

# ZANZIBAR AIDS COMMISSION (ZAC)



## UNGASS COUNTRY PROGRESS REPORT

### ZANZIBAR

*REPORTING PERIOD: JANUARY 2006 – DECEMBER 2007*

*Submission date: 30<sup>th</sup> January 2008*

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## List of Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
CSO	Community Service Organization
FBO	Faith Based Organization
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Users
MARPs	Most At Risk Population
NGOs	Non- Governmental Organisations
OVC	Orphans and Vulnerable Children
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
STIs	Sexual Transmitted Infections
VCT	Voluntary Counselling and Testing
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar AIDS Control Programme
ZAIADA	Zanzibar Against AIDS infection and Drug Abuse
ZANCOG	Zanzibar Non- Governmental Organization Cluster
ZANSP	Zanzibar National Strategic Plan
ZAPHA+	Zanzibar People Living with HIV/AIDS
ZAYEDESА	Zanzibar Youth Education, Environment and Development Support Association

## **Acknowledgements**

Many individuals from different organizations have contributed in writing this report. ZAC wishes to recognize the critically important contributions made by colleagues from the public and private sectors, civil society organizations, faith-based groups, academia and the donor community and more important is their time taken to read, review and comment on earlier drafts of this document.

ZAC would also wish to appreciate and acknowledge the Consultant for the UNGASS 2008 reporting - Dr. Robert Mhamba of the Institute of Development Studies, University of Dar es Salaam -Tanzania, who prepared this report, Mr. Kimwaga Mhidin Ali (M&E Coordinator and Head of Unit - ZAC); Mr. Gharib Said Gharib (Database Manager); Ms. Amina Makame Ameri (M&E Officer); Mr. F. Kashaga and Miss Rachel Zephaniah for fully participating in the data collection process.

We would also like to appreciate and acknowledge Dr. Luc Barriere-Constantin (UNAIDS Country Coordinator for the overall support and direction throughout; Mr. Fredrick Macha - UNAIDS M&E Advisor for providing significant inputs and who dedicated strong support from the initial stage and during data collection, analysis and writing of the report.

Various stakeholders provided insightful and challenging comments and inputs during the stakeholders' validation workshops and at various stages of writing the report. Their inputs enriched the document.

Finally we wish to extend our special appreciation to the other many people eg PHLA networks and umbrellas and ZAC staff members who in one way or the other contributed towards making this important report a reality.

To all we say thank you.

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# Table of Contents

LIST OF ACRONYMS.....	2
ACKNOWLEDGEMENTS .....	3
TABLE OF CONTENTS .....	4
<b>1 STATUS AT A GLANCE.....</b>	<b>5</b>
<b>2 OVERVIEW OF THE AIDS EPIDEMIC .....</b>	<b>8</b>
2.1 TRENDS IN PREVALENCE / EPIDEMIOLOGY .....	8
2.1.1 HIV Rates.....	8
2.1.2 Transmission Routes .....	9
2.1.3 HIV Infection Patterns in the General Population .....	9
2.1.4 HIV Infection among TB Patients.....	9
2.1.5 HIV and the Most at Risk Populations .....	9
3.1.6 Factors Fuelling the HIV Epidemic in Zanzibar.....	11
<b>3 NATIONAL RESPONSE TO THE AIDS EPIDEMIC .....</b>	<b>11</b>
3.1 POLICY LEVEL RESPONSES.....	12
3.1.1 One Coordination Body – Making it a Reality.....	13
3.2 COMMUNITY LEVEL HIV PREVENTION SERVICES.....	14
3.3 HIV PREVENTION AT FACILITY LEVEL .....	20
3.3 HIV CARE AND TREATMENT AT FACILITY LEVEL .....	24
3.3.1 Health system strengthening.....	24
3.5 IMPACT MITIGATION.....	26
<b>4 BEST PRACTICES.....</b>	<b>28</b>
<b>5 MAJOR CHALLENGES AND REMEDIAL ACTIONS .....</b>	<b>28</b>
5.1 MAJOR CHALLENGES REPORTED IN THE 2005 UNGASS COUNTRY PROGRESS REPORT. ....	28
5.2 MAIN CHALLENGES AND REMEDIAL ACTIONS TO THE HIV/AIDS RESPONSE IN ZANZIBAR .....	29
5.2.1 Challenges in Prevention .....	29
5.2.2 Challenges in treatment, care and support.....	30
5.2.3 Challenges in strengthening organization and management systems .....	31
<b>6 SUPPORT FROM THE COUNTRY’S DEVELOPMENT PARTNERS.....</b>	<b>33</b>
<b>7 MONITORING AND EVALUATION ENVIRONMENT .....</b>	<b>33</b>
7.1 THE ZANZIBAR M&E SYSTEM.....	33
REFERENCES .....	36
ANNEXES.....	37

## 1 Status at a glance

Zanzibar is made up of the two islands of Pemba and Unguja, constitutes, together with Tanzania mainland, the United Republic of Tanzania. The population was estimated to be 1,144,000 in 2006 with the majority still residing in the rural areas.<sup>1</sup> Unlike its mainland sister, Zanzibar has a concentrated HIV/AIDS epidemic. The first three AIDS cases in Zanzibar were officially reported in 1986 at Mnazi Mmoja hospital in Unguja. Since then, the number of reported cases has been on the increase in both Unguja and Pemba. Roughly about 180 people are diagnosed with HIV infection annually. Based on the Validation Survey 2002, it is estimated that 6,000 adults are currently living with HIV. It has been discerned that women are being infected more than men at a rate of about 0.9% versus 0.2% [*Source: Zanzibar Substance Abuse – HIV & AIDS Strategic Plan (2007 – 2011)*].

Recent studies on MARPs showed prevalence rate of 15.1%, 28.1%, 6.1% and 0.3%, for HIV, Hepatitis C, Hepatitis B and Syphilis among (IDU) respectively. The findings also shows a prevalence of HIV, Hepatitis C, Hepatitis B and Syphilis among of 10.8%, 2.0%, 5.3% and 1.3% respectively among the Female Sex Workers (FSW). With respect to Males having sex with Males (MSM), the findings revealed that the prevalence of HIV, Hepatitis C, Hepatitis B and Syphilis is 12.3%, 14.7%, 4% and 0.2%, respectively. Furthermore 20.2% of MSM had experienced STI symptoms in the past six months and 58% of the respondents sought health care services in response to these symptoms.<sup>2</sup>

The Revolutionary Government of Zanzibar adopted the Zanzibar National HIV Strategic Plan (2004/5 to 2008/9) in 2005 (ZNSP). The consequent publishing of ZHAPMoS Guidelines or Zanzibar HIV and AIDS Programme Monitoring System was an important milestone for the Zanzibar AIDS Commission (ZAC). It is the achievements of one of the strategies of the ZNSP. ZHAPMoS is used to enable ZAC and its partners to collect, analyse, interpret, store and use HIV service data generated by the non-health sector. This data provides a basis for Zanzibar's Multisectoral Monitoring and Evaluation System (HIV M&E System). The HIV M&E System enables ZAC and its partners to monitor the spread of AIDS in Zanzibar, to monitor the efficiency of the national response to HIV, and to evaluate the effectiveness of the national response to HIV, using appropriate and accurate HIV data. [*Source: Guidelines for Zanzibar's HIV and AIDS Programme Monitoring System, (published by the Zanzibar AIDS Commission, May 2006)*].

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<sup>1</sup> Population estimates according to the National Bureau of Statistics

<sup>2</sup> ZAC, 2007, Study Reports on IDU, FSW and MSM

**Table 1: Core Indicators for the Implementation of the Declaration of Commitment on HIV/AIDS 2008 Reporting—Zanzibar**

	<b>INDICATORS BY YEARS</b>		<b>2003/2004</b>	<b>2005/2006</b>	<b>2006/2007</b>
1	Domestic and international AIDS spending by categories and financing sources				
2	National Composite Policy Areas covered (%)				
	Gender,				100
	Workplace programmes,				100
	Stigma and discrimination,				100
	Prevention,				100
	Care and support				100
	Human rights,				60
	Civil society involvement				100
	Monitoring and evaluation				71
3	Percentage of Donated Blood Units screening for HIV in a quality assurance manner			100	100
4	Percentage of Adults and Children with advanced HIV infection receiving antiretroviral therapy			50	50
5	Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of MTCT			20	20
6	Percentage estimated HIV positive incident TB cases that received treatment for TB cases that received treatment for TB and HIV			100	100
7	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and know their results.	Women		NA	4.2
		Men		NA	2.4

	<b>INDICATORS BY YEARS</b>		<b>2003/2004</b>	<b>2005/2006</b>	<b>2006/2007</b>
8	Percentage of most at risk populations that have received an HIV Test in the last 12 months and who know their results			NA	NA
9	Percentage of most at risk populations reached with HIV prevention programmes			NA	NA
10	Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child			NA	NA
11	Percentage of schools that provided life skills-based HIV education in the last academic year			NA	NA
	<b>KNOWLEDGE AND BEHAVIOUR</b>				
12	Current school attendance among orphans and among non-orphans aged 10-14			NA	NA
13	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.			NA	NA
14	Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.			NA	NA
15	Percentage of young women and men aged 15-24 who have had sexual intercourse before age 15.	Female		4.1	
		Male		2.3	
16	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	Females		1	NA
		Males		18	
17	Percentage of women and men aged 15-49 who had more than one sexual partner in the 12 months reporting the use of condom during last sexual intercourse.	Females		34.5	NA
		Males		NA	NA

	<b>INDICATORS BY YEARS</b>		<b>2003/2004</b>	<b>2005/2006</b>	<b>2006/2007</b>
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client			NA	NA
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner			NA	NA
20	Percentage of injecting drug users reporting the use of a condom the last they had sexual intercourse			NA	NA
21	Percentage of young women and men aged 15-24 who are HIV infected				
	<b>IMPACT</b>				
22	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected			NA	NA
23	Percentage of most at risk populations who are HIV infected				15.5
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy				
25	Percentage of infants born to HIV infected mothers who are infected.				

## **2 Overview of the AIDS epidemic**

### ***2.1 Trends in Prevalence / Epidemiology***

#### **2.1.1 HIV Rates**

Since the first three HIV/AIDS cases were diagnosed in 1986 at Mnazi Mmoja hospital, the number of reported cases has been on the increase with women being more infected compared to males (0.9% versus 0.2%). Based on the HIV validation survey and Ante-Natal Clinic (ANC) surveillance done in 2002, the HIV prevalence rates in Zanzibar among the general population and ANC clients are 0.6% and 0.9% respectively. According to this data, Zanzibar was placed among the concentrated HIV prevalence country category. It is estimated that more than 1,000 people have died of AIDS since the first case was identified in 1986. Recent data on HIV transmission rate are not available. The Zanzibar Aids Commission (ZAC) and the Zanzibar Aids Control Programme (ZACP) are planning to carry out population studies to update the data.

### **2.1.2 Transmission Routes**

Sexual transmission among the general population accounts for 90% of the total infection rates. Data from ZACP estimates that about 4% of HIV transmission is of vertical nature (mother to child transmission) inclusive of breast-feeding period.

### **2.1.3 HIV Infection Patterns in the General Population**

According to available data, 86% of HIV transmissions take place in people aged between 20-49 years, peaking in the 35-39 years age category. For women, the age range of 15-29 years was observed to be infected at a much higher rate compared to males in the same age group. The infection trends reveal a high female to male ration of 5:1 respectively. Results from the recently conducted population-based survey (2002) revealed that women especially house workers (HIV prevalence 3.8%) and housewives (HIV prevalence 0.8%) to have been among the affected categories.

### **2.1.4 HIV Infection among TB Patients**

The available data shows that HIV prevalence among the TB patients is 25.5%. The majority of those infected were in the age group of 25-29 years. 76% of them were male and 24% female. In previous years, similar high levels were recorded among this category; in 1994 (18.7%); in 1995 (17.7%) and in 1996 (23.4%).

### **2.1.5 HIV and the Most at Risk Populations**

There are some indications from studies in Zanzibar, which shows that Zanzibar has a concentrated HIV epidemic.<sup>3</sup> High-risk behaviour among the substance users, commercial sex workers (CSWs) and Males having Sex with males (MSM) has been identified in the Islands. The findings from these studies have been summarized in the Joint Review Report (2007) and shows three reasons why substance users and IDUs in particular have been identified as a MARP:

- i. Zanzibar is located along the major corridor for drug trafficking;
- ii. Increasing numbers of young people using illicit drugs; and
- iii. Increase in drug trafficking activities

The study by ZACP, in collaboration with the Department of Substance Abuse Prevention and Rehabilitation (DSAPR) and ZAC, collected data from 503 substance users, 5% were females and 18% were from Pemba. The research findings indicated high percentages of risky behavior amongst substance users, including:

- 39% of substance users are IDUs
- 46% of IDUs share needles

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<sup>3</sup> Dahoma, 2006; Revolutionary Government of Zanzibar and ZAC, 2007, Taking Stock: Joint Review of the National HIV Response in Zanzibar, ; ZACP, 2007, HIV/Sexuality Transmitted Infection (STI) Sero-Prevalence and Risk Behaviours Assessment among Female Sex Workers (FSW) in Unguja; ZACP, 2007, HIV and Sexually Transmitted Infection (STI) Sero-Prevalence and Risk Behaviours Assessment among Injection Drug Users (IDU); ZACP, 2007, HIV and Sexually Transmitted Infection (STI) Sero-Prevalence and Risk Behaviours Assessment among Males who have Sex with Males (MSM) and Lugalla et al. (2007).

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

Three studies one for each of the three categories of MARPs i.e. IDU, FSW and MSM, by the ZACP revealed the following results:<sup>4</sup>

- Findings from the IDU showed that 51.1% have ever shared a needle, and 3.1% have injected blood (flash blood) within the past one-month. The prevalence of HIV, Hepatitis C, Hepatitis B and Syphilis among IDU is 15.1%, 28.1%, 6.1% and 0.3%, respectively. 75.5% of IDU reported seeking health care services in response to having an STI symptom in the past six months.
- Findings from the FSW indicated that condom use at last sex was 70.8% and 40.3% for paying and non-paying partners, respectively. Median number of sex partners on last day was three sex partners (range 1 – 10). The prevalence of HIV, Hepatitis C, Hepatitis B and Syphilis among FSW is 10.8%, 2.0%, 5.3% and 1.3% respectively.
- Findings from the MSM revealed that condom use during the last sex was 28.8% and 27.1% for male and female partners, respectively. 68% of MSM reported using drugs other than alcohol in the previous three months, among them 23% are injection drug users. The prevalence of HIV, Hepatitis C, Hepatitis B and Syphilis among MSM is 12.3%, 14.7%, 4% and 0.2%, respectively. 20.2% of MSM had experienced STI symptoms in the past six months and 58% of the respondents sought health care services in response to these symptoms.

The study by Lugalla et al. (2007) reported that commercial sex workers in Zanzibar are indeed a MARP. 73% of persons (n=353) in a tourism sector study said that the number of CSWs are increasing.<sup>5</sup> A pilot project covering 240 male and female CSWs (89.2% of whom were between 16-35 years of age) in Unguja urban district revealed that CSWs did engage in high risk behaviour (ZACP, 2006).

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<sup>4</sup> ZACP, 2007, HIV/Sexuality Transmitted Infection (STI) Sero-Prevalence and Risk Behaviours Assessment among Female Sex Workers (FSW) in Unguja; ZACP, 2007, HIV and Sexually Transmitted Infection (STI) Sero-Prevalence and Risk Behaviours Assessment among Injection Drug Users (IDU); ZACP, 2007, HIV and Sexually Transmitted Infection (STI) Sero-Prevalence and Risk Behaviours Assessment among Males who have Sex with Males (MSM) and Lugalla et al. (2007).

<sup>5</sup> This study however covered only the North Zanzibar Region, which may not be very representative

### 3.1.6 Factors Fuelling the HIV Epidemic in Zanzibar

There is a multitude of factors, which assist the viability, and pathogenicity of the Human Immunodeficiency Virus in aggravating the HIV pandemic. All these factors have caused today's documented HIV/AIDS rates in Zanzibar, and they are:

- i. Biological determinants;
- ii. Socio-economic factors like rural-urban migration, employment opportunities, level of poverty, proportion of female-headed households, food security; Marked levels of gender imbalances. These include the underlying documented factors (from various studies) in Zanzibar and a number of cultural values and norms namely – stereotypes; gender roles, violence and harassment and power relations;
- iii. Cultural and traditional factors: these include early marriages which are propagated under the belief that this might help in reducing teenage and other unwanted pregnancies; high divorce rates; unsupported Female Headed Household (FHHD) and perceiving that single women are a threat / promiscuous to the society; male macho promiscuous tendency, persistent remarrying tendencies (i.e. exposure to multiple partners); polygamous relationships particularly when partner/s are unfaithful. Another indirect factor fuelling up the epidemic is the attrition of values on communal upbringing of children in the society by not teaching sexual reproductive education immediately after menarche/puberty;
- iv. Stigmatisation and Discrimination against people living with AIDS and affected families;
- v. Negative effects due to cultural clash between the young and old generations in the Islands emanating from infiltration of foreign culture in Zanzibar as the result of globalisation and media developments
- vi. Vulnerability of certain sub-groups to STD/HIV infection e.g. women, girls, young boys, migrant workers, sex workers, men having sex with men, population in very difficult circumstances such as prisoners (correctional facilities students) and people with disabilities especially the mentally handicapped women/girls and substance abusers, especially Injected Drug Users (IDUs).

## 3 National response to the AIDS epidemic

Since the first AIDS case was diagnosed in Zanzibar, two decades now, there has been successive increase in the momentum to respond to the AIDS epidemic in all fronts—policy, community and facility levels responses. The achievement of such success is attributed to the commitment of the government of Zanzibar and Zanzibar AIDS Commission ZAC to provide space for collaboration and involvement all stakeholders, i.e. government departments and agencies, the non-profit organization, and the private sector in all processes. The responses at policy community and national levels are detailed in the following sections

### ***3.1 Policy Level Responses***

The government of Zanzibar has endeavored to establish a good enabling environment as one of the critical ingredients in the process to address HIV epidemic. The enabling environment includes the development of guiding tools (i.e. national policy, strategic plan, M&E framework and tools, Advocacy strategy), and orientation of stakeholders to the guiding and M&E tools. Besides, the government of Zanzibar through ZAC endeavored to broaden and clear more space for partnership between government ministries, departments and agencies MDAs and with stakeholders i.e. CSOs, the private sector and development partners.

The government has launched the National HIV and AIDS Strategic Plan for the period 2004/5 to 2009/10 – the ZNSP. The ZNSP paved way for the development of the Zanzibar Health Sector HIV Strategy (HSSP) for the period 2005-06 to 2010-11. The HSSP defines specific goals, objectives and strategies (in line with the broad ZNSP objectives) for the health sector's HIV response.

The launching of the ZNSP enabled the government in 2006/2007 to consolidate its HIV responses in the MDAs by having the TACs and Ministerial HIV Focal Persons in all the public sector ministries. The TAC members and the HIV Focal Persons were provided with capacity building training to enhance their capabilities in executing their roles. As the outcome, MDAs are now capacitated in developing own HIV work plans. The work plans were included the MDAs' Medium Term Expenditure Framework (MTEF) budgets for 2005/06; 2006/07. Besides, the government of Zanzibar in 2006 also approved the national HIV policy. The policy is very comprehensive and addresses every aspect of the HIV response including the MARPs.

Furthermore, other strategies have also been developed: the National HIV Advocacy and Communication Strategy; the Health Sector HIV Strategic Plan; the HIV and AIDS Strategic Plan for Substance Abuse; National HIV Monitoring and Evaluation Operational Framework; and strategies for UWAKUZA and for ABCZ (Joint Review Report 2007). These documents have been important guiding tools in the development of the annual implementation plan of HIV responses by the public sector, and by both non-profit and private organizations.

The government of Zanzibar through ZAC also launched a joint review of the HIV in 2007. The purpose of the Joint Review was to assess the extent to which Zanzibar has mounted a relevant and comprehensive HIV response of appropriate scale, and what should be done in future to improve the HIV response. Amongst the critical contributions of the Joint Review Report was the generation of new evidence that revealed that the Zanzibar MoHSW 2002 HIV epidemic estimates were questionable. The new findings suggests establishment through research, new epidemiological evidence to determine the drivers of the epidemic in the Zanzibar population. The Zanzibar AIDS Control Program ZACP in collaboration with ZAC and other stakeholders are currently researching to generate the new evidence. The new evidence will be used to review strategies and targeting of intervention over the coming years.

### 3.1.1 One Coordination Body – Making it a Reality

There has been a broad and growing recognition of the need to intensify and accelerate actions towards universal access to comprehensive prevention, treatment, care and support in Zanzibar. The government in 2006/2007 sought to strengthen coordination of HIV responses in the country and to move towards a unified coordination structure. As the first step, the government therefore undertook a mapping and ranking assessment of CSOs. 242 CSOs in Unguja and 137 CSOs in Pemba were identified; of which 59 and 37 have been given the green light as having the capacity to implement HIV interventions in Unguja and Pemba respectively.

The government also recognizes the importance of involving the persons living with HIV. To this effect ZAPHAR+, an NGO that represents persons living with HIV in Zanzibar has been registered and is involved in all HIV response activities by ZAC. ZAPHA+ provides HIV services for individual members and associations that belong to ZAPHA+. ZAPHA+ delivers services (food, shelter, loans etc) for a small group of PLHIVs in Stone Town and collaborates with other CSOs in HIV response activities.

Though, a formal structure to coordinate CSOs and FBOs responding to HIV in Zanzibar has not yet been established. The CSOs in principal are supposed to be coordinated through ZANGOC, the umbrella organization for CSOs working on HIV. ZANGOC nevertheless concentrates on providing HIV services to target beneficiaries, like any other CSOs working on HIV.

The FBOs on the other hand have established an Inter- Faith Forum (IFF), as a coordination body for the FBOs involved in HIV responses in Zanzibar. The IFF has become very active in advocating for faith-inspired HIV responses. The IFF collaborates closely with ZAC through regular meetings and reporting. The IFF has also established the Zanzibar Interfaith Association on AIDS and Reproductive Health (ZIADA). This association, with the assistance of ZAC, has already been registered; and UNFPA has shown interest in assisting the association. The IFF has developed a guideline and curriculum for teaching children on HIV/AIDS in Madrassa and Sunday schools.

As far as the private sector is concerned, the AIDS Business Coalition of Zanzibar (ABCZ) was formed in 2006 with the help of development partners and the AIDS Business Coalition of Tanzania (ABCT) mainland. Already the ABCZ has developed a Strategic Plan with clear vision and core strategies. The vision is “To have the private sector workforce and community in Zanzibar free from HIV and AIDS epidemic and which cares and supports all those infected and affected by HIV and AIDS”.

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

### **3.2 Community Level HIV Prevention Services**

The 2007 HIV joint review report for Zanzibar provides a comprehensive assessment of the community level HIV prevention services. The evidence are collected along four important areas as of assessment:

- I. Relevance of HIV prevention services in the community
- II. Comprehensiveness of HIV prevention services in the community
- III. Scale of HIV prevention services in the community and
- IV. Achievement of ZNSP Objectives in Terms of HIV Prevention in Communities

As far as the relevance of HIV prevention services in the community is concern, the report shows that the messages focus primarily on creating awareness that there is “HIV”, and on sexual transmission of HIV. Because of this limited orientation in focus, not all MARPs are being reached by the prevention efforts. Furthermore, HIV prevention efforts are not linked to substance use prevention (particularly for the youth) or to income-generating activities for the youth and are therefore not relevant to all the drivers of the epidemic.

With regard to comprehensiveness of HIV prevention services in the community, available evidence shows that Zanzibar is yet to receive comprehensiveness in community HIV prevention service for seven important reasons:<sup>6</sup>

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

In terms of Scale of HIV prevention services in the community, more persons in the period 2006 to 2007 have been reached with HIV prevention efforts in the community. In addition, more institutions from all sectors (civil society, the public sector, and higher learning institutions) are involved in HIV prevention efforts. There are 242 Civil Society

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<sup>6</sup> Revolutionary Government of Zanzibar and ZAC, 2007, Taking Stock: Joint Review of the National HIV Responses in Zanzibar (2004 – 2007)

Organisations (CSOs) based in Unguja and 137 based in Pemba working in all aspects of development; many of these CSOs provide HIV prevention services to different segments of the population. Almost all CSOs, even those who implement programmes unrelated to HIV, incorporate HIV prevention education in their programmes, which has enabled more people to be reached with HIV information. So far ZAC coordinates 38 CSOs providing HIV prevention services. Efforts are underway to ensure that all CSOS providing HIV prevention services are under ZAC coordination.

Voluntary Counselling and Testing (VCT) efforts have been scaled up, with positive response from the general population. The positive response to VCT is partly attributed to the increasing political cognizance and commitment to raise VCT awareness through political rallies and speaking about it in almost all the political forums and government meetings. A total of 17, 554 people were tested between January and September 2007 and were given the test results. The results VCT are provided on the Table 1 below. In general, Zanzibar has made important strides in the period 2006/2007 in terms of realization of the ZNSP objectives of HIV prevention in communities as indicated in Table 2 below.

**Table 2: Status of VCT in Zanzibar (January to September 2007)**

	Male			Female		
	Number of VCT	HIV +	Percentage HIV+	Number of VCT	HIV +	Percentage HIV+
0 – 4	56	11	19.6	55	7	12.7
5 – 9	29	8	27.6	30	4	13.3
10 – 14	36	1	2.8	72	3	4.2
15 – 24	2499	16	0.6	4451	86	1.9
25 - 34	4208	75	1.8	2875	170	5.9
35 – 44	1473	75	5.1	824	67	8.1
45 – 54	460	17	3.7	206	14	6.8
55 +	126	5	4.0	44	4	9.1
Not Specified	70	4	5.7	40	2	5.0
<b>Total</b>	<b>8957</b>	<b>212</b>	<b>2.4</b>	<b>8597</b>	<b>357</b>	<b>4.2</b>

*Source:* ZACP,

**Table 3: Type of community-based HIV prevention provided in the period 2006 to 2007**

	<b>Type of community-based HIV prevention provided</b>	<b>Situation as of may 2007</b>
1	<b>Information, Education and Communication (IEC) programmes</b>	<p>(i) The most popular form of communication is the radio, followed by live drama, posters and billboards</p> <p>(ii) Messages about abstinence and being faithful have been more prominent than messages about condom use. Different faiths in Zanzibar have always promoted abstinence-until marriage as a moral imperative and not necessarily a method of HIV prevention. The last three years saw religious leaders include the prevention of HIV transmission as an <i>additional</i> reason for adhering to the abstinence-until-marriage lifestyle</p> <p>(iii) The distribution of IEC materials in Zanzibar during this period was generally quite good. 15,433 IEC materials were distributed to end users in all regions. Booklets were distributed in all regions and posters were distributed in three out of five (3/5) regions, while other IEC materials were distributed in four of the five (4/5) regions</p>
2	<b>Peer Education</b>	<p>(i) Different types of peer-educators have emerged some focus on the general population, and some on specific groups such as MARPs, in-school-youth or out-of-school youth, and some are service-oriented peers.</p> <p>(ii) Pee-education efforts by the government includes training of peer educators by three ministries i.e. Ministry of Tourism, Trade and Investment (MoTTI), MoALE, and MORASD. ZAC also provided training-of-trainers in peer educators for the Ministry's HIV Focal Persons</p> <p>(iii) Peer-educators by civil society and trade unions: A number of CSOs, including ZANGOC, ZAYEDES and ZAIADA, provided peer education programmes focused on HIV awareness for the general public and youth.</p> <p>(iii) 820 active peer educators and active communicators were used by ZAC</p>
3	<b>Condom promotion and distribution</b>	<p>(i) <i>Promotion of condom access points:</i> Condom promotion is low, and strong cultural opposition to condoms remains. ZACP is currently the sole distributor of condoms. The condom outlets used include VCT stations, Family Planning Programme, Peer Educators and CSOs. The</p>

	Type of community-based HIV prevention provided	Situation as of may 2007
		<p>Ministry of Health is currently in the process to develop a comprehensive Condom Programme Strategy for Zanzibar.</p> <p><i>(ii) Condom 'promotion' for discordant couples by religious leaders:</i> In the last three years, the FBOs' capacity has been built to engage in discussions around AIDS. Instead of being completely opposed to any kind of condom promotion, religious leaders of the Muslim faith in Zanzibar now promote condom use amongst discordant couples.</p> <p><i>(iii) Condom distribution and promotion in the general public:</i> Condoms are not readily available in Zanzibar, but more limited in Pemba than Unguja. Government does not actively support their distribution and a condom policy has not yet been developed. One of the two political parties promotes individual condom use, but not condom distribution – “where one accesses it, is a private matter”. Condom distribution is '<b>medicalised</b>', meaning that distribution is primarily through health facilities as a family planning measure. Condoms are also available at a small number of NGOs and pharmacies in urban centres – recently, flavoured condoms have become available at a lower price. Development partners have assisted in procuring, storing and distributing condoms.</p> <p><i>(iv) Demand for condoms:</i> Despite the limited communication efforts, there is a strong demand for condoms, as proven by these selective distribution figures: MDM procured over 7,6 million condoms for the 2005/6 financial year. Since taking over the CSW peer education programme in Sept 2006, ZACP has distributed almost 39 000 condoms.</p> <p><i>(v) There were, however, no female condoms distributed in the whole of Zanzibar. Also, it is of great concern that condoms were distributed in the Urban West region only, and the number distributed was very small. Generally the attitudes and practices towards condom use in Zanzibar seem to have improved, but there is still a need for a good condom procurement and distribution strategy especially targeting Most at Risk Populations so as to limit the spread of HIV within the general population as well.</i></p>
4	HIV Workplace Programmes	(i) In the public sector, Ministries were trained in HIV

	Type of community-based HIV prevention provided	Situation as of may 2007
		<p>workplace programmes with SIPAA funding, and now have workplace programme action plans, with funding from the World Bank to implement them. ZACP has assisted in implementing workplace programmes in the public sector. HIV is currently being mainstreamed into the General Orders of government. Besides, a study has been done on the tourism and education sectors to examine risk behaviours, risk behaviour driving factors and responses to HIV/AIDS. The findings will be used in the development of the forthcoming strategic plans.</p> <p>(ii) CSOs do not yet have workplace programmes in place. Also, most private sector institutions have not been pro-active in addressing HIV at the workplaces, with the exception of a few organizations.</p> <p>(iii) 2,098 employees in organizations have participated in and benefited from an HIV workplace programme during this quarter. In general, the Urban Region has a good number of people reached by workplace programmes. But the rest of the regions have very minimal on the people reached by workplace programmes. It is recommended that ZAC follows up and encourages heads of civil society, public and private sector organizations to avail resources so that internal mainstreaming efforts can be increased to benefit more employees through HIV workplace programmes</p>
5	<b>HIV Prevention for out-of-school youth</b>	<p>(i) Findings from the Rapid Assessment of Report of HIV Preventive Services for Young people in Zanzibar conducted in 2007, indicated that the existing STI and VCT services are predominantly general, available for all people and not exclusively for the general young people and no specific provisions for females and young people with disabilities.</p> <p>(ii) Accessibility of these services is limited to the majority of young people because of associated costs and location - given that large numbers of young people are unemployed and can hardly afford paying for health services or fare to go far from their residences.</p> <p>(iii) <i>Youth centres to reach out-of-school youth:</i> Some youth centres are run by CSOs, some by FBOs and others by government – nine in total. Centres mobilize young people aged 13 – 24 to become centre members. They have different HIV interventions for their members,</p>

	<b>Type of community-based HIV prevention provided</b>	<b>Situation as of may 2007</b>
		<p>including music entertainment, education, helping with design of appropriate messages, and discussion sessions with opinion leaders. District governments also support youth centers, which sometimes double-up as mini library and/or information centers. Some FBOs have youth centers in their churches. Some Global Fund sub-recipients also are also providing youth friendly services.</p> <p><i>Success of youth centres:</i> The centres have been successful in providing a forum for young people to meet, discuss and find solutions around the public health challenges they face.</p>
6	<b>HIV prevention for in-school youth</b>	<p>(i) MoEVT has developed a curriculum, approved by religious authorities and the MoEVT, for middle and secondary schools. Despite that, comprehensive mainstreaming of HIV curriculum in the education system is still a problem. A recent impact assessment in the education sector has shown that HIV is not routinely taught at either primary or high school level. Most of the HIV prevention work in schools take place through Anti-AIDS clubs, which aim to disseminate scientifically correct information about HIV to in-school youth. Most schools have established clubs – some are active (meet on a regular basis), others are not.</p>
7	<b>Pre-marital voluntary HIV counselling and testing</b>	<p>This is an example of a good practice that developed locally in Zanzibar, provided that it takes place ethically, confidentially and that it does not increase stigma and discrimination. In just three years, religious leaders have advocated strongly for pre-marital HIV testing – it has now become a norm. Although the practice is not mandatory, communities have come to expect couples who plan to marry to undergo HIV testing. Mothers play a strong role in promoting the practice. Women in polygamous marriages embrace the practice. This data is confirmed by recent VCT statistics from ZACP: in 2005, 37% of VCT clients were married, and 48% had never been married (ZACP, 2006).</p>
8	<b>HIV prevention for Substance Users ('demand, supply and harm reduction programmes')</b>	<p>(i) Demand Reduction: The focus in Zanzibar has been on education to prevent substance use and on counselling persons who are already involved in it to quit. Education has been done through NGOs (ZAYADESA), a resource centre focusing on substance use (Zanzibar Association of Information Against Drug Abuse and Alcohol (ZAIADA)), and religious leaders. A</p>

	Type of community-based HIV prevention provided	Situation as of may 2007
		rehabilitation centre is also being built. (ii) Supply Reduction: The Police (anti-narcotics squad) are responsible for supply reduction. However, it is felt by stakeholders that the drug policing strategy is inconsistent in its implementation: it seems to focus on punishing substance users, while those who traffic drugs can buy protection from officials in the Department.

*Source:* The Revolutionary Government of Zanzibar, and ZAC Taking Stock: Joint Review of the National HIV Response in Zanzibar (2004-2007); The Revolutionary Government of Zanzibar, 2007, A Report of Assessment of HIV Preventive Services for Young People in Zanzibar. Ministry of Labour, Youth, Women and Children's Development: Zanzibar; Data were also provided by Stakeholder during the validation workshop of the draft UNGASS Report for Zanzibar, on December 19, 2007.

### 3.3 HIV Prevention at Facility Level

**Table 4: HIV Prevention Efforts and Facility Level**

	Type of Facility level HIV prevention provided	Situation as of may 2007
1	<b>Condom Procurement and Distribution</b>	<p>(i) The Clinton Foundation on HIV and AIDS (CHAI) is now providing financial support for procurement of condoms for health facilities. ZACP also procures condoms through the Global Fund Round 6 and World Bank Multisectoral AIDS Program (MAP). However, female condoms are not available and therefore not in use. Besides, there is no quality assurance testing of the condoms distributed.</p> <p>(iii) An evidence-based and culturally sensitive condom distribution, promotion and use strategy has not yet been developed. However, free condoms are distributed at major hospitals through mother and child health (MCH) clinics. These condoms are intended for family planning purposes rather than for STI and HIV prevention (although their use will help prevent infection). Condom distribution at health facilities is routinely monitored, as it is included in the health sector indicator list. Condoms are not available in rural areas, and it is hard for the youth to access condoms.</p> <p>(iv) Accessibility to condoms in Pemba generally and in rural areas is still a critical problem. This is mainly due to socio-cultural factors.</p>

	<b>Type of Facility level HIV prevention provided</b>	<b>Situation as of may 2007</b>
2	<b>Safe blood supply</b>	<p>(i) Blood transfusion using the replacement blood donor system is still being done at all public hospitals and a few private hospitals (e.g. Al-Rahma). In the past four years, a system has been put in place to screen the replacement donor for HIV, HBV, HCV and syphilis prior to transfusion. The safety of blood and blood products in this system therefore depends on the quality of the laboratory services in the hospital. Mostly, it is men who provide replacement blood – the 2005 VCT results confirm that 1775 men (13% of all VCT patients) and only 9 women attended VCT for the purpose of participating in the blood replacement system.</p> <p>(ii) A national blood transfusion policy guideline has been developed; a national blood bank established at the national referral hospital (this is meant to eventually replace the replacement donor system); the promotion of volunteers for blood donations has been initiated; health care workers' capacity on blood transfusion services improved through training some of them as technicians, technologists, phlebotomists, recruiters (2) and a counselor. All donated blood are screened for HIV, HCV, HBV and Syphilis. The blood bank services are only available at the national referral hospital and cannot yet provide stock to other site</p>
3	<b>PMTCT</b>	<p>(i) After the PMTCT formative study, PMTCT trainer manuals, participant manuals and pocket guides were developed in June 2006, and guidelines on PMTCT service delivery in October 2006 (Guidelines focus on: Integration with reproductive and child health, Testing and counseling, Standards for ARV prophylaxis and treatment, Continuum of care &amp; treatment, Infant feeding, Stigma and discrimination, Safe and supportive care in the work setting, and PMTCT programme monitoring).</p> <p>(ii) Staff have been trained on PMTCT (90 health care workers, 10 lab staff, 9 clinicians, 71 nurses, 46 staff from new sites &amp; 44 staff from existing sites, and 479 HCWs). ZACP prepared radio announcements, television announcements, developed brochures and posters to communicate information about the importance of PMTCT.</p> <p>(iii) PMTCT services commenced in 2005. There is high uptake of PMTCT services in RCH clinics (98%) and</p>

	<b>Type of Facility level HIV prevention provided</b>	<b>Situation as of may 2007</b>
		<p>high acceptance of PMTCT services by clients (99%). By March 2006, 4 012 pregnant women (70% of ANC clients at the three sites) had accessed PMTCT services at three sites with 1.8% HIV positive. By March 2007, 9 553 pregnant women (99% of ANC clients at the six sites) accessed PMTCT at six sites, with 1.3% HIV positive. All HIV positive women at PMTCT sites were referred to Care and Treatment Clinics</p> <p>(iv) The increase in the number of PMTCT sites, accompanying capacity building and IEC has led to an increased in the PMTCT coverage – from 0% in 2004, to 3.5% in 2005 when PMTCT started (NBS and ORC Macro, 2005), to 20% of all pregnant women in 2007.</p> <p>v) 78% of pregnant women who delivered at hospitals were given Nevirapine in 2006 (n=32), compared with 71% of HIV positive women in 2007 (n=73)</p>
4	<b>Harm, Supply and Demand Reduction</b>	<p>(i) No specific strategies have been put in place to reduce needle sharing amongst injecting drug users. However, a Substance Use and HIV Strategic Plan (SU-HISP) was developed in January 2007. The goal of SU-HISP is to reduce new HIV/ STI infections by 50% by 2011, and to provide treatment, care and support to substance users with special focus on IDU and their affected families.</p> <p>(ii) Resources to implement the (SU-HISP) have been mobilized through the Global Fund Round 6. UNDP has supported capacity enhancement of the DSAPR. A site has also been identified for a detoxification centre – as funds for it has been mobilized.</p>
5	<b>VCT</b>	<p>(i) In 2004 there were 12 VCT sites. By June 2007, there were 27 functional VCT sites in Zanzibar.</p> <p>(ii) VCT outreach services are currently provided by the Zanzibar NGO Coalition (ZANGOC) in collaboration with ZACP and Youth Challenge Internation (YCI) . In addition, there are 10 Youth Friendly facilities providing VCT services to youth.</p> <p>(iii) There is an uneven distribution of VCT sites in the country. Most sites are located in urban/peri-urban settings and are stand-alone sites.</p> <p>(iv) Guidelines for HIV counseling and testing and a training manual for HCWs were developed in December</p>

	<b>Type of Facility level HIV prevention provided</b>	<b>Situation as of may 2007</b>
		2006 (and includes provider-initiated testing)
6	<b>STI Control</b>	<p>(i) The number of STI sites in Zanzibar has almost doubled from 26 in 2004 to 45 in 2006 and as of 2007, STI services are available in 60 health facilities in Zanzibar.</p> <p>(ii) Zanzibar uses Tanzania mainland's STI syndromic management guidelines, which were printed and distributed to all health facilities offering STI services. Staff at PHCUs and both public and private hospitals have been trained in the syndromic management of STIs. ZACP has used the radio, television and other media to run IEC programmes about STIs and to promote early treatment seeking behaviour.</p> <p>(ii) ZACP has distributed STI drugs, HIV test kits and condoms to all STI clinics, and have started to collect STI data as part of the HMIS. Youth-friendly service has been established by NGOs, whilst some operate as part of youth-friendly reproductive health services for the youth. Supervision of STI sites has commenced. On average, 600 newly diagnosed STI clients are treated per month; around 60% of STI clients are married couples (ZAC, 2006). It was estimated in 2006 that 50% percent of patients with STIs are treated using syndromic management STI guidelines, compared with the target of 100%. Traditional healers have also been briefed on the need to refer STI patients that they cannot manage.</p>
7	<b>Universal Precautions and PEP</b>	<p>(i) Availability of equipment for universal precautions (gloves, adequate supply of needles and syringes, aprons) has improved in the four hospitals in Zanzibar in the last three years. Coverage is 100% in Mnazi Mmoja hospital, and has just started in Chake Chake. Other health facilities do not yet have universal precaution programmes in place.</p> <p>(ii) Medical Waste not effectively managed. The medical waste management plan developed in 2003 has been piloted in 2 sites since then.</p> <p>(ii) Mnazi Mmoja hospital and Chake Chake hospital are pilot hospitals for implementation of a health facilities protective gear project, supported by John Snow International. The project has trained over 110 health workers on preventing nosocomial infections, waste management and post exposure prophylaxis. IEC</p>

	Type of Facility level HIV prevention provided	Situation as of may 2007
		<p>materials have also been developed and are available</p> <p>(ii) PEP guidelines (Prevention of Exposure to Blood Borne Pathogens and Post Exposure Prophylaxis), a facilitator's guide and a training manual were developed late in 2006 for use in all health facilities. Pilot training programmes are planned for 2007. PEP guidelines for use after sexual assault were developed with support from CHAI, and some clinicians have been trained.</p> <p>(iii) <i>Medical waste disposal</i>: Incinerators are available at Mnazi Mmoja, Makunduchi and Bububu hospitals, any other sites. Some education of health attendants have been done, but coverage is not 100%.</p>

*Source:* The Revolutionary Government of Zanzibar, and ZAC Taking Stock: Joint Review of the National HIV Response in Zanzibar (2004-2007); The Revolutionary Government of Zanzibar, 2007, A Report of Assessment of HIV Preventive Services for Young People in Zanzibar. Ministry of Labour, Youth, Women and Children's Development: Zanzibar; Data were also provided by Stakeholder during the validation workshop of the draft UNGASS Report for Zanzibar, on December 19, 2007.

### **3.3 HIV Care and Treatment at Facility Level**

#### **3.3.1 Health system strengthening**

Currently, human resources for health is a critical obstacle for scaling up facility level HIV/AIDS responses. In efforts to scale up HIV/AIDS responses in Zanzibar an adequate health system is required to support care and treatment at the facility level. This requires adequate training, strategic deployment, recruitment and retention of human resources for health. Training and capacity building is critical for enhancing the capability of the health care workers to perform the required duties efficiently and effectively to ensure access to quality facility level HIV/AIDS care and treatment services. Among others, training and capacity building is required in provider initiated counselling to enable service providers to initiate testing and counselling to patients as well as prevention of accidental exposure to HIV at facility level. Availability of competent and motivated health staff, will complement the community level VCT effort and thus increase the uptake of VCT services and access to the facility level care and treatment services .

In addition to that , availability of the required medical supplies is critical for the success of HIV/AIDS responses at the facility level. A good procurement, logistics and supply system will ensure provision of quality health care services, which is a critical factor for ensuring clients satisfaction and trust. Procurement, logistics and supply systems are critical areas that still requires both financial and technical support from the development partners. Addressing this problem would have potential impact in health system strengthening.

**Table 5: HIV Care and Treatment at Facility Level**

	<b>Type of HIV Care and Treatment at Facility level</b>	<b>Situation as of may 2007</b>
	<b>Treatment of Opportunistic Infections (OIs) and Integrating TB services</b>	<p>(i) OI treatment is important: OI prophylaxis and relevant OI treatment reduces mortality and morbidity even without HAART.</p> <p><i>Extent of TB as one of the main Opportunistic Infections:</i> TB is one of the main opportunistic infections. There are an average 300 new annual TB cases per year, with about two-thirds being smear-positive. (Case detection rates are not available). In 2002 that 25% of TB patients were HIV-positive; this has increased to 33% since 2002. The relapse rate for TB is high – around 6% (ZACP, 2005; ZAC, 2006).</p> <p><i>Provision of capacity building, OI drugs and treatment protocols:</i> ZACP trained some civil society organizations on treatment of opportunistic infections. OIs are treated according to the National Clinical Guidelines on the Management of HIV and AIDS. The initiative to avail Fluconazole supported by Pfizer was re-started in 2005 and is now widely available. Prophylactic therapy for OIs using co-trimoxazole has been introduced in the guidelines. Isoniazid prophylactic therapy has not yet been introduced in treatment guidelines. Pfizer provides free Diflucan as one of the key medication against fungal OIs.</p> <p><i>TB and HIV integration:</i> TB and HIV care are not integrated but discussions are underway, partly because of the inadequate human and infrastructural capacity in ensuring quality integrated service provision, technical know how and promoting HIV &amp; TB overlaps.</p>
	<b>Laboratory support</b>	<p>Infrastructure rehabilitation to support laboratory, counselling and testing, adherence counselling and ART delivery has taken place. The CD4 laboratory service was launched in July 2005, and quality assurance for CD4 services initiated in November 2005. All quality assurance results show that quality is of acceptable standard.</p>
	<b>ARV Treatment</b>	<p>(i) In the Zanzibar context, MARPs have high HIV prevalence and ultimately severe immunosuppression warranting antiretroviral treatment. There are over 700 people who are eligible for HAART in Zanzibar – most of these persons are MARPs. Providing ARVs to MARPs is essential – it will help reduce the risk of HIV</p>

	Type of HIV Care and Treatment at Facility level	Situation as of May 2007
		<p>transmission to the general population but will reduce the efficiency of transmitting HIV infection to the general population.</p> <p>(ii) The introduction of ARVs using a triple therapy protocol started at Mnazi Mmoja and Chake Chake hospitals in 2005 with support from development partners in training, equipment procurement and management, M&amp;E, training of HCWs, as well as procurement of drugs/supplies and reagents. The rollout expanded to another two hospitals in 2006. Provision of ARVs to Bububu military hospital is planned for 2007. In total, there will be four Care and Treatment Centres (CTCs) where the continuum of care will be provided to PLHIVs in the future.</p> <p>(iii) Current estimates suggest that between 3,500 and 9,000 adults and children in Zanzibar live with HIV, which accounts for 4.0% of hospital beds. By May 2006, the care and treatment programme had registered 820 PLHIVs, and by March 2007, 1 289 patients were enrolled for care and treatment. Over the persons enrolled for care and treatment, 88% of the target of 300 PLHIVs were placed on care and treatment</p>

*Source:* The Revolutionary Government of Zanzibar, and ZAC Taking Stock: Joint Review of the National HIV Response in Zanzibar (2004-2007); and Data provided by Stakeholder during the validation workshop of the draft UNGASS Report for Zanzibar, on December 19, 2007.

### **3.5 Impact Mitigation**

Zanzibar has invested commendable efforts and resources in support of most vulnerable children (MVC). There is concern, however, that widows, the elderly and other vulnerable groups have been ignored and a token number was given emotional support only. Implementers are being encouraged to especially consider allocating increased efforts and resources towards supporting widows and other vulnerable community groups in all ways possible so as not to marginalize and forget them altogether.

Most of the support provided to vulnerable and affected groups focused on emotional and psychological support. In most regions, minimal attention was given to healthcare, nutrition, financial support and education. It has been recommended that Zanzibar identifies organizations with strategic niches that can provide nutritional support and micro credit schemes, and facilitate them to provide these basic services to vulnerable groups. However the healthcare supplies can continue to be handled by the ZACP and health facilities in Zanzibar.

Notable achievements have been realized in the provision of Home Based Care over the 2006/2007 period. The achievements include development of the Zanzibar home based care guideline<sup>7</sup> and training of HBC trainers as well as Training of 27 Community Home Based Care providers from different CSOs in Unguja and Pemba, namely Zanzibar Association of People Living with and Affected by HIV&AIDS (ZAPHA+); JWAZA (jumuiya ya maimamu Zanzibar)<sup>8</sup>, Zanzibar AIDS Support of orphans (ZASO); Zanzibar Muslim Women Assosiation Support of orphans (ZAMWASO) and Zanzibar children funds from Pemba (ZCF). Training was also provided to 20 Community home based care providers from the communities. So far 10 districts are implementing HBC services and each district has at least 2-3 district trainers of trainers cum District HBC supervisors. There are 174 Home Based Care (HBC) providers, 77 Community Home Based Providers (CHBC) (Table 6) and 164 oriented community volunteers providing HBC to patients in Unguja and Pemba.

**Table 6: Providers of Home Based Care in Zanzibar by District**

District	Health facilities implementing HBC service	HBC Trainers	Home based care providers	Community HBC providers
Urban	16	5	30	32
West	12	3	24	14
South	8	3	12	2
North "A"	11	3	14	7
North "B"	3	3	3	1
Central	12	4	15	5
WETE	10	3	22	3
CHAKE	12	3	18	11
MKOANI	14	4	14	2
MICHEWENI	2	3	2	-
<b>TOTAL</b>	<b>100</b>	<b>30</b>	<b>174</b>	<b>77</b>

*Source:* ZACP, 2007, Annual Progress Report covering the period March 2006-march 2007.

According to ZAC (2007),<sup>9</sup> there is a gross underutilization of the trained HBC volunteers. For instance, 98 registered home care volunteers made a total of only 65 home care visits in the last quarter of 2006, which is an average of less than one visit undertaken by a home care volunteer in three months. Only North Pemba reported more than one visit per volunteer over three months, but still this performance is minimal. Apart from examining the factors for gross underperformance in HBC provision, there is a need to carry out a scientific evaluation to establish the demand, availability and resource implications for HBC in Zanzibar. This is critical if effective HBC in the Islands is to be implement and sustained.

<sup>7</sup> The HBC guideline was developed with technical support from Family Health International (FHI).

<sup>8</sup> The English translation is "Zanzibar Society of Imamus"

<sup>9</sup> Zanzibar Quarterly HIV Services Coverage Report, May 2007

## 4 Best Practices

The best practices include the steps taken in Zanzibar to enhance VCT and PMTCT turn out among the pregnant women. The approaches used includes the following:

- i. The involvement of Traditional Birth Attendants (TBAs) in HIV prevention by training them on how to encourage pregnant women to go for VCT and PMTCT. This approach has significantly contributed to increase in the number of pregnant women accepting VCT and enrolment and adherence on PMTCT programme.
- ii. The “Opt Out” approach is another factor that has contributed to the good turn out for PMCT. All pregnant women are provided with counselling and 100% of women opt for testing.
- iii. Enhanced VCT and PMTCT awareness in the communities through the involvement of the Faith Based Organizations (FBOs).
- iv. Involvement of males in the PMTCT programme. Every woman attending antenatal clinic for the first time is provided with an invitation letter for her husband to come for VCT. This approach has encouraging males to accompany their wives for VCT.
- v. Lastly but not least, is the availability of free ARVs. The availability of ARVs has motivated women to come in for VCT in order to start early treatment if diagnosed having HIV.

Furthermore, the best practices also include research-based interventions in the prevention of HIV. So far five studies related to Most at Risk Population (MARPs) have been conducted in Zanzibar between 2005 and 2007. The findings from these studies are feeding into the strategies to target interventions on the MARPs.

Moreover, the Revolutionary government of Zanzibar through ZAC, has provided space for collaboration and partnership with CSOs and FBOs. This is out of the realization that collaboration and partnership with the wider community of stakeholders is vital for scaling-up HIV responses and in ensuring universal access to essential services by the PLHAs.

In addition to that, premarital testing has been given preeminence. ZAC is currently in the process of designing guidelines on premarital testing. The guidelines are intended to ensure that premarital testing process is carried out in an ethical way without violating human rights.

## 5 Major challenges and remedial actions

### 5.1 *Major Challenges Reported in the 2005 UNGASS Country Progress Report.*

A number of challenges remain for a comprehensive response to HIV/AIDS in Zanzibar: -

- i. Leadership is needed to address the shortfall in HIV/AIDS resources, particularly the human resources, sound information system, well managed and

- regular supply of drugs and other commodities to ensure uninterrupted supplies and a sustainable funding systems for priority interventions
- ii. Advocacy by all leaders and partners to mitigate stigma and discrimination of people living with HIV/AIDS in all institutions and at household level;
  - iii. Intensification of preventive measures among those at risk and most vulnerable groups, including availability of condoms (a very negative issue in Zanzibar)
  - iv. Expansion of Voluntary Counselling and Testing (VCT) services country-wide including treatment preparedness, ensure community engagement for support services, promote an efficient and reliable supply chains (that will address the existing lengthy procurement processes) , intensify training and capacity building efforts, develop M&E system to monitor drug adherence, treatment success and resistance levels.
  - v. A national strategy to provide care and treatment to people living with HIV/AIDS for opportunistic infections and TB, sexually transmitted diseases, and provision of Antiretroviral drugs to enable PLHA to live longer and productive lives.
  - vi. Limited Mainstreaming of HIV/AIDS and particularly external mainstreaming
  - vii. Limited capacities at all levels (including ZAC in-house) for the Multi-sectoral responses.
  - viii. Development of the national M&E systems need to start with capacity building efforts
  - ix. M&E Framework is not yet disseminated and operational at all regional and district levels
  - x. Integrating of HIV/AIDS in poverty monitoring systems

## ***5.2 Main Challenges and Remedial Actions to the HIV/AIDS Response in Zanzibar***

### **5.2.1 Challenges in Prevention**

- i. A commendable zeal to mobilize resources for scaling up HIV/AIDS responses has been demonstrated by both government and other stakeholders. These efforts however are hampered by slow absorption capacity and poor oversight of funds in the government ministries, departments and agencies and in some of the Civil Society Organization (CSOs). This problem is attributed to low levels of capacity throughout the government system.
- ii. Low capacity at district level and lower levels (Shehia level) to implement HIV/AIDS interventions. This problem significantly hinders achievements of the programmatic milestones.
- iii. There is a limited capacity of the health sector to roll-out provision of ARVs and drugs for the Prevention of Mother-to-Child Transmission (PMTCT). Even though Zanzibar has demonstrated significant achievements in the provision of ARVs and PMTCT, this problem is encumbering further progress.
- iv. Strong socio-cultural norms and traditional practices that impinge on efforts to fight the epidemic and which makes women and girls particularly more vulnerable to HIV infection.

- v. Inadequate child protection measures for orphans and vulnerable children (OVC) and lack of legislations to protect the rights of women, girls and People Living with HIV and AIDS. Consequently this problem makes this people even more vulnerable to among others disinheritance and HIV infection.
- vi. A lot of training on HIV prevention as well as care and treatment has been given to volunteers and practitioners in Zanzibar. However, translating the acquired skills and knowledge into practical application at the programmatic implementation level has remained one of the critical challenges. This is mainly due to limited capability for creativity and lack of incentives among practitioners generally and in particular among the volunteers.
- vii. Limited condom access: To date there have been no female condoms distributed to end users in the whole of Zanzibar. Furthermore, outside health facilities an insignificant amount of male condoms were distributed to end users, and these condoms were distributed in the Urban West region only. Limited condom distribution is particularly a problem in Pemba Island and in rural areas both in Pemba and Unguja.
- viii. Low usage of radio and television communication: Only Urban West and North Pemba regions used radio, while radio is known to be an effective means of Information Education and Communication (IEC) because it can reach many people very quickly. Little airtime was given to radio and television totalling 19.45 hours in around 90 days.
- ix. Most IEC materials are provided on public events only and the use of posters is of limited effectiveness, as people in Zanzibar do not have a culture to read posters. In general IEC materials a provided in a “one jacket fits all fashion” without considerations for differences in age groups and the existing socio-cultural differences.
- x. Un-established workplace programmes: Workplace programmes are active and reaching out to many people in the Urban Region. But other regions currently have only minimal programmes in place and have an insignificant number of people reached through the work place programmes.

### 5.2.2 Challenges in treatment, care and support

- i. **Marginalization of some vulnerable groups:** Although many MVC in Zanzibar were supported, some other vulnerable groups like widows and elderly were only supported with a very limited amount of emotional support without getting nutritional, financial, healthcare and other services.
- ii. **Vulnerable groups received mostly emotional and intangible support:** Most of the support provided to vulnerable and affected groups focussed on emotional and psychological support. Healthcare, nutritional, financial and school related support was largely unaddressed.
- iii. **Home based care volunteers are heavily underutilized:** Although they are trained and **registered** in all regions, on average there was less than one visit undertaken by a home based care volunteer in the quarter of around 90 days. The reason for this underperformance was not immediately established.

- iv. **Around 75% of pregnant women do not access HIV services:** It was estimated that around 75% of pregnant women give birth outside the medical facilities. The traditional birth attendants who deliver then are normally not trained or provided with supplies and equipment; as such all these women and their deliverers do not access the HIV education and prevention services.
- v. **Health sector data was not readily available:** It was noted that data was not easily available from the health sector, for instance: the South Region did not provide some data on their interventions; ARV data was not available and; condoms distributed by the health sector in October 2006 could not be quantified. This was partly due to the collapse of the Health Management Information System (HMIS) during the time of reporting.

### 5.2.3 Challenges in strengthening organization and management systems

- i. **There was no training on stigma reduction and home based care:** Capacity training focused on many topics of which knowledge level among implementers is good. But the training was not offered for two critical areas of stigma reduction and home based care, yet these are the areas in which the HIV implementers do not have sufficient capacity and require improvement on programme quality.
- ii. **Only three regions trained a small number on PEP:** This is another area that is under addressed. There are only three regions out of five that have trained emergency personnel on Post **Exposure** Prophylaxis (PEP). The total numbers of trained personnel twenty people in the whole of Zanzibar. This number is extremely small for effective PEP in the entire health sector in Zanzibar Islands.

### 5.2.4 Achievements & challenges in M&E

Several achievements on M&E in Zanzibar have been made. Among them are the following:-

#### *Achievements*

- i. M&E infrastructure, staffing and job descriptions are in place both in ZAC and ZACP.
- ii. A comprehensive national HIV M&E operational framework, plus a strategic plan with M&E components for the health sector are in place and functional.
- iii. For the data reporting both in ZAC and ZACP, a clear definition of indicators, instructions and format for reporting, procedure to address late and incomplete reporting are in place.
- iv. The M&E units of the ZAC and ZACP produce regular quarterly and annual compilations of M&E results for decision makers and the public.
- v. Procedures in practice to avoid double counting of major services, such as ART and PMTCT are in place.
- vi. Database has been installed and awaiting finalization of uploading at ZAC and move to the next step of operationalization.

*Challenges:*

- i. Part of the indicator definition and data collection requirements of ZACP are different from the national HIV M&E framework which is multi-sectoral and is being coordinated by ZAC. Another example related to the same was when ZAC was preparing the quarterly M&E report for April-June 2007, the data that was required was not readily available from Ministry of Health mostly due to the fact that the MoHSW has not yet aligned their data collection systems to provide data required in the National HIV M&E framework. Also data was not available from some implementers mainly because of capacity constraints
- ii. There are gaps in staffing and capacity in data management and reporting at all levels, including ZAC and HMIS (for M&E in ZACP) and other implementers at the district level; For example, some of the community organizations staff members still do not have capacity to obtain and report the required M&E data. Unfortunately even data auditing and supportive supervision had not yet commenced by the time of reporting, this would otherwise have helped strengthen the weak organizations with reporting
- iii. There are gaps for data reporting from lower level to ZAC and ZACP, such as without log sheets to record the number of commodities distributed; double counting for VCT services; no tracking for stock-outs of condoms etc. at the service points.
- iv. Some of the forms for collecting M&E data (ZHAPMoS) are not submitted timely, completely and mistake free; and at the district level, there are no assigned staff nor comprehensive written procedure and terms of references to verify the data before submitting to the national level.
- v. No written procedure available to address late, incomplete and inaccurate reporting
- vi. Weak or lack of implementer M&E system led to inaccurate data: Some community based implementers filled out ZHAPMoS forms with inaccurate or irrelevant data because they do not have functional M&E systems to generate reliable and accurate data.
- vii. Negative implementer attitudes and absence of a law to compel reporting: Some implementers have a negative attitude toward M&E and reporting to government, but there is no law that ZAC could enforce in order to compel them to report. So a lot of time and efforts were spent on persuading the resistant implementers to report.
- viii. Funding constraints and delays: Some implementers did not have the funding for travel to go and submit their ZHAPMoS forms at the Districts, they did not even have coordination offices where ZAC or Districts could easily reach them; and most of their reports were late. Additionally, the Districts too did not have a travel budget to go and collect the delayed ZHAPMoS forms and this caused more delays because the ZAC M&E staff went out to collect the forms themselves from the implementers who report late.

## 6 Support from the country's development partners

Development partners are providing financial and technical support in almost all areas of HIV/AIDS prevention, care and treatment as well as impact mitigation. A United Nations Joint Programme of Support on HIV and AIDS for the period 2007-2010 has been developed in partnership with Government and other key partners to harmonize and align the activities of UN agencies working on HIV and AIDS in Tanzania. The Joint Programme is fully consistent with UNDAF and Government priorities as well as the Zanzibar's National HIV and AIDS Strategic Plan (2004/5-2008/9).

Zanzibar also is receiving support for HIV/AIDS responses from the World Bank for the implementation of the Multisectoral Aids Programme. Besides, Zanzibar also secured funding from the Global fund and generous support from other development partners including the bilateral organizations including the US government support through PEPFAR.

The government of Zanzibar has always appreciated the generous support it receives from the development partners. The government however has always grappled with the critical challenge of monitoring and ensuring effective utilization of funds for HIV/AIDS that are channeled by the partners directly to CSOs and FBOs.

## 7 Monitoring and Evaluation environment

### 7.1 *The Zanzibar M&E System*

The development of the national multisectoral HIV M&E system in Zanzibar started in late 2003 and was completed in June 2006 when the system was launched. The goal of the national Multisectoral HIV M&E system is 'to enable ZAC and its partners to monitor the spread and impact of the epidemic in Zanzibar, monitor the efficiency of the national response to HIV, as well as to evaluate the effectiveness of the national response to HIV, using relevant and accurate HIV data for planning effective HIV interventions in Zanzibar.'

In early 2006 Zanzibar trained a team of eighteen accredited national trainers, and by July 2007 these national trainers had rolled out M&E training to all stakeholders in all sectors from national to community levels namely: Government Ministries Departments and Agencies (MDAs), Civil Society Organizations (CSOs), Private Sector Organizations and Schools. These accredited trainers also mentored the stakeholders in developing their day-to-day functional data collection and reporting systems within their organizations. ZAC has also increased the frequency of disseminating and publicizing the M&E information products especially through the mass media.

So far the HIV M&E system in Zanzibar has experienced five main challenges as follows:<sup>10</sup>

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<sup>10</sup> ZAC 2007, Zanzibar National HIV M&E System bears fruits soon after its launch: Sharing Strategies, challenges and lessons learnt: Workshop paper, presented August 2007

- i. Stakeholders are reporting after the set deadline for reporting has passed. The reporting rate is quite high with currently over 70% of the organizations who were trained and now providing M&E reports to ZAC. But over 90% of the reports are being received by ZAC from the implementers only after the deadline for reporting during the quarter has passed. This has in turn caused a delay in ZAC generating and disseminating the information products from the M&E system.
- ii. Data is being manually analyzed because the database is not yet operational. However, from January 2008 the database would be up and running and starts generating data.
- iii. Districts need a lot of supportive supervision before fully embracing their M&E roles. Despite many efforts previously made to build knowledge, skills and experience of district authorities in order to manage and coordinate HIV M&E and reporting activities at the sub national levels in the districts; the district staff still do not have enough capacity to fully implement their M&E functions without support of ZAC. Reports from some districts are at times delayed, unreliable and inaccurate therefore places an unforeseen burden on ZAC staff to continue supportive supervision of districts one year after the system was launched.
- iv. Publicity and dissemination of M&E information products is still low. This is the first year of generating and disseminating information products from the HIV M&E system. Currently ZAC does not disseminate the reports through mass media in Zanzibar. This is mainly because the team was waiting for the system to mature up to a stage whereby they can confidently conclude that reliable and accurate data has been provided by almost all the HIV implementers in the Isles. As time goes along this requirement will be achieved and the ZAC will go full blast in disseminating the M&E data and reports through mass media.
- v. A deliberate and conscious culture of using M&E data needs to be nurtured in Zanzibar. The only one major challenge that is now dogging the M&E system in Zanzibar is to change the culture and way of work of all stakeholders. Much as the stakeholders truly appreciate the M&E information products, they still need a conversion of mind frame so as to be able to consciously and deliberately use M&E data and information products for decision making, programme design, policy advocacy and formulation, and resource allocation.

Apart from the above mentioned challenges, other gaps include:-

- vi. The national HIV M&E system linkages with ZACP, HMIS, OCGS and MKUZA monitoring system in terms of data collection requirements, electronic exchange of data, indicator selection, and approval of information products have not yet been harmonized
- vii. There are not enough structured opportunities for different sectors to learn from each other and share information.
- viii. There are no mechanisms to build M&E capacity through an academic course, thereby making the profession of M&E official and a defined career choice and career path
- ix. All strategic information (surveys, surveillance and routine data) required in the national HIV operational framework are not being produced and captured in the national HIV database

- x. Zanzibar does not have sufficient data on MARPs, however, estimation of MARS is currently on-going by ZACP. Also in support of the same effort, Tanzania HIV Indicator Survey will be carried out during 2008 in Zanzibar and the outcome will also provide more information on MARS.
- xi. A national HIV research strategy is not yet developed, nor an accompanying research agenda. Such a strategy would provide a solid basis for planning and soliciting funds to undertake research

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## **ANNEXES**

The report writing process involved all the stakeholders i.e. the people living with HIV; the government; development partners, the UN Family; Faith Based Organizations (FBOs); the Civil Society Organizations and the private sector. The stakeholders were involved in the data collection process, analysis and report writing. A small team of people representing the government, CSOs, the Joint UN team, and academic institutions did the data collection, analysis and report writing process. The zero and first drafts of the report were circulated to all stakeholders for comments and inputs to fill the information and data gaps. After the incorporation of all the comments and inputs, a meeting with representatives from all the stakeholders was held to validate the report. All the comments raised at the validation meeting were incorporated into this final report for Zanzibar.

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## Names of Organizations Filling the Questionnaires

### PART A

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1	CHIEF MINISTER'S OFFICE
2	MINISTRY OF LABOUR, YOUTH & DEVELOPMENT OF WOMEN AND CHILDREN
3	MINISTRY OF FINANCE & ECONOMIC AFFAIRS
4	MINISTRY OF EDUCATION AND VOCATIONAL TRAINING
5	MINISTRY OF AGRICULTURE, LIVESTOCK AND ENVIRONMENT
6	MINISTRY OF REGIONAL ADMINISTRATION, LOCAL GOVERNMENT & SPECIAL DEPARTMENTS
7	MINISTRY OF WATER, CONSTRUCTION, ENERGY & LAND
8	MINISTRY OF INFORMATION, SPORTS AND CULTURE
9	ZANZIBAR AIDS COMMISSION (ZAC)
10	MINISTRY OF STATE CONSTITUTION & GOOD GOVERNANCE
11	MHSW - ZANZIBAR AIDS CONTROL PROGRAMME (ZACP)

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### PART B

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1	FYSABILILLAH TABLIKH MARKAZ ZANZIBAR – FBO
2	NUSRA ISLAMIC CENTRE – FBO
3	ZANZIBAR PRESS CLUB – NGO
4	ZANZIBAR ASSOCIATION OF INFORMATION AGAINST DRUG ABUSE AND ALCOHOL (ZAIADA) – NGO
5	AIDNET- NGO
6	ZANZIBAR ASSOCIATION OF PEOPLE LIVING WITH HIV/AIDS – ZAPHA+
7	ZANZIBAR ASSOCIATION FOR CHILDREN'S ADVANCEMENT – ZACA
8	NGO CLUSTER – NGO
9	ZANZIBAR WOMEN DEVELOPMENT ORGANISATION (ZAMWASO) – NGO
10	ZANZIBAR YOUTH, EDUCATION, ENVIRONMENT AND DEVELOPMENT SUPPORT ASSOCIATION (ZAYEDES) – NGO
11	ZANZIBAR ASSOCIATION AND FARMERS AND FISHERMEN ASSOCIATION (ZAFIDE) – NGO
12	WEDTF – NGO
13	UMOJA WA WAWAKILISHI WA KUPAMBA NA UKIMWI ZANZIBAR (UWAKUZA)- NGO
14	ZANZIBAR WOMEN DEVELOPMENT ORGANISATION (ZAWDO) - NGO
15	CATHOLIC CHURCH
16	AIDS BUSINESS COALITION OF ZANZIBAR – ABCZ

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