to gather data, analyse it and use findings for planning and effective implementation

of specific interventions. Inadequate distribution of data collection tools and lack of equipment, such as computers and vehicles at the peripheral facilities, remain a challenge. Data auditing and quality assurance is rarely done; and when this is undertaken, it is mostly during studies or while verifying it with/for partners (donors). There is limited functionality of feedback and referral mechanism in the country, and in addition, Zanzibar does not have a documented national research agenda/plan.

CHAPTER THREE

3.0 THE ZANZIBAR NATIONAL HIV STRATEGIC PLAN 2011-2016

3.1 The Vision, Mission and Overall Goal of the Zanzibar National HIV Strategic Plan 2011-2016 (ZNSP-II)

Vision: *A Zanzibar population that is free of HIV Infection and empowered to take positive action*

Mission: *To support the national HIV response to reduce impact of the epidemic on the country's economy through better coordination, leadership and resource mobilization and financing for effective implementation of the planned interventions*

Overall Goal: *To prevent the spread of HIV infection among Zanzibaris, provide quality continuum of care to all PLHIV, and mitigate the accompanying negative psycho-social outcomes (including among key populations in Zanzibar).*

3.2 Thematic areas, and impact results

The ZNSP-II has been developed to build on the best practices, lessons learnt and achievements of ZNSP-I, and to address both the identified challenges and emerging issues of the HIV epidemic in Zanzibar. To contribute to the Vision, Mission and Overall Goal of the National HIV Response, ZNSP-II Strategies have been developed around the following five thematic areas:

1. HIV Prevention
2. Treatment, Care and Support
3. Impact Mitigation
4. Creating an Enabling Environment
5. Research, Monitoring and Evaluation.

These thematic areas have their own identified priorities that are discussed in detail under each in the following eight chapters of the ZNSP-II. Further, each thematic area has its own specific **strategies, action areas, outputs, outcomes, and impact results**. Chapter Nine (9) of this ZNSP-II outlines the operationalisation of this strategic plan.

3.3 Guiding principles of the ZNSP-II

1. **High-level Government commitment, enduring leadership and ownership of the National Response:** The GoZ is fully committed to the national HIV response, and will create an enabling environment, provide leadership and mobilize the necessary resources for effective implementation of the planned activities through a multi-sectoral approach. The required stewardship role shall be through ZAC, which shall provide the required leadership for a sustained and more effective management of the national HIV response that reflects the country's own priorities.
2. **Compliance with Three Ones Principles:** The national HIV response will be aligned to the “Three Ones (3Is)” principle comprising:
 - i. *One agreed National HIV Strategic Plan/ Action Framework that provides the basis for effective coordination of all stakeholders' efforts in the national HIV response;*
 - ii. *One National AIDS Coordinating Authority, with a broad based multi-sector mandate;*
 - iii. *One agreed National Monitoring and Evaluation System to support effective implementation and reporting on the HIV response.*
3. **Greater and meaningful involvement of PLHIV (GIPA):** Greater involvement of PLHIV in all settings is of paramount importance to ensure an effective national HIV response. Behaviour change is pivotal to a successful ZNSP-II take-off, and to achieve this, Zanzibar will continue to ensure full engagement and involvement of PLHIV at various levels of the HIV response. This commitment to GIPA includes meaningful engagement of PLHIV in i) the planning process, ii) strategy implementation, and iii) promotion of prevention and care services. In addition, PLHIV shall continue to play the role of expert patients to support i) demand creation and adherence to treatment, and ii) increased service coverage as part of the continuum of care, and iii) the development of responsive national laws and policies as appropriate.
4. **Multi-sectoral partnership:** For a successful and sustainable national HIV response, and in recognition of the multi-faceted nature of the epidemic, all sectors of the Zanzibar society will play a role fitting their capacity in the implementation of planned activities. Collaboration and cross-fertilization of knowledge and skills will be encouraged among various stakeholders in the national HIV response for effectiveness. The stakeholders include Government, private and business communities, civil society organizations, bilateral and

multilateral partners, and the target community. These stakeholder groups shall be part of the team in the design, implementation, monitoring and evaluation of the national HIV response based on their comparative advantages.

5. **Respect for Human Rights:** In line with the Zanzibar Health Policy, citizens have a basic right to access all HIV/STD/RCH services in all settings. These services will be accessed, either free of charge or at a minimal fee based on the type of facility visited. To ensure this promise is achieved, the health system must be strengthened to address the needs of public and private sector, confined (“prisons”) individuals, and the vulnerable and marginalised people in society. The PLHIV, orphans, widows, other women, and the key populations have the right to access basic quality services and be protected against all forms and types of discrimination and stigmatisation while soliciting and/or accessing HIV services. Specifically, the vulnerable populations are to be targeted with services including students in the Institute of Education for Offenders, fishermen, the uniformed services/forces and migrant workers, etc.
6. **Gender Responsiveness:** All actors in the national HIV response will pay particular attention to gender issues, which pose unique and ever-changing challenges to the programme and exacerbate the course and impact of the epidemic on the people. The ZNSP-II shall scale up efforts and build on the gains realised during ZNSP-I. The developed strategies and activities will address the needs of boys and girls, men and women, vulnerable and marginalised groups.
7. **Strategies based on evidence:** Evidence is needed to ensure that all implemented activities are effective in achieving the national goals including i) prevention of new infections and ii) improving the lives of those who are infected and affected. Given the limited resources available in Zanzibar, there is also a need to establish cost-effectiveness benchmarks for the planned interventions to ensure rational allocation of resources and outcomes.

Formative research is a national priority, and especially to help stakeholders involved in the national HIV response to understand and quantify risk behaviours and vulnerabilities of various population groups. Credible data is needed that enables stakeholders to undertake size estimates of key populations, define further the character of the epidemic, and to set baselines that help in designing more targeted interventions and reporting on performance. The ZNSP-II will facilitate the development of the national research agenda to be implemented to gather data for planning and effective implantation of strategies in support of the HIV response.

- 8. Community empowerment approach:** A community empowerment approach strengthens the capacity of families and society to address their own vulnerabilities to HIV infection, and to care for the PLHIV, OVCs, widows, widowers and the affected elderly. Hence, there is need for full community involvement in the HIV response to ensure better ownership of the designed interventions for effectiveness.
- 9. Good governance, transparency and accountability:** An effective national HIV response requires the presence of good governance, transparency and accountability at all levels, and especially in resource mobilisation, allocation, utilisation and reporting/accounting.

3.4 A deliberate Programmatic Shift to specifically target key populations

Based on the growing evidence that the HIV epidemic in Zanzibar has a mixed character, the ZNSP-II has been aligned to deliberately and specifically target the key populations (MARPs), now recognized as the key driver of the epidemic. During the formulation of ZNSP II, several but limited reviews of the current contexts were made that led to the conclusion that Zanzibar should design and implement strategies which reduce the risk of increased HIV infection/transmission among individuals in the key populations and transmission into the general population. An HIV response which is predominantly key populations' focused might fuel stigma and discrimination, and thus drive this key sub-population underground.

There is need to undertake operational research to help clearly define the *modes of transmission* and the *key populations'* contribution (associated risk behaviours) to the HIV epidemic in Zanzibar. Undertaking size estimates of the key populations will help in the design and implementation of specific strategies that are well targeted and responsive.

ZNSP-I had its focus on the general population and was able to keep the national HIV prevalence at below one percent (in the general population). This was confirmed by all population based surveys conducted in Zanzibar (the *Validation Survey -2002*; and the *Tanzania HIV and Malaria Indicator Survey- 2008*). The ZNSP-II is expected to be proportionately more focused on the key populations than the general population, and therefore effective in reducing incidence due to its greater targeting of this recognized driver of the epidemic in Zanzibar. Drawing up a 100 percent key populations' inclined national HIV strategy would have resulted in the creation of

a document that is difficult to effectively implement, and especially because of the potential risk of fuelling stigma and discrimination, and violation of their human rights of this key population group.

4

CHAPTER FOUR

4.0 HIV PREVENTION

4.1 Introduction

Implementing an effective HIV prevention strategy requires one to have relevant information on the factors driving the epidemic in the country. The HIV epidemic in Zanzibar was believed to be mixed in character, but there is growing evidence to suggest it is more of the concentrated type in orientation¹⁸. Reasons for such observation include: i) the nature and types of clients (and service attendees) seen at the HIV care and treatment clinics; and ii) the trend and pattern of blood borne infections seen in clients seeking services, particularly Hepatitis C, which is a surrogate marker of an early epidemic, etc. In view of the above, and taking into account the lessons learnt from ZNSP-1 implementation (in the general and key populations), this ZNSP-II aims at more aggressively implementing HIV prevention strategies which encourage risk reduction (through behaviour change) among the key populations. In addition, special focus shall be made on vulnerable populations as informed by data gathered on their lifestyles, social status and risk behaviours.

The proposed framework of interventions below puts emphasis on the achievement of results using a combination of medical and non-medical strategies involving leadership, commitment and contribution of various key stakeholders in the national HIV response. These stakeholders include Government, private sector, civil society organisations, development partners and the target communities. This is especially so, to address among other factors, multiple concurrent partnerships which are now a recognized risk factor for HIV acquisition/or transmission. The HIV prevention strategies in ZNSP-II are aimed at building on successes of ZNSP-I especially with regard to increasing HIV related knowledge and behaviour change interventions. This will be supported by biomedical services namely HCT, PMTCT, STI management, and both safe blood and medical procedures.

Key HIV Prevention Issues for the ZNSP-II (2011 – 2016)

The following are key issues to be addressed during the ZNSP-II plan period:

¹⁸ An epidemic affecting the general population that has reached a maturity plateau while that of concentrated epidemic affecting MARPs has not reached epidemic maturity as is evident with other co-infection rates such as HCV

1. Greater emphasis on risk reduction among key populations and their clients.
2. Continued HIV prevention programmes for the general populations.
3. Increased attention to young people aged 10-24yrs, mobile and other vulnerable populations.
4. Prevention with positives (PwP) for PHIV.
5. Programming for male and female condoms and water-based lubricants.
6. Increased access to and availability of HCT services (VCT, PICT, DCT, and PMTCT).
7. Promotion of early STIs diagnosis and management.
8. Proper use of IEC/BCC materials and use of media (radio, TV, newsletters and newspapers) and new media (mobile phones) to support the national HIV response.
9. Effective planning in the current religious, cultural and socio-economic environment in Zanzibar.
10. Effective integration of HIV related gender dynamics into the national prevention strategies.
11. Greater and meaningful involvement of PLHIV and key populations in the response.
12. Enhanced universal access to HIV related information and services in urban and rural Unguja and Pemba.
13. Improved capacity and coverage/reach of civil society organizations working with key populations.

4.2 HIV Prevention Impact Results

The national HIV prevalence is reduced by 33 percent (from the current 0.6% - 0.4%) by 2016

This **Impact Result** focuses on the reduction of HIV prevalence in the general population from 0.6% in 2010 to 0.4% by 2016 and in the key populations from 15.5% in 2010 to 7.8% by 2016. This will be achieved through seven **outcome results** arising from a **combination of outputs** as shown below:

Core Impact indicators:

No.	Indicator	Baseline	Target 2016
1	% of persons who are HIV infected, by age group (15-24, 24-49, older than 49)	0.2% (15-24yrs) ¹	Reduction by 50%
2	% of key populations who are HIV-infected	15.5 % (UNGASS: 2007)	Reduction by 50%

1.3 Outcomes, Outputs, Strategies**4.3.1 Outcome 1: 50 percent of Key Populations in Zanzibar embrace risk reduction including the correct and consistent use of condoms and 80 percent of IDUs use clean injecting paraphernalia by 2016****Output 1.1: 70% of key populations mobilized to utilise specific prevention programmes and services**

Strategy 1: Enhance institutional capacity to audit and address needs of key populations in Zanzibar

Strategy 2: Strengthen and scale up key populations friendly facility-based and outreach services.

Output 1.2: Number of trained peer educators (among key populations) and counsellors working with key populations increased by 50% from baseline**Strategies**

Strategy 1: Strengthen the capacity of training institutions/health facilities to impart appropriate helping skills to peer educators and counsellors to address the unique needs of key populations.

Strategy 2: Facilitate the trained peer educators and counsellors to implement key populations/MARPs' specific activities in Zanzibar.

Output 1.3: 2,400,000 units of condoms and 50,000 tubes of water-based lubricants distributed per year to key population groups through special peer education outreach services

Strategies:

Strategy 1: Improve the national procurement and supply chain system to support better access to (male and female) condoms and water-based lubricants as an HIV prevention intervention.

Strategy 2: Develop a culturally sensitive and socially acceptable comprehensive condom programming strategy.

Strategy 3: Enhance the capacity of peer educators to promote and distribute condoms and water-based lubricants among key populations/MARPs groups.

Output 1.4: 60% of IDUs trained on risk reduction and both on accessing & using clean injecting paraphernalia and on HIV and co-infections (Hepatitis B & C virus, Syphilis) interventions

Strategies

Strategy 1: Develop and operationalise a strategy/ program on Needle Exchange for IDUs

Strategy 2. Strengthen the operationalization of substance abuse and HIV strategic plan.

Strategy 3: Establish comprehensive detoxification and rehabilitation network/ centres that include opiates substitution with Methadone

Strategy 4: Promote HBV immunization among IDUs and key populations/ MARPs in congregate settings (viz. prisoners)

Output 1.5: 80% of providers in the health system trained on issues affecting MARPs, and especially to improve their own attitudes towards this key population group

Strategy: *Develop and implement a training program for health providers which addresses the special needs of MARPs/key populations*

4.3.2 Outcome 2: 50 percent of the Zanzibari general population embraces safe sex practices (reduction of multiple concurrent partnerships, adoption of ABC) by 2016

Output 1.1: 80% more community resource persons and structures (civil society organizations, political leaders, peer educators, and others) trained from baseline and communicating effectively on modes of HIV transmission, risk reduction and HIV

prevention strategies to their constituents

Strategies

Strategy 1: *Develop the skills of community resource persons and structures to undertake HIV/STI prevention programmes at community level.*

Strategy 2: *Promote advocacy campaigns that improve tolerance on issues related to HIV epidemic and MARPs/key populations*

Strategy 3: *Facilitate the community resource persons and structures provided with requisite skills to undertake HIV/STI prevention programmes at community level.*

Output 2.2: 192,000,000 units of condoms per year (8 pieces per person per month*12 months* 400,000 people*5 years) distributed through the community, public and private outlets to the general population in Zanzibar

Strategy: *Develop and implement a national condom programming strategy*

Output 2.3: One annual national campaign per year on HIV prevention developed and broadcast using a variety of communication channels by 2015

Strategy: *Develop and implement a targeted and effective communications strategy on HIV prevention in Zanzibar*

Output 2.4: 40% of public and private sector organizations in Zanzibar have established functional HIV workplace policies and programmes by 2015

Strategies

Strategy 1: *Develop and implement workplace HIV interventions in all sectors with a particular focus on MARPs/key populations hot spots*

Strategy 2: *Enhance capacity of key sectors (public and private) to effectively design, implement, monitor and evaluate comprehensive workplace HIV interventions (including those targeting MARPs)*

4.3.3 Outcome 3: 50 percent of the mobile and vulnerable populations (including young people aged 10-24yrs) embrace safe sex practises by 2015

Output 3.1: By 2015, 50% of mobile and vulnerable populations are educated and provided with specific HIV prevention tools

and services (RH, early STDs diagnosis and management, and condoms)

Strategies

Strategy 1: Develop and implement a targeted mobilization strategy for the mobile vulnerable populations

Strategy 2: Scale up access of HIV information and services by the mobile and vulnerable populations

Output 3.2: 80% more peer educators in schools/madrassas and institutions of higher learning are trained from the baseline; and are sufficiently equipped and supported to provide comprehensive HIV prevention interventions including appropriate information and life skills to clients

Strategies

Strategy 1: Develop and implement targeted training curricula for peer educators on HIV prevention intervention including involvement of most-at-risk young people as peer educators

Strategy 2: Monitor the work of educators based on the operationalisation of the targeted curricula.

Strategy 3: Facilitate those provided with the skills to train others/peers and to provide HIV prevention services, as appropriate.

Output 3.3: 80% of young people aged 10-24yrs in-school & out of school and at faith-based training centres (madrassas & Sunday schools, etc) are provided with knowledge and skills to make informed decisions and choices about their sexual behaviours

Strategies

Strategy 1: Develop and implement an Action Plan for strengthening and expanding life-skills education among the young people aged 10-24years using the TOTs/peer educators trained under Output 3.2 above.

Output 3.4: By 2015, 80 percent of young people aged 15-24 years are supported to embrace positive behaviours (ABC) to mitigate HIV transmission.

Strategy: Improve access to HIV prevention services (tools and commodities/supplies) by young people

Output 3.5: One national multi-media campaign targeting young people and safe sex (including condom use) practices launched

Strategy: Develop and implement a BCC campaign targeted at the young people and both monitor and evaluate its impact

4.3.4 Outcome 4: 70 percent of public and private health facilities providing comprehensive quality STIs diagnosis and treatment services by 2016

Output 4.1: 80 percent of health care workers trained to deliver quality and confidential STIs management services in public and private health facilities by 2015

Strategies

Strategy 1: Improve capacity of health care workers to diagnose and provide quality STIs management services.

Strategy 2: Strengthen health care facilities to provide comprehensive STIs diagnosis and management services.

Output 4.2: A MARPs/key populations specific STIs' diagnosis and management package developed and rolled out in all health facilities in Zanzibar

Strategy: Develop and implement MARPs specific STIs diagnosis and management service package in Zanzibar

4.3.5 Outcome 5: 60% of the adult Zanzibari population (including 80% of MARPs) reduce dramatically their HIV related risk behaviour in general, by 2016

Output 5.1: 80% of the Zanzibari adult population (including 90% of MARPs) are mobilized annually to access HTC to know their correct status by 2013

Strategies

Strategy 1: Develop and implement a HCT advocacy strategy to create demand for services.

Strategy 2: Enhance access and availability of non-discriminatory HIV counselling and testing services at the integrated, stand-alone sites and mobile/outreaches in Zanzibar

Output 5.2: 90% of the Zanzibari adult index cases testing HIV positive annually counselled and encouraged to bring their partners for HTC to know their correct status by 2016

Strategy: Develop and effectively implement a PwP strategy targeted at PLHIV in Zanzibar to reduce their own risk of HIV transmission

4.3.6 Outcome 6: 80 percent of pregnant women accessing quality hospital based PMTCT services by 2016

Output 6.1: The capacity of all public and private sector health facilities built to provide PMTCT services to pregnant women (who are PLHIV) attending clinic

Strategies

Strategy 1: Improve the capacity of public and private health care facilities to provide comprehensive and integrated PMCTC services.

Strategy 2: Strengthen PMTCT linkages with other HIV services (CTC, HBC, Early Infant Diagnosis, TB, and Reproductive and child health services, etc) to ensure effective for services.

Output 6.2: All pregnant women educated and encouraged to seek skilled delivery in health facilities to ensure they have access to PMTCT services as necessary

Strategies

Strategy 1: Promote greater male involvement in PMTCT services.

Strategy 2: Strengthen follow-up of HIV+ve mothers and exposed infants to ensure treatment compliance.

4.3.7 Outcome 7: 100 percent of PLHIV accessing PwP services to reduce their own risk of HIV transmission to their partners and society by 2016

Output 7.1: 100% of staff (facility based and outreach) trained on delivering specific PwP services to PLHIV by 2012

Strategy: Improve capacity of the service providers to deliver PwP services to PLHIV and their partners.

Output 7.2: All PLHIV in Zanzibar mobilized and encouraged to embrace risk reduction practices including taking up all PwP services provided in the health system

Strategies: *As under Output 5.2 above, and including;*

Strategy 1: Promote greater and meaningful involvement of PLHIV during development and implementation of prevention programmes.

Strategy 2: Enhance the capacity of PLHIV as peer counsellors and expert patients to support those initiating therapy.

4.3.8 Outcome 8: All health facilities have 100 percent safe blood and infection control by 2016

Output 8.1: All health providers in the facilities trained on blood safety and infection control by 2013

Strategy: *Develop and implement a Safe Blood and Infection Control Action Plan including the capacity building of health providers at the health facilities to take appropriate action*

Output 8.2: All health facilities provided with the equipment and HIV testing consumables to effectively undertake infection control and screen all donated blood by 2013

Strategy: *Strengthen the capacity of health facilities to undertake infection control and screening of donated blood (in line with national screening and quality assurance standards) through the provision of necessary equipment and consumables*

Output 8.3: 100 % of service providers exposed to contaminated blood products and medical procedures provided with appropriate PEP services

Strategy: *Develop and implement an effective national protocol on PEP for those exposed to potentially HIV infected material/body fluids*

5 CHAPTER FIVE

5.0 CARE, TREATMENT AND SUPPORT

5.1 Introduction

Care, treatment and support of the PHIV and the affected individuals are an important part of mitigating effects of the HIV epidemic. Institutionalization of effective quality care and treatment has the following added advantages:

- o Decreased morbidity and mortality among the PLHIV;
- o Prevention of secondary re-infection with HIV (prevention with positives);
- o Decreased HIV associated stigma emanating from service providers;
- o Mitigation of the impact of AIDS at household level.

This chapter describes the best practices, lessons learnt, achievements, challenges and gaps identified while delivering HIV care and treatment services to eligible PLHIV in Zanzibar. It also outlines and addresses the fundamental strategic issues in ZNSP-II (2011- 2016).

Key issues captured in the ZNSP-II (2011 – 2016)

To provide care, treatment and support services, the ZNSP-II builds on the best practices, lessons learnt and achievements of the ZNSP-I to address identified challenges, gaps in the health system and other emerging issues. It is becoming evident that the HIV epidemic in Zanzibar is largely a concentrated one. In view of this, there is an unequivocal need to target MARPs/key populations and especially PLHIV with prevention and treatment interventions as appropriate. To ensure success of the proposed approach, the following key issues need to be holistically addressed:

- o Improved access to early HIV/STDs diagnosis and treatment services.
- o Increased ART adherence counselling programs.
- o Decentralized HIV care, treatment and support services.
- o Improved capacity of health service delivery systems to cope with the expected increase in number and clinical needs of PLHIV.
- o Strengthened TB/HIV collaborative activities.
- o Initiation of Hepatitis/HIV co-infection management programs.
- o Sustainable home-based care and nutritional support (house-hold support and food by prescription) programmes.

- o Increased care and treatment services coverage for MARPs/key populations.

Cross-cutting issues

- o Health worker projected and self-stigma among PLHIV;
- o Gender equity in the recruitment and deployment of health care workers;
- o Application of the human rights approach to care and support services delivering;
- o The right to information for all on - where and how to get - care and treatment services.

Emerging issues

- o Isoniazid prophylaxis therapy (IPT) for PLHIV.
- o Adoption of higher CD4 count threshold (>350 cells/ml) for PLHIV to initiate ART.
- o Replacement of Nevirapine single dose with combination therapy in PMTCT.

5.2 Impact Result for Care, Treatment and Support

Morbidity and Mortality among PLHIV are reduced by 50 percent (from current level) by 2016

The **Expected Results** for care, treatment and support of PLHIV is as shown below:

No.	Indicator	Baseline 2009	Target 2016
1	% adults and children with HIV still alive and known to be on treatment 12 months after initiation ART (UNGASS)	79% ²	95%
2	% children aged 14 years or younger that are accessing ART in 12 months	53%	75%
3	% of Hospital beds occupied by AIDS related diseases	4.02% ³	2%
4	% patients with STIs at health care facilities who are appropriately diagnosed, treated and counselled (UNGASS)	100%	100%
5	% women and men with advanced HIV infection receiving ART in the preceding 12 months (UNGASS)	64.2%	80%
6	Number of PLHIV accessing HIV care and treatment services who were screened for TB symptoms, in the preceding 12 months (WHO)	1084	5760
7	% PLHIV who received home based care services	38%	TBE

5.3 Outcomes, Outputs, Strategies

5.3.1 Outcome 1: 80 percent of eligible PLHIV receive appropriate OIs prophylaxis and management services by 2016

Output 1.1: 80% of health facilities have developed capacity to deliver free OIs prophylaxis and management services to PLHIV

Strategies

Strategy 1: Improve the capacity of health providers to provide comprehensive OIs diagnosis and treatment services for PLHIV.

Strategy 2: Strengthen the infrastructure at the health facilities to support the diagnosis and effective treatment of OIs

Strategy 3: Scale up the procurement and provision of health commodities necessary for OIs diagnosis and management

Output 1.2: 75% more health facilities from baseline providing OIs prophylaxis and management services to PLHIV

Strategy: Increase the number of health facilities offering OIs management services in areas known to have high HIV prevalence, and expand the catchment areas through strengthened outreach programs.

5.3.2 Outcome 2: 80 percent of PLHIV eligible for ART receive appropriate care and treatment by 2016

Output 2.1: 80% of PLHIV identified and enrolled into care and treatment

Strategy 1: Scale up access to VCT through outreach programs and mobile services to identify PLHIV.

Strategy 2: Expand interventions that encourage PLHIV to enrol for early care and treatment services

Output 2.2: 100% of PLHIV, who are enrolled and eligible for treatment, readily receive ART

Strategies

Strategy 1: Improve the capacity of staff at CTCs to undertake effective treatment adherence counselling and to provide ART to PLHIV (including involvement of peers as expert patients)

Strategy 2; Improve the national ART commodity security to ensure those started on treatment are maintained for life

Strategy 3: Strengthen the ART adherence and defaulters tracing mechanisms.

Strategy 4: Strengthen the capacity of laboratories to undertake treatment monitoring and early infant diagnosis (EID).

5.3.3 Outcome 3: 50 percent of Key Populations access comprehensive and friendly HIV/STIs care and treatment services by 2016

Output 3.1: 50% of key populations screened at user-friendly service sites for HIV and STIs and given proper treatment.

Strategies:

Strategy 1: Create a conducive and supportive social, legal and policy environment for key populations to access comprehensive HIV /STIs services.

Strategy 2: Improve the attitude of health providers towards key populations visiting health facilities for services.

Strategy 3: Undertake advocacy among key populations to encourage them to access services available at the health facilities

Strategy 4: Strengthen the involvement of key populations in the planning and implementation of services at the health facilities targeted at this key population

Output 3.2: 50% of IDUs identified, counselled and provided with services including opiates substitution therapy.

Strategies

Strategy 1: Develop and implement a comprehensive package of services for IDUs including opiate substitution therapy

Strategy 2: Improve the skills of health workers to effectively implement the Comprehensive Package of Services for IDUs including opiate substitution therapy

Strategy 3: Mobilize and encourage IDUs (including through peer education) to freely access the Comprehensive Package of Services available at the health facilities and Rehab Centres in the country

5.3.4 Outcome 4: 80 percent of PLHIV receive high quality HBC services according to national guidelines

Output 4.1: All the PLHIV identified as needing home-based care services are supported as necessary

Strategies

Strategy 1: Scale up identification and enrolment of more PLHIV into home-based care on account of the set eligibility criteria

Strategy 2: Ensure sustainable access to home-based care kits for all, including basic medicines and food rations for eligible PLHIV.

Output 4.1: Adequate number of community volunteers trained to provide home-based care services to PLHIV**Strategies**

Strategy 1: Strengthen community ownership of the home-based care strategy including greater involvement of community based home-based care providers

Strategy 2: Strengthen linkages and referrals between health facilities and the community to ensure PLHIV on home-based care get the needed services

CHAPTER SIX

6.0 IMPACT MITIGATION

6.1 Introduction

The major objective of impact mitigation in the implementation of the national HIV response is to reduce the burden of the epidemic on the infected or affected persons, may it legal, socio-economic and/or psychosocial. Impact mitigation activities include those that empower individuals and the community to cope with the challenges of the HIV epidemic. The HIV epidemic has been shown to affect greatly the households due to AIDS related loss of productive labour and attendant income. Savings are diverted and assets depleted in the family's quest to meet the associated health care and/or funeral costs. As the disease progresses, more and more individuals and households are forced to seek support from the broader community. In order to response to these needs effectively, the Government of Zanzibar has had the HIV epidemic factored into most development strategies, programs and plans in nearly every sector of the economy.

In Zanzibar, the HIV prevalence is about 0.6 percent, and at the macro level is not very conspicuous or evident yet. However at the community, family, and individual levels, the impact of HIV in Zanzibar is evident. To ensure the impact of the HIV epidemic is kept in check, there is need to sustain and/or scaling up mitigation interventions rolled out during ZNSP-I.

There are some organizations providing impact mitigation services to households targeting orphans and vulnerable children, but this is being done on an ad hoc basis. The support provided during the ZNSP-I was neither planned to cater for a given percentage of those who need it, nor was it offered according to the need and preference of those in need (this calls for more participatory approaches in needs assessment). HIV related mitigation assistance was largely given using provider-organizations' own criteria of what needs to be offered. There were no clear guidelines on what constituted the minimum package of services for different levels and population groups. Coverage has also been a challenge in providing material and psychosocial support to the needy. Not all people that need support have been reached; and sometimes, the services provided focus on infected individuals while disregarding their family members. The types of support commonly provided in general include – cash, food, school uniforms, exercise books, tuition and transport,

etc.

Key issues identified for the period 2011 – 2016

The identified issues to be addressed include:

- o Development of a legal framework and human rights policies to support Impact Mitigation for PLHIV, key populations, MVCs, etc
- o Development of guidelines on what constitutes the minimum package of support services for PLHIV, key populations and MVCs
- o Reduction in HIV related stigma and discrimination at the community and workplace level projected at/on PLHIV, key populations and MVCs
- o Adequate involvement of the community/kinship, PLHIV and key populations in impact mitigation programmes;
- o Adequate coverage of PLHIV, key populations and MVCs with sustainable economic and psychosocial support; development of adequate and sustainable livelihood programs that target key populations
- o Clear roles for non-state actors (viz. civil society organizations) in impact mitigation programs;
- o Access to updated information for PLHIV, key populations and MVCs through different channels as part of advocacy strategy on impact mitigation
- o Enhanced capacity of the social welfare system to adequately provide support to PLHIV, key populations and MVCs;
- o Development of well nurtured, coordinated and sustained structures at all levels to support PLHIV, key populations and MVCs

Cross-cutting Issues

- o Quality monitoring and evaluation, coordination, collaboration and network building to cover adequately issues related to impact mitigation;
- o Adequate use of religious, cultural and socio-economic structures to adequately support the reduction of stigma and discrimination in society;
- o Effective use of IEC materials and media (Radio, TV and folk media) to air and convey audio-visual messages on impact mitigation programs;
- o Adequate and focused capacity building efforts for implementers to undertake impact mitigation activities;
- o Sufficient gender mainstreaming into impact mitigation interventions (utilization of gender checklists);
- o Human rights issues to be considered as an integral component of impact mitigation interventions;

Emerging Issues

- o The use of cash transfers approach in support of MVCs, and PLHIV;
- o The rights of key populations (e.g. roll out of harm reduction strategies for IDUs).

1.2 Impact result for Impact Mitigation

The negative impact of HIV epidemic is significantly reduced on the eligible individuals (PLHIV, Key Populations and MVCs) in Zanzibar by 2016.

This **result** focuses on actions to help alleviate the impact of HIV epidemic on the economic and social well-being of the infected and affected people in Zanzibar. It will be achieved through four **Outcome Results** arising from **Twelve Outputs**. The **Expected Result** for Impact Mitigation is shown below:

6.3 Outcomes, Outputs, Strategies

6.3.1 Outcome 1: The negative impact of HIV epidemic significantly reduced on the eligible individuals (PLHIV, Key Populations and MVCs) in Zanzibar by 2016.

Output 1.1: All health providers trained to change their attitudes and reduce their HIV related stigma and discrimination projected on the PLHIV and Key Populations by 2016

Strategies: As for **Output 3.1** above

Output 1.2: 50% of PLHIV and 20% of Key Populations recruited and serving at health facilities or civil society organizations as expert patients or outreach workers respectively.

Strategies

Strategy 1: *Promote Meaningful Involvement of PLHIV (MIPA) and key populations at all levels of the national response.*

Strategy 2: *Improve knowledge and skills of PLHIV and Key Populations to meaningfully participate and contribute to the national HIV response.*

Output 1.3: 30% of Substance Users identified, counselled to access harm reduction services

Strategies: As for **Output 3.2** above

6.3.2 Outcome 2: 50 percent of PLHIV and 50% MVC are able to support themselves by 2016

Output 2.1: 50% of Key Populations (e.g. PLHIV and MVCs) provided with impact mitigation support services (including financing to start IGA, nutritional and psychosocial services).

Strategies

- Strategy 1: *Link Key Populations (e.g. PLHIV and MVCs) economic support strategies with implementation of the Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP);*
- Strategy 2: *Determine the magnitude of social economic needs of Key Populations (e.g. PLHIV and MVCs) in Zanzibar.*
- Strategy 3: *Improve resource mobilization and allocation strategies including the establishment and maintenance of civil society organizations' driven micro-finance institutions/SACCOs to increase employment opportunities for PLHIV, and MVC caretakers.*
- Strategy 4: *Strengthen the partnership and networking between Government Agencies, the civil society organizations and community to effectively support the Key Populations (e.g. PLHIV and MVCs) in Zanzibar.*

6.3.3 Outcome 3: All men and women participate equally in the delivery of services to PLHIV and MVCs in Zanzibar by 2016

Output 3.1: A revised national HIV policy to comprehensively address gender issues relating to HIV impact mitigation

- Strategy: *Define the gender roles in HIV related impact mitigation; and comprehensively review of the National Policies to ensure gender equity in implementation of planned activities*

6.3.4 Outcome 4: 80 percent of all civil society organizations involved in the national HIV Response have Impact Mitigation Activities aligned to specific plans and guidelines by 2016

Output 4.1: A national Community Systems Strengthening Strategy developed which clearly defines the role of civil society organizations in HIV related impact mitigation

Strategies

- Strategy 1: *Strengthen coordination of the civil society organizations' (including*

partnerships and networking) implementation of impact mitigation activities.

Strategy 2: Develop a standardized package of support for key populations (e.g. PLHIV and MVCs) to be implemented by civil society organizations

Strategy 3: Strengthen monitoring and evaluation to track progress of indicators set for impact mitigation and use the evidence to support scale up.

CHAPTER SEVEN

7.0 ENABLING ENVIRONMENT

7.1 Introduction

An enabling environment is necessary for all stakeholders in the national HIV response to make their full contribution in any of the thematic areas and/or where this can have the most impact. To create an enabling environment in the country, the following attributes must be present: i) good policies and a fitting legal framework, ii) equitable and fair implementation of these policies and laws, iii) a culture of leadership for results, iv) well spelt out coordination and institutional roles, and v) both a financial framework and adequate funding to finance planned activities¹⁹. Further, there ought to be i) the right number and equitably distributed skilled human resources to effectively implement planned HIV related activities including mainstreaming of HIV and AIDS throughout all levels of the economy, ii) measures to reduce stigma and discrimination, and iii) to address cross-cutting issues such as poverty, gender and human rights.

A lot was achieved in Zanzibar during the ZNSP-I and to ensure that the gains in enabling environment made over the last five years are consolidated, there is need for strong advocacy to sustain commitment to the national HIV response (including commitment for resource allocation). This is necessary to ensure complacency does not creep in and thus lead to reduced commitment to the fight against the HIV epidemic in Zanzibar. There is need to ensure there exist a supportive legal and policy environment to ensure effective implementation of the national HIV response using human right-based approaches that among other things, address gender issues, vulnerability of key populations, and universal access to HIV related services for all. The programmatic shift to cater for the unique need needs of key populations requires considerable efforts to enhance the capacity of implementers targeting them. Under the new strategic plan, emphasis shall be placed on working with those who provide services to the key population in Zanzibar.

Key strategic issues for ZNSP-II (2011-2016)

In the next five years, eight strategic issues will be addressed to create and sustain an enabling environment to support effective implementation of the national response.

¹⁹ This refers to mobilization of resources, thematic allocation, judicial use of resources and classified reporting

These issues are on:

- o HIV policy and legal framework;
- o HIV advocacy campaigns targeting key populations
- o Coordination of the HIV response at national and local level;
- o Financing of the HIV programmes;
- o Capacity development to ensure quality and equitable access to HIV related services including for key populations;
- o Active involvement and participation of beneficiaries in the national HIV response including key populations and PLHIV;
- o The linkage between HIV and poverty & development;
- o Mainstreaming of HIV response into the core functions of institutions to address effectively the needs of key populations.

Emerging issues that are important in creating an enabling environment

To have an accommodative environment that allows the smooth implementation of the national response, the following emerging issues are key:

1. Effective coordination of the HIV response at national and district levels that ensures all strategic partners are well coordinated through ZAC;
2. Capacity strengthening of all strategic partners is done to align them with the proposed programmatic shift including health and community systems strengthening and a greater focus on key populations;
3. Promoting transparency and accountability in line with the national HIV action/operational plan
4. Active involvement of most-at- risk population (key populations) groups in the national HIV response including PLHIV, MSMs, IDUs, SWs, etc.

7.2 Impact result for Enabling Environment

The PLHIV and Key Populations experiencing their full human rights including accessing optimal HIV services in Zanzibar by 2016

1.3 The Outcomes, Outputs, Strategies

7.3.1 Outcome 1: The HIV response is well coordinated at the national, regional and district levels for effectiveness

Output 1.1: Coordination structures reviewed to support effective implementation of ZNSP II.

Strategy: Review and strengthen the decentralized ZAC coordination structures to support effective implementation of ZNSP-II.

Output 1.2: Terms of reference (TORs) reviewed and the roles and responsibilities of all clearly defined including of the civil society organizations involved in the national HIV response elements targeted at key populations.

Strategy: Review and implement terms of reference (TORs) which clearly define the roles and responsibilities of all including civil society organizations involved in the national HIV response elements targeted at key populations.

Output 1.3: Relevant HIV policies and legislation in place to ensure protection of the rights of key populations, PLHIV and the uninfected

Strategy: Review and strengthen HIV policies and legislation to ensure protection of the rights of PLHIV, the uninfected, and key populations.

7.3.2 Outcome 2: Planned HIV programme activities in Zanzibar are sustainably financed for effective implementation and better outcomes

Output 2.1: A funds mobilization action plan developed to get resources to finance implementation of planned activities

Strategy: Develop and implement a funds mobilization action plan to get resources to finance implementation of planned activities

Output 2.2: A national financial framework developed to support the allocation of funds to HIV implementers and their effective accounting

Strategy: Develop and implement a national financial framework to support the allocation of funds to HIV implementers and their effective accounting

7.3.3 Outcome 3: The key populations are accessing appropriate quality HIV related services at the health facilities and community level

Output 3.1: A relevant policy framework and package of HIV services for Key Populations in Zanzibar developed and implemented.

Strategy: Develop and implement a relevant policy framework and package of HIV services for Key Populations in Zanzibar.

Output 3.2: A national advocacy campaign to create a supportive and tolerant environment for Key Populations to improve their access to appropriate HIV related services developed and implemented

Strategy: Develop and implement a national advocacy campaign to create a supportive and tolerant environment for Key Populations to improve their access to appropriate HIV related services

CHAPTER EIGHT

8.0 MONITORING, EVALUATION AND RESEARCH

8.1 Introduction

Monitoring and evaluation, and research are crucial in generating strategic information on the HIV epidemic in the country. Moreover, a functional M&E system provides evidence on the HIV burden and on the magnitude of the response. In principle, a robust monitoring and evaluation system is a key part of an evidence-driven response. Generally, ZACP and partners, undertake surveillance activities that regularly track the epidemic as part of the overall M&E System. These include *HIV Sentinel Surveillance* (using a PMTCT approach), *routine service based surveillance*, *Integrated Behavioural and Biological Surveillance Surveys (IBBSS)*, and ad hoc surveys such as *indicator surveys*. In addition, ZAC's monitoring and evaluation unit coordinates non-health interventions which include tracking programme activities on a routine basis. Programme managers also commission research from time to time in order to generate evidence that helps shape programme design.

Key issues for the next five years

The following have been identified as M&E and research issues for the next period:

- o Improvement in the synthesis and dissemination of strategic information to policy makers and programme planners;
- o Building a culture of data use in planning and decision-making among stakeholders;
- o Improvement in capacity for routine data collection and analysis and use at district level and among civil society organization;
- o Development of a robust national monitoring and evaluation plan that is widely disseminated and implemented by all partners and stakeholders at all levels;
- o Development of a Zanzibar HIV research agenda and research implementation plan.
- o Building up of knowledge and skills in M&E for key populations at all levels;
- o Strengthening the M&E funding mechanism at all levels;
- o Promotion of the production of reliable quality data at service delivery points in both community and health facility settings.

8.2 Impact result for the M& E System

Appropriate policies, legal framework and effective HIV related services in place and which are informed by quality and timely strategic HIV information

This **Impact Result** is achieved by the presence of an active and robust monitoring and evaluation system. The **Expected Results** for Monitoring, Evaluation and Research are as below:

8.3 Outcomes, Outputs, Strategies

8.3.1 Outcome 1: HIV related Strategic Information available for use by policy makers, programme planners and implementers at all levels of the national response

Output 1.1: *A fully costed national HIV Monitoring & Evaluation Plan in Zanzibar developed and implemented to support the operationalization of the ZNSP-II (2010-2016)*

Strategy: Review and implement a fully costed national HIV Monitoring & Evaluation Plan in Zanzibar to support the operationalization of the ZNSP-II (2011-2016)

Output 1.2: *The Capacity of ZAC and all other national agencies strengthened to collect, analyse and report on HIV related data in Zanzibar.*

Strategy: Strengthen the Capacity of ZAC and other national agencies to collect, analyse and report on HIV related data in Zanzibar.

Output 1.3: *A national HIV related Research agenda and plan developed and implemented*

Strategy: Develop and implement a national HIV related Research Agenda and Plan

8.3.2 Outcome 2: Increased access and utilization of strategic information by policy makers and programme planners at all levels of the national HIV response

Output 2.1: A dissemination plan for national HIV related strategic information to relevant stakeholders developed and implemented

Strategy: *Develop and implement a dissemination plan for national HIV related strategic information to relevant stakeholders*

Output 2.2: A plan developed, implemented and monitored to improve use of HIV Strategic Information by policy makers, programme planners and implementers involved in the national response

Strategy 1: *Strengthen and monitor use of HIV Strategic Information by policy makers, programme planners and implementers involved in the national response*

CHAPTER NINE

9.0 IMPLEMENTATION OF ZNSP-II

The effective implementation of the Zanzibar HIV Strategic Plan 2011-2016 is predicated on: i) *the development and implementation of an Annual Operational Plan each year of its five year life*; and ii) *the coordination, resources mobilization and their activity-linked allocation, and an inclusive and effective implementation of ZNSP-II (2011-2016)*. A narrative on the annual operational plan and the respective roles/responsibilities of the key stakeholders are elaborated further below:

9.1: Annual Operational Plan to operationalize the ZNSP-II (2011-2016)

This National HIV Strategic Plan 2011-2016 is a five year plan, and for its effective implementation there is need to develop an Annual Operational Plan over each of the five year period. The preparation of an Annual Operational Plan will allow the regular review of both the internal and external environments, and the appraisal of current strategies as necessary to ensure successful implementation to achieve the set objectives. The operational plan (work plan and budget) developed must have clear links to the set objectives, strategies and activities in line with the ZNSP-II (2011-2016) to ensure performance indicators are tracked and appropriate action taken including in planning.

The ZNSP-II shall be well communication to all relevant stakeholders in-country and out to ensure it is well understood to elicit optimal effort by all, and the needed resource mobilization and allocation is done for its successful implementation.

9.2: The coordination, resources mobilization and an inclusive and effective implementation of ZNSP-II (2011-2016)

The national coordination, resource mobilization, and an inclusive and effective implementation of ZNSP-II (2011-2016) is key in our quest to realize the set targets of the national HIV response. The roles and responsibilities of the various stakeholders contributing to the realization of our set goal and objectives in line with the agreed inclusive and multisectoral approach to the national HIV response are articulated below:

- **Ministry Responsible for HIV and AIDS issues (governance)**

Overall governance of the national HIV response is the mandate of the Office of the First Vice President. The Office of the First Vice President will ensure that performance of ZAC is exemplary, including provision of effective leadership of the national HIV response. Under its guidance, ZAC will work with the Committee of Principal Secretaries, to review reports/results of the national HIV response once a year. This will ensure the set national targets are achieved and that the various MDAs and other actors in the sub-sector are held accountable, especially with respect to their internal and external mainstreaming of the planned HIV activities.

- **Zanzibar AIDS Commission**

It is the responsibility of ZAC to coordinate the national response to the HIV epidemic under the guidance of the Board of Commissioners. This involves reviewing and updating of the national strategy, the coordination of all relevant implementing partners and efforts, and monitoring and evaluation of the national HIV response. To this end, ZAC will coordinate the development and implementation of the Annual Operational Plan throughout the plan period. The ZAC has to have the requisite structure and capacity to coordinate the national response including the programmatic shift to key populations focused interventions. Two of the core responsibilities of ZAC are:

- o ***Resource mobilization to finance the national HIV response***

ZAC is responsible for spearheading the assessment and quantification of the resource requirements for the national HIV response; thorough gap analysis; the mobilisation of the required resources from the Government of Zanzibar and development partners; the rational allocation of resources across strategies and partners; and monitoring and reporting on resource utilisation. As part of an inclusive and multisectoral approach to the national HIV response, every implementing partner is encouraged to raise additional resources, either locally or from international sources.

- o ***Monitoring and Evaluation of the national HIV response***

ZAC is responsible for monitoring the HIV epidemic and the fitting national response elements; gathering and analysing data, and the dissemination of strategic information to policy makers, programme planners and implementers to ensure the national HIV response is evidence informed. ZAC will commission joint reviews as appropriate; and all implementers

including Government Ministries, non-state actors and development partners are expected to monitor progress of their efforts and evaluate their responses at the outcome and impact levels. All HIV programme related information gathered by all stakeholders involved in the response will be shared with ZAC for further dissemination as appropriate.

- **Political Parties**

Political parties will keep the HIV epidemic on their agenda and provide the necessary leadership within their structures and constituencies as well as support the RGOZ in their multi-sectoral response to the HIV challenge. The House of Representatives has three main committees which provide oversight to the national HIV response, and these are: i) ***The Social and Welfare Committee***; ii) ***Public Accounting Committee and Constitution***; and iii) ***Laws and Good Governance Committee***. These committees will get reports from ZAC and the key Ministries, and review them in line with their strategic mandate to support the effective implementation of national HIV response.

- **The House of Representatives**

The House of Representatives through its committees will get HIV reports from the Zanzibar AIDS Commission and Government Ministries (Public Sectors); and assess them in accordance with the mandate of the House of Representatives in order to support an effective implementation of the National AIDS Response. The Outstanding Committees of the House of Representatives will have to mainstream HIV issues in their daily routine works and ensure the implementation of HIV Programs and accountability of public sectors in the allocation and the use of funds planned for HIV and AIDS activities.

- **UWAKUZA**

The House of Representatives' Coalition on HIV and AIDS in Zanzibar (UWAKUZA) will act as a catalyst to ensure the Representatives in the House are reminded of their role in support of the national HIV response both within the House and their Constituencies. UWAKUZA will essentially work with ZAC to ensure HIV related policies are in place to provide the necessary support for effective implementation of the HIV response.

- **The Zanzibar ZGFCCM**

The Zanzibar Global Fund Country Coordinating Mechanism (ZGFCCM) is

another important multisectoral forum for the coordination and sharing of information. Over the next five-year plan period, ZAC will work with ZGFCCM to expand its role beyond the Global Fund.

- **The Ministry Responsible for Regional Administration and Special Departments**

This is a key Ministry in the implementation of the national response and local government in general. Section 7.2.3.8 of the HIV and AIDS policy mandates the MoRASD to ensure there is proper planning, management and oversight of the HIV interventions at the district and community level²⁰. The Ministry will have a focal person to serve as liaison between it and ZAC, and also to work with local governments to coordinate all DACCOMS.

- o Roles and Functions at the Regional Level

The Regional Commissioners will work with their teams to ensure that there is access to reliable HIV related information for those involved in designing and implementing HIV activities in the community in Zanzibar. In particular, data will be used by implementers to identify and respond to risk factors associated with most-at-risk populations in the target regions to reduce incidence. The regional teams will also monitor service delivery at the district level. A focal person at the regional level will coordinate and facilitate interventions at the district level.

- o Roles and Functions at the District Level

The District Commissioners will be responsible for the implementation of the HIV response at the district level through the DACCOM and SHACCOM. All districts will be supported to develop HIV programmes that will be included in their annual plans and budgets to be submitted as part of their MTEF. Planning must be done in a participatory manner and especially the solicitation of inputs from the public via the DACCOM members. Such plans will also ensure that KPs are involved and that impact mitigation issues are addressed.

- **The Ministry Responsible for Finance**

In relation to **Outcome 2** under **Enabling Environment**, the Ministry of Finance has the responsibility of coordinating resource mobilization internally

²⁰ According to this section, the ministry will actively participate in planning, monitoring, mobilization, capacity building to DACCOMS and SHACCOMs and HIV programming under special departments.

and among the development partners to finance the national HIV response. The Ministry will also coordinate and enforce the ring-fencing of the HIV funding provided by the Government of Zanzibar to ensure the resources intended for planned activities at the regions and districts are not reallocated to other competing needs. The effective mechanisms to ensure resources for the HIV interventions are retained for the planned activities include use of a unique coding system, and performance based financing linked to audit reports, etc.

- **The Office of the Auditor General**

Given the large financial and technical resources mobilized and made available to support the national HIV response, the role of the Auditor General is of extreme importance in conducting regular performance and regulatory audits. It is the responsibility of the Auditor General to ensure that all implementers of HIV activities do adhere to Public Finance Management and Procurement Regulations, and that they use resources obligated for HIV interventions for this sole purpose as per the agreed plan of action.

- **Civil Service Commission**

The Civil Service Commission (CSC) will provide directive to all Government Ministries to ensure that the HIV intervention focal persons do have in their job descriptions performance targets and that these are measured. The CSC will monitor HIV related policies to ensure that PLHIV are not discriminated against at work places and/or the key population sub-groups based on their sexual orientation or life style.

- **The Ministry Responsible for Employment**

This Ministry will give directives on the code of conduct at workplaces and especially to reduce and eventually eliminate stigma and discrimination targeted at the PLHIV. The rights of the PLHIV have to be respected. The ministry will also provide guidelines on the establishment or intergration of HIV Programs in workplaces.

- **The Ministry Responsible for Youth, Women and Children Development**

The Ministry will also spearhead life skills development programmes for out- of school youth and to mainstream HIV related interventions into development activities focusing young people, women and children.

- **The Ministry Responsible for Education**

This Ministry will develop and support the implementation of the Life Skills Education Programme (LSEP) in all primary and secondary schools in Zanzibar. The LSEP will not only focus on HIV and AIDS but integrate into school health clubs, school counselling and feeding programmes as necessary. The Ministry of Education will ensure that HIV issues are effectively mainstreamed within the school curricula at all levels.

- **Ministry Responsible for Legal Affairs and Governance**

This Ministry will work with standing committees in the House of Representatives to enforce the HIV related policies and to develop and support measures for accountability among institutions in line with agreed task sharing/specific roles. The Ministry will review and strengthen the national HIV laws and binding regulation.

- **The Ministry Responsible for Health and the Zanzibar AIDS Control Program (ZACP)**

Under its specialized unit, Zanzibar AIDS Control Programme (ZACP), the Ministry will facilitate the review of policies and development of guidelines to ensure universal access to HIV prevention, care and treatment for all. The ZACP will also conduct routine HIV epidemiological surveillance as well as biomedical research related to the HIV epidemic in Zanzibar. In this the Ministry's Strategic Information department will work closely with the Monitoring & Evaluation unit of the ZAC, the Office of Chief Statistician and the HMIS of the MOH.

- **Ministry Responsible for Social Welfare**

Through its Department of Social Welfare, the Ministry will support implementation of impact mitigation activities focusing PLHIV and MVCs. The Ministry will develop systems to support the orphaned and vulnerable children in school and out of school through a sustainable family centred approach.

- **Other Ministries, Departments and Agencies**

All other ministries will have to formulate or update and implement their sectoral HIV Strategic Plans, with emphasis on mainstreaming HIV issues into their core functions and implement workplace programmes as appropriate. They will all have to submit regular reports to ZAC, and also to ensure that TACs are active and fully functioning. Annually, in their planning process they ensure the allocation of funds in the MTEF for the HIV interventions within their respective sectors.

- **Institutions of Higher Learning**

Institutions of Higher Learning (public and private universities) will play a significant role in the national HIV response based on their comparative advantage, and especially because of the large number of young people they serve. The Ministry will develop and implement HIV educational and anti-stigma programmes for both students and teachers who may be infected.

- **The Development Partners' Group on AIDS (DPGA):**

This group will build on the achievement realized in the harmonization and alignment of national HIV response elements. The Revolutionary Government of Zanzibar will engage them on a common financing framework and sustainability of the activities. A Memorandum of Understanding will be developed and signed between the Government of Zanzibar and development partners to ensure resources are provided, used and accounted for appropriate. The principal role of DPGA is to provide technical and financial support for the implementation of ZNSP-II to address national priority areas based on the 'Three Ones' principles.

- **Civil Society Organizations (CSOs)**

The civil society organizations will to play a leading role in the implementation of the national HIV response especially in the community settings. These CSOs will complement the public sector efforts to deliver services to the community. The civil society organizations implementing HIV activities will report on performance through the SHACCOMs and DACCOMs upstream to the national level; and further, monitor and hold Government accountable on its commitment to the national HIV response.

- **The Media Houses**

Culturally sensitive and appropriate programmes addressing issues related to HIV prevention, stigma reduction and access to care and treatment for eligible PLHIV will be developed and aired widely in Zanzibar. This will be done both at the national and local level. The media houses will be engaged and supported to play a role in the national HIV response.

- **People living with HIV (PLHIV)**

Greater and meaningful involvement of persons living with HIV (PLHIV) in the national response is key to the success of this strategy. The ZAPHA+ will be supported, under this strategic plan, to scale up its HIV related activities in all regions of the country. The capacity of the PLHIV will be built to ensure they

make their contribution to the HIV response. Among other activities, the PLHIV who have publically their status will be supported to become expert patients to mentor those on care and treatment.

- **The formal Business Sector**

The *AIDS Business Coalition in Zanzibar (ABCZ)* mobilizes resources and coordinates private sector workplace HIV programmes. It also facilitates sharing of lessons learnt and best practices identified during the implementation of programmes by its members. The ABCZ will be strengthened to a key role in the implementation of the national HIV response.

- **The Informal Business Sector**

The informal sector is a key employer in Zanzibar. The workforce in the sector has significant vulnerability to HIV. The sector lacks both the requisite resources and a structured approach to effectively implement workplace HIV interventions. In orders for this important sector to make its contribution to the national HIV response, capacity building will be undertaken and resources provided to support the design and implementation of evidence informed workplace HIV programmes.

10.0 GLOSSARY

DACCOM: District AIDS Coordinating Committees are the HIV and AIDS coordinating structures at district level. These committees are multisectoral in nature.

Flash blood: Flash blood is an extremely risky technique used by drug users in which an addict injects into their veins blood extracted from another drug user's body with the intention to elicit a rapid experience of substance intoxication.

Key Populations (KPs) refers to populations that are key to the epidemic and response based on their epidemiological and social context.

Most-at-risk populations (MARPs) refer to individuals and **groups** of people that provide the settings and are involved in practices that lend themselves to efficient HIV acquisition and transmission. In Zanzibar these include injection drug users (IDUs), men who have sex with men (MSMs); sex workers (SWs) and students in Institute of Education for Offenders.

Respondent-driven sampling: Respondent-driven sampling (RDS), combines “snowball sampling” with mathematical modelling that involves weighting of the sample to compensate for the fact that the cohort identification is/was done in a non-random way.

Snowball sampling is a non-probability method used to select a cohort for study, when the desired sample characteristic is rare and the ability to locate the respondent(s) is both difficult and/or the cost prohibitive. Snowball sampling relies on referrals from the initial cohort to generate additional subjects.

Shehia: is the lowest Government Administrative structure in Zanzibar.

SHACCOMs: Shehia AIDS Coordinating Committees are the HIV and AIDS coordinating structures at Shehia level. These committees have representation of different key groups residing in the respective Shehia, including technical personnel.

Sex Workers (SW): This is a non-judgmental term used to avoid negative connotations and refers to people who engage in transactional sex work as a means of survival, or to earn a living. (UNAIDS).

Vulnerable groups: The definition of vulnerable groups varies between countries, but amongst the most important defining characteristics are age, sex, ethnicity and location. Some of the most vulnerable groups include people with disabilities and/or living with stigmatised illnesses. In areas facing war or civil conflicts, displaced people and refugees form an important part of the vulnerable groups.



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