REVOLUTIONARY GOVERNMENT OF ZANZIBAR
ZANZIBAR AIDS COMISSION [ZAC]

Zanzibar National HIV/AIDS Strategic Plan

2003-2007

NOVEMBER 2003

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LIST OF ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Anti- Natal Care
AO	AIDS Orphans
ARV	Anti–Retroviral Therapy
CBO	Community Based Organization
CBD	Community Based Distributors
CCM	Chama Cha Mapinduzi
CRC	Convention on the Rights of Children
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CMO	Chief Minister's Office
CSO	Community Service Organisation
SW	Sex Worker
CUF	Civic United Front
DACCOM	District AIDS Coordinating Committee
FBO	Faith Based Organizations
FHHD	Female Headed Household
GDP	Gross Domestic Product
HAART	High Active Anti-Retroviral Therapy /Treatment
HIV	Human Immunodeficiency Virus
HBC	Home Based Care
HPC	Highly Prevalence Countries
IDU	Injecting Drug Users
IEC	Information, Education and Communication
ILO	International Labour Organization
KAP	Knowledge, Attitude and Practice
MCH	Mother and Child Health
MCHA	Mother and Child Health Assistant
MDG	Millennium Development Goals
MDM	Medicos Del Mundo
MEES	Moral Ethics and Environmental Studies
MTEF	Medium Term Expenditure Framework
MTP	Medium-Term Plan
MoECS	Ministry of Education, Culture and Sports
MoFEA	Ministry of Finance and Economic Affairs
MoHSW	Ministry of Health and Social Welfare
MoRASD	Ministry of Regional Administration and Special Departments
MoYEWCD	Ministry of Youth, Employment, Women and Children Development
Mo ANEC	Ministry of Agriculture, Natural Resources, Environment and Corporation
MSM	Men having Sex with Men
NGO	Non Governmental Organization
OPLD	Organisation of People Living With Disability
OVI	Objectively Verifiable Indicators
PER	Public Expenditure Review
PLHA	People Living with AIDS
PMTCT	Prevention of Mother To Child Transmission
RGoZ	Revolutionary Government of Zanzibar
SHACCOM	Shehia AIDS Coordinating Committee
SRH	Sexual Reproductive Health
STD	Sexual Transmitted Diseases
STI	Sexual Transmitted Infection
TAC	Technical AIDS Committee
TBA	Traditional Birth Attendants
TB	Tuberculosis

TH	Traditional Healer
ToT	Training of Trainers
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
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar AIDS Control Programme
ZANGOC	Zanzibar Non-Governmental Organization Cluster
ZAIADA	Zanzibar Against Aids infection and Drug Abuse
ZAPHA+	Zanzibar People Living with HIV/AIDS
ZNSP	Zanzibar National HIV/AIDS Strategic Plan
ZPRP	Zanzibar Poverty Reduction Plan

FOREWORD

Zanzibar, like many countries, is facing one of the greatest challenges: winning the fight against the HIV/AIDS pandemic. This pandemic has caused the loss of lives of many people especially young men and women at their most productive age. The pandemic has raised many challenges. The greatest challenge is that we must have plans and strategies to slow down and stop this pandemic. Since the first three cases were reported in Zanzibar in 1986, the HIV infection has spread throughout the islands of Unguja and Pemba affecting several thousands of people in all walks of life. Surveillance reports and surveys indicate that the number of those infected is increasing. With limited possibility of having effective cure or vaccine in the near future, the epidemic will continue to grow unless serious and effective measures are taken by all Zanzibaris.

HIV/AIDS is a major threat to the goals for sustaining development and reduction of poverty. It is for these reasons that the national leadership has impressed on all, including the Government, political, religious and civil leaders as well as non-governmental organisations to do all that is necessary to fight against the epidemic. The *Zanzibar National HIV/AIDS Strategic Plan* is intended to consolidate interventions that will prevent HIV infections and reduce the risk of vulnerability to HIV among the Zanzibar population. Those who are infected and affected will be assisted with measures that relieve the impact.

This Strategic Plan has been prepared to focus attention on what is known and what needs to be learned about scaling up the response to HIV/AIDS. The Strategic Plan should be used at all levels.

I want to thank all sections of Zanzibar Society and all institutions who contributed to the development of this Strategic Plan. I also want to thank the development partners particularly UNDP for contributing both financially and technically to the preparation of this document. Special mention needs to be made about the consultants who put this document together [F.S Chizimbi--team leader, I.A. Shamte, M.J.U. Dahoma, A.H. Sheha together with the strong support from M. Halima]

I wish to invite every person in Zanzibar to fully participate in the implementation of this Strategic Plan. With the kind assistance of development partners Zanzibar will slow down and stop the epidemic. Let us all play our part .

Zanzibar
November 2003

Name of Minister
Chief Minister

EXECUTIVE SUMMARY

Combating HIV/AIDS is one of the biggest challenges facing Zanzibar. Even with a low prevalence rate of 0.6%, Zanzibar is trying hard to establish better prevention, treatment and care interventions to control the epidemic.

For the past seventeen years, the focus of the national response has been on the key areas of, surveillance, voluntary counselling and testing, management of sexually transmitted infections, promotion of behavioural change, blood safety and care, including home based care.

The Zanzibar National Strategic Plan on HIV/AIDS is intended to address all issues that fuel the spread of the disease while at the same time underline strategic actions towards control and prevention of any further spread of HIV. The strategy spells out the basic approaches and principles, with clearly identified objectives and strategies for the period 2004–2009. It also contains an institutional /coordinating mechanism, financial mobilisation framework as well as a monitoring and evaluation system to be used during the implementation process. All this will help to provide strategic guidance to the planning of programmes, projects and interventions by various stakeholders.

The HIV epidemic is to a larger extent driven by heterosexual transmission. Young girls and women are especially vulnerable to HIV. The biological, cultural and economic vulnerability of girls and women in general, limit their position to defend themselves against male pressure. This weak position of women has sometimes forced them to resort to alternative survival strategies for themselves, their children and families.

Poverty has been acknowledged to be among the factors that force women to indulge in sex, and in most cases unsafe sex. Poverty is believed to limit the economic safety nets, to provide support to individuals, families and communities hard hit by the impact of the epidemic.

Currently it is difficult to establish the magnitude of the impact of HIV/AIDS in the various sectors of the society, economy, or on the overall development, due to its low level impact. Moreover, there is limited information on the dynamics of the epidemic although the current level of knowledge about the epidemic is better than at any time in the past.

The impact of the national response to the epidemic under MTPs in the last seventeen years has been markedly health oriented and spearheaded by the Ministry of Health through ZACP. The main noted constraints include structural and input factors, low implementation rate, and lack of adequate human and financial resources, inadequate capacity of the implementing agencies, insufficient coordination and limited development partner involvement, especially during the 1995 embargo period. However the experience gained in the past seventeen years will benefit the implementation of the Strategic Plan.

Lack of financial and human resources to implement responses to HIV/AIDS has remained the single most important obstacle throughout the MTPs. Nevertheless it is assumed that with the government commitment and more responses from development partners, the allocation and distribution of these resources will be made according to needs and demands of the planned

activities. Moreover the involvement of many different stakeholders at all levels during the development of the strategic plan will greatly improve resource mobilisation from other sources such as communities, the private sector and non-governmental organisations.

This Strategic Plan has initiated ***five thematic*** (prioritised areas), namely:

1. Prevention (especially to the vulnerable groups and general population)
2. Health {treatment, care and support, surveillance and research}
3. Strengthening the organisation and management of implementing institutions
4. Cross cutting issues
5. Way forward.

Each thematic area constitutes a number of objectives to be achieved. For each objective, a number of strategies have been structured with related activities as seen in the Action Plan. Although the Action Plan is a separate volume, it is very much an integral part of this document. It will be especially useful as a monitoring and evaluation tool.

CHAPTER ONE

1.0 BACKGROUND AND CONTEXT

1.1 Physical Features

As part of the United Republic of Tanzania, Zanzibar consists of two main islands of Unguja and Pemba, plus a number of smaller islands some of which are uninhabited. Unguja, with a land area of 1,665 square kilometres is the largest, and serves as the administrative and trade centre. Pemba Island covers a total of 980 square kilometres and is the second largest. The two islands are located in the Indian Ocean just 40 miles off the East Coast of Africa between Latitudes 5^0 and 7^0 South of the equator.

According to the 2002 Population and Housing Census, it was found that Zanzibar has a population of 984,625 with a growth rate of 3.1% and a population density of 400 people per square km. This population density makes the Islands to be among the most densely populated areas in Africa. About 31 percent of the population currently live in urban areas.

1.2 Economic and Social Features

Zanzibar economy is to a large extent dependent on agriculture. Agriculture (including livestock and fishing) shares an average of 38% of the GDP. Other main sector that shares high in the economy are trade (including tourism) with 25% of GDP; while administration and finance shares 24% in total. The average GDP growth has been ranging from 4.2 % to 5.6% between the years 1998–2002, with a per capita income averaging USD 200. Zanzibar is fairing well in the development of social infrastructure. Almost 90% of the population are leaving within a five-kilometre radius to a health centre; there is a primary school to every village and enrolment rate has now reached more than 90%. Nevertheless supplies to these infrastructures have been constrained by limited financial budget allocation. Some of the basic economic and social indicators are as shown in the table below.

Summary of Socio-demographic Indicators for Zanzibar

Population	984,625
Population Growth Rate	3.1% per annum
Urban population (percentage)	33.4
Rural population (percentage)	66.6
Female male ratio	105:95
Infant mortality rate per 1000	90
Under five mortality rate per 100,000	114
Maternal mortality rate per 100,000	377
Life expectancy	48 years
Per Capita income	US$250 (2002)

Source: Ministry of Finance and Economic Affairs, 2002

1.3 Political and Administrative System

Prior to the revolution of 1964, Zanzibar had been ruled by the Sultanate of Oman under the British Protectorate. In 1965, decree Number 11 was passed that dissolved all political parties and civil associations that existed prior to the revolution. Zanzibar was under one party rule until

1992 when the Political Parties Registration Act of 1992 provided a legal right to establish and register political parties based on amendments made under article 5 (1984) of Zanzibar constitution. This Act automatically ended the single party system that had existed since 1964. To date, 14 political parties have registered. The two main political parties [operating in Zanzibar] are Chama Cha Mapinduzi (CCM), the ruling party; and the Civic United Front (CUF) the main opposition party.

The first multiparty election under this Act was conducted in 1995 with CCM presidential candidate winning by a margin of 0.4% of the total votes. This fuelled disagreement from the main opposition party who did not acknowledge the results. This in turn placed Zanzibar under a political impasse, followed by donors' embargo that led the country into economic stagnation and social service deterioration. The next election was conducted in October 2000. To ease the tension, an inter-party political accord was formulated resulting in the successful by-election in May 2003 for Pemba constituencies.

The effect of the boycott from donors affected a number of developmental and social projects. Donor support to development programs and projects in Zanzibar covers 75% of the total development budget; hence the miss-inflows resulted in a shock to the society. HIV/AIDS is one of the programs that is donor dependent; hence the boycott greatly affected the implementation of MTP III and its good intended outcome.

Zanzibar, as part of the United Republic of Tanzania, has semi- autonomous powers of running the government with a legislative council (House of Representatives), a full Cabinet (Revolutionary Council) and a Judiciary system. The islands are divided into five regions, with ten districts, 50 constituencies and 254 shehias. The Shehia is the lowest recognized governmental administrative structure. In total there are 50 electoral constituencies each with elected councillor, member of the House of Representatives and a Member of Parliament.

1.4 Union Implications

The union between Tanganyika and Zanzibar in 1964 identified special areas as articles of union. The Articles of Union sets out administrative responsibilities assigned to the Revolutionary Government of Zanzibar and those that are attended to under the provision of the United Republic of Tanzania. The day-to-day management of Union matters are under the responsibility of the Vice President's Office.

Zanzibar benefits from donor support under special Union arrangement. In this arrangement, Zanzibar receives an agreed proportion of some financial assistance annually. The assistance covers recurrent as well as development funding in the country. With limited revenue sources, this support has periodically assisted Zanzibar in filling the financial resource gaps.

1.5 Vision 2020.

The Government of Zanzibar has opted for a long term development plan, the **Vision 2020** in order to finely adopt sound social and economic policies focussed towards the eradication of absolute poverty and the bridging of income gaps between various social groups, geographical zones and finally, to enhance individual capacity to attain essential needs of life.

Vision 2020 was officially launched in January 2000. It is clearly stated in the Vision that poverty eradication in both urban and rural areas means *increasing the ability of the people to afford their basic necessities, namely food, better shelter/housing, adequate and descent clothing, improving democracy and social security.*

Vision 2020 has considered the HIV/AIDS epidemic as an issue under the health sector goals and strategies, and not as a national and cross-cutting agenda developmental agenda. The health sector is required to provide special emphasis on the fight against the spread of HIV/AIDS through popular mass education programs that should lead people to change their unsafe sexual behaviours.

1.6 Zanzibar Poverty Reduction Plan (ZPRP) and HIV/AIDS

The Zanzibar Poverty Reduction Plan (ZPRP) is one of the important socio–economic development policies implemented to set Zanzibar a step towards addressing the concerns of the Vision 2020. The Poverty Reduction Plan was officially launched in May 2002. Amongst the most important strategic interventions are:

- The need to balance development between sectors; to improve the quality of sustainable growth; and the need to have a resource redistribution mechanism embodied in the policies and strategies in favour of the most vulnerable groups in the society;
- To address principles of inequalities, particularly between the islands of Pemba and Unguja;
- To create a favourable enabling environment for investment.

Based on these strategic areas, ZPRP aims at:

- Reducing income and non-income poverty;
- Improving human capabilities, survival and social well being;
- Containing extreme vulnerability, including various epidemics.

Nevertheless the Plan is being implemented under severe financial resource constraints. The pledges put forward by many development partners during the launching of the Plan have not been forthcoming. This situation has affected many of the activities outlined in the plan, including the HIV/AIDS programs proposed in it.

Zanzibar has joined other countries of the world in implementing a number of social and economic programs under the context of Millennium Development Goals (MDGs). Zanzibar is also working under these MDGs indicators concurrently with the ZPRP in order to synchronise how best the two directives could improve the socio- economic conditions of her people.

- Like the Vision 2020, ZPRP has considered HIV/AIDS mainly as a health issue even though it recognises the epidemic as a cross cutting issue, requiring intervention beyond the health sector. The plan recognizes the implication of HIV/AIDS on economic and social development, in terms of the inability of the labour force to effectively meet the demands of the society in the production sectors and social services; as well as in terms of reduction in family labour input, and other demands in the household care and

dependency. The Plan acknowledges that although HIV/AIDS prevalence in Zanzibar is low compared to many of our neighbouring countries, *precautionary measures need to be taken to ensure that HIV does not become entrenched.*

- Goal No 6 of the MDGs indicates the halting and reversing the trend in the spread of HIV infection by 2015. Through this Strategic Plan, Zanzibar is aiming to implement what it can do based on the three indicators stipulated in the convention, namely;
    a. HIV prevalence among 15-24 years old pregnant women,
    b. Condom use rate, and
    c. Number of children orphaned by HIV/AIDS

1.7 Methodology Used

The data collection for this phase of the work was undertaken from July to August of 2003. The report was finalized in September 2003. The Situation and Response Analysis team performed the following tasks:

1. Held discussions with the Technical Committee which was constituted to guide and supervise the assignment. This was done in order to clarify and have a common understanding and agreement on the terms of reference. The consulting team also agreed on a tentative schedule of work.
2. Undertook an extensive review of documents on studies, surveys, reviews, etc on Zanzibar, mainland Tanzania and some selected documents from Africa and other parts of the world.
3. Sourced several documents from the world-wide web (the internet).
4. Visited many organisations in both Unguja and Pemba Islands over a period of 14 days. A total of 66 institutions were visited and over 250 individuals were consulted. Only two appointments failed to materialise because one did not consent while the other was not on the Island. The institutions visited include those in the private and public sectors. Multilateral and bilateral agencies were also visited. Non-governmental organisations were also consulted. Information was gathered through interviews held with people ranging from one person to a group of fifteen people. Arrangements were made to ensure that all sectors at all levels of society were visited.

The respondents included people from a variety of backgrounds including professionals, the military, the disabled, women groups, young people/peer educators, politicians; NGO representatives, FBO representatives, members of the House of Representatives, and sex workers (SW[1]), drug abusers including IDUs and PLHA. All respondents contacted were willing and committed.

This first phase of the plan development process combined two phases of (i) the Situation Analysis and (ii) the Response Analysis. The study team was guided by the **technical committee** established by ZAC to oversee the preparation of the Situation and Response Analysis.

[1] Sex workers [SW] has been used to reflect people who exchange sex for monetary benefit [small or large] irrespective of condition and or set-ups as a component of the underground business.

CHAPTER TWO

2.0 SUMMARY OF SITUATION AND RESPONSE ANALYSIS

2.1 Situation Analysis

In order to better understand the HIV situation in Zanzibar, the Zanzibar AIDS Commission [ZAC] had to prepare a Situation and Response Analysis Report as the first step towards the preparation of the Strategic Plan. What came out from this report was a marked level of incidence and measures taken to combat the epidemic since 1986 when the first HIV case was identified. Some of the basic elements were as follows:

2.1.1 HIV/AIDS Epidemiological Situation in Zanzibar

2.1.1.1 HIV Rates in Zanzibar

The first three HIV/AIDS cases were diagnosed in 1986 at Mnazi Mmoja hospital. Since then, there has been a marked escalation of the reported numbers [cumulative from three in 1986 to 2500 by the end of 2002]. In 2002, the MOHSW with the support from the UN system conducted an HIV population based survey in both Unguja and Pemba. This study established the HIV prevalence in the general population at 0.6%. Women show infection rates that are four to six times higher than their male counterparts. It is estimated that more than 600 Zanzibaris have died of AIDS since the first case was identified in 1986. To date, 500 AIDS orphans have been registered by NGOs dealing with HIV/AIDS and around 6,000 adults and children are estimated to be living with HIV/AIDS.

2.1.1.2 Transmission routes

Sexual intercourse, especially the heterosexual form accounts for more than 90% of HIV transmission in Zanzibar. HIV transmission through body fluids and blood products in hospital settings is controlled/minimised through standard screening and sterilization procedures of invasive equipments. HIV transmission through piercing and other surgical invasive equipments accounts for the remaining proportions. Guidelines/directives to ensure aseptic techniques are now in use in all health facilities. Data from ZACP estimates that about 4% of HIV transmission is of vertical nature [mother to child transmission] inclusive of breast-feeding period.

2.1.1.3 HIV infection patterns in the general population

Available data on HIV infections shows that around 86% of the transmissions take place in people aged between 20-49 years, peaking up in the 35-39 years age category. ***Women in the age range of 15-29 years*** were observed to be infected at a higher rate compared to males in the same age group. The infection trends reveal a high female male ratio of 5:1 respectively. Annually, around 180 people are diagnosed to be HIV positive. Concurrently, results from the recently conducted population based survey [2002] revealed that women especially house servants [HIV prevalence 3.8%] and housewives [HIV prevalence 0.8%] to have been among the affected categories.

2.1.1.4 HIV infection trends among pregnant women

Regular annual monitoring of HIV infections trends using pregnant women as proxy indicator of the general population started from 1987. Sentinel sites representing both islands have been identified and the protocol for conducting HIV sentinel survey in pregnant women was reviewed and standardised in 1998. The general HIV trend in this population has been fluctuating from 3.8% in 1995 to 1% in 2002.

In June 2002, an exercise to validate the HIV prevalence and its generalisation to the public prevalence rates was done. This revealed that in Zanzibar ANC data could still be used as proxy to the general HIV transmission pattern in the whole population.

2.1.1.5 HIV infection among blood donors

HIV screening among blood donors revealed fluctuating HIV rates. The rates ranged from 0.7% in 1996 to 1.4% in 1999 being highest in 1998 [1.5%]. The HIV rates observed among blood donors in 2000 were 0.4%. However, the blood donor system in Zanzibar is that of replacement donor system whose donors are predominantly men.

2.1.1.6 HIV infection among TB patients

A survey to determine the magnitude of HIV among the TB patients was done in 2000. The study revealed the prevalence of HIV in this category to be 25.5%. The majority of those infected are in the age group of 25-29 years, with males accounting for 76% and in females 24%. Similar high HIV levels among this category were also documented in 1994[18.7%]; 1995 [17.7%] and in1996 [23.4%].

2.1.1.7 HIV infection among STD clinic attendees

The monitoring of STD clinic attendees is based on the fact that they have a higher risk of acquiring HIV especially if untreated. The majority of the attendees in these clinics are women. The major forms of STD syndromes reported in Zanzibar are genital discharge [78.3%]; pelvic inflammatory disease [10%] and genital ulcer [6.5%]. The majority of STDs are reported in urban and peri-urban areas or in towns namely Urban district-30.2%, South–17.6% and Chake Chake–23%].

2.1.1.8 HIV as a Burden of Disease in Zanzibar

The recently completed hospital based [cross sectional] study in November, 2002 on the HIV prevalence among the hospital admitted patients and other clients who attended seven main health care facilities in Zanzibar has revealed that 3.1% of under five children and 6.5% of clients aged 30-34 years to be HIV positive. Similarly, about 7.3% and 8.3% of admitted patients in medical and TB wards respectively were HIV positive. Furthermore, HIV virus was diagnosed in 4.6% of STD clinic attendees.

In general, irrespective of the nature of hospitalisation, 4.02% [42 out of the admitted 1,044 patients in various wards in Zanzibar] of hospital beds were being occupied and utilised by HIV infected patients [based on bed capacity per hospital].

With the current documented HIV prevalence of 4.02% in admitting clinics [apart from OPD and other clinics] at any given point in time in Zanzibar, around 33 beds in all major public hospitals are being utilised or occupied by HIV infected subjects. This situation has implications in the areas of cost, care and medicament requirements. If no effective interventions are timely introduced, and with the upsurge of HIV prevalence in the general population, the number of hospital beds occupied by HIV subjects will increase and be similar to those documented in the neighbouring countries e.g. bed occupancy rates for HIV related diseases is 30% in Kenya; over 50% of admitted patients at Rubaga hospital in Uganda [1994] and 50% in Muhimbili Hospital [1996] *–{reference UNAIDS, country by country 2000}.*

2.1.1.9 Factors fuelling the HIV epidemic in Zanzibar

The currently documented HIV/AIDS rates in Zanzibar have been a result of a multitude of determining [underlying] factors that assist the viability and the pathogenicity of Human Immunodeficiency Virus in aggravating the HIV pandemic. These determinants of the HIV epidemic include:

1. Biological determinants;
2. The level of Political [governmental] Commitment;
3. Socio-economic factors including rural urban migration, employment opportunities, level of poverty, proportion of female-headed households, food security;
4. 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;
5. 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 FHHD and perceiving that single women are a threat /promiscuous to the society; male macho promiscuous tendency, persistent remarrying tendencies [i.e. exposures to multiple partner]; 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;
6. Stigmatisation and Discrimination against PLHA and affected families;
7. Negative Effects of Globalisation and Media especially on the younger generation;
8. Religious Influences in HIV Transmission Dynamics *[please refer to the situation and response analysis document];*
9. Vulnerability of certain sub-groups to STD/HIV infection e.g. women, girls, young boys, migrant workers, sex workers, MSM, Population in very difficult circumstances such as prisoners [correctional facilities students] and people with disabilities especially the mentally handicapped women/girls and Substance Abuser especially IDUs.

2.1.2 Main issues /gaps identified in the Situation Analysis

The situation analysis has also acknowledged the following main issues that require immediate attention in mitigating the spread of HIV/AIDS in Zanzibar:

1. Absence of national HIV/AIDS policy document;
2. High political commitment with unequal reciprocation of internal financial commitment.
3. Absence of decentralisation policy/exercise;

4. Presence of non-functioning sectoral Technical AIDS Committees;
5. High level of denial, stigma and discrimination;
6. Risk behaviours are widely practiced in Zanzibar [unsafe sexual practices, multiple sexual relationships etc];
7. There is marked low risk perception among the general public;
8. Marked levels of gender imbalances;
9. Existence of multiple categories of vulnerable groups [including FHHD, mobile populations, SW, substance abusers]. All these **must be considered a priority** and targeted interventions must be developed if the transmission of HIV among these groups and to the general population is to be halted;
10. Young people were also found to be vulnerable to HIV infection. Special intervention must be developed if this future generation is to be protected;
11. Low active involvement of Faith Based Organisations;
12. Low or weak capacity [human, institutional mechanisms] in addressing the HIV/AIDS interventions;
13. Absence of a sound educational strategy that would protect the majority of young people [the future generation];
14. Low involvement of private and civil/community in the mitigation of HIV/AIDS;
15. Early sexual debut, early marriage and high divorce rate;
16. Attrition of cultural norms, values and traditions;
17. Emergence of sex tourism[2];

2.2 Response Analysis

Even though the Response Analysis was done concurrently with the Situation Analysis, the Response Analysis followed up issues that were identified in the Situation Analysis and those that were outlined in MTP III framework.

The Response Analysis clearly revealed that the nature of the national response to the epidemic had been weak. For example, although a number of ministries established focal point persons for HIV, these never really functioned. Some ministries, [for example MoHSW] that established Technical Committees for HIV/AIDS, did not fully implement the mandates given to those committees due to the concurrent existence of ZACP. The Special Task Force of Principal Secretaries on HIV/AIDS was not functional. Although the health sector was active in spearheading the HIV/AIDS interventions, it failed to develop an HIV/AIDS health sector policy. The health sector also failed to mainstream HIV/AIDS activities within that sector.

To compound this picture even more, the Ministry of Finance and Economic Affairs has never allocated funds to ministries for HIV/AIDS except for limited allocations to MoHSW in 2002 and 2003. The national response was further retarded by the development partner's embargo, which was placed on Zanzibar [from 1995]. This markedly affected the national response because the main instruments [particularly financial resources] for implementing the national response [MTP III] was mainly dependent on donor financing. Even the few activities that were implemented by MoHSW suffered from low capacity (human, financial, and material). Even

[2] Sex tourism is a newly emerging phenomenon accompanying the tourism sector whereby some of the tourists come specifically for sex exchange and exploration. Concurrently, the season is accompanied by a marked influx of sex workers from neighbouring countries

though there was an embargo, the UN agencies [WHO, UNDP, UNICEF and UNFPA] and few International NGOs [such as AFRICARE] continued to provide assistance for HIV/AIDS activities in Zanzibar.

Many non-governmental organisations were identified to be actively involved in responding to HIV/AIDS. Although some of them are doing a good work, their capacity is very low [human, infrastructure, resource mobilization and absorption] and coverage is mostly in urban areas.

Most of the responses to HIV/AIDS by the various stakeholders have concentrated on raising of awareness. It was found that over 95% of the population is aware of the epidemic. ***It is translating this awareness to behavioural change*** that remains a challenge. Achieving higher levels of behavioural change seem to be quite a challenge especially among vulnerable groups such as SWs, clients of SWs, IDUs and the youths. It was also found that the current institutional arrangements are not adequate to provide appropriate care and support to those infected and affected by HIV/AIDS.

It was also clear from the Situation and Response Analysis that women, house girls, PLHA, mobile populations, young people, people living in special circumstances, IDUs, SWs and their clients, were more vulnerable to HIV/AIDS. Several reasons were identified for this vulnerability. The report mentioned some of the challenges for providing supportive environments for these groups of people.

2.2.1 A *summary* of the main recommendations of the Response Analysis

The main recommendations from the response analysis are outlined below:

1. ZAC, in consultation with stakeholders, should as a matter of urgency plan for the formulation of the Multisectoral National HIV/AIDS Policy that will act as a guideline for sectoral HIV/AIDS policies.
2. In the course of the next revisions of **Vision 2020** and **ZPRP**; HIV/AIDS should be considered as a national development issue, and no longer as an issue only for the health sector.
3. Behavioural issues are an important component in the system of surveillance. The policy and the strategic plan on HIV/AIDS should incorporate the second-generation behavioural surveillance system.
4. In order to place HIV/AIDS on the national development agenda, there should be both financial (internal) and political commitment at all levels, from national level to the grass root.
5. Decision makers and other influential leaders should be educated and empowered in order to understand HIV/AIDS knowledge and behaviour changes as well as how to fight against the misconceptions behind the epidemic.
6. In order to effectively implement an HIV/AIDS strategy, externalities such as gender imbalance, globalisation, vulnerability etc at all levels of operation should be taken on board concurrently.
7. There is need to have in place, a proactive engendered response with clearly defined and sustainable strategies.
8. Immediate clear efforts should be taken to mainstream HIV/AIDS activities at national, sectoral as well as at district and community level.

9. Capacity building at all levels of operation should be given the highest priority.
10. Health sector infrastructure should be strengthened and improved; in order to effectively serve the purpose it is intended for.
11. MoECS should clearly outline the teaching guidelines, providing comprehensive, simple and effective curricula to be used in schools at all levels of education.
12. The on going decentralisation exercise should be completed and implemented in order to create a mechanism for effective HIV/AIDS operations at regional, district and shehia level.
13. Labour laws and employment regulations should be streamlined in order to derive effective HIV guidelines for proper implementation in consonance with the ILO Code of Practice on HIV/AIDS and the World of Work; and the SADC Code of Conduct on HIV/AIDS and Employment.
14. ZAC should effectively coordinate HIV/AIDS activities in all sectors of the economy,
15. ZAC as a coordinating arm of the government on issues of HIV/AIDS should design a mechanism that will make military and paramilitary alliances be among the potential stakeholders in the fight against the epidemic.
16. A well defined system of education and awareness should be put in place to make community understand their role in caring and support to infected and affected families,
17. NGOs should be empowered and educated in order to trickle down their assistance and knowledge to district and shehia levels.
18. ZAC should facilitate and collaborate with relevant institutions to establish National Multi-sectoral research institutions that will govern/oversee research execution which are ethically accepted and of high standard.
19. Faith Based Organisations, which occupy a central role in the lives of people, should be more involved in educating people to change their behaviour.
20. The role of businesses, the private sector, the informal sector and the Trade Unions should be enhanced.

2.3 Strengths, Weaknesses, Opportunities and Threats of the Current HIV/AIDS Response

The development of the Zanzibar Strategic Plan included several steps of analysis including an analysis of Strengths, Weakness, Opportunities and Threats [SWOT]. Below are a number of salient features of this analysis, in a matrix form that informs the strategic approaches and activities selected for sectoral responses.

PIORITY AREAS	STRENGTH	WEAKNESESS	OPPORTUNITIES	THREATS
Poverty reduction [through the implementation of ZPRP]	Outlined HIV/AIDS among priority areas for intervention. Coordinate all sectors of the economy. Strengthening social sector for poverty reduction Presence of strategy papers.	HIV/AIDS was narrowly featured in the plan with no clear targets. Low financial commitment by the government. Slow implementation pace of ZPRP. Sectors are not well synchronized. Mechanism for HIV/AIDS mainstreaming not clearly outlined	Involvement of ZAC in the ZPRP working group that is to effectively integrate HIV/AIDS issues. ZPRP review to accommodate HIV/AIDS targets.	High dependence on donor assistance.
Vulnerable groups **i) SW**	Currently under ZANGOC but recently facilitated by MDM. Attended various training on STIs. Prepared as peer educators.	Community does not accept SW. Existing laws and regulations marginalize SW.	Trained SW can be used as peer educators.	Highly discriminated and stigmatised
ii) Substance Abusers	Established public institution to deal with drug abuse	Lack of care and rehabilitation centres. Demand reduction not adequately addressed	Presence of NGOs providing information and education on drug abuse.	Continuing illegal importation of drugs.
iii) Mobile Population	Some are working in groups with defined leadership hierarchy.	No strategic intervention prepared for this group.	Organize in cluster of their business. Work with prominent persons in their business/cluster. Use their seasonal settlement for HIV/AIDS interventions.	Difficult to capture in one centre.

PIORITY AREAS	STRENGTH	WEAKNESESS	OPPORTUNITIES	THREATS
vi) People with disability	Legal presence of various disability associations Initiatives by NGOs to support people living with disability	Lack strategies to protect and develop this group. Absence of a national disability policy.	Existence of NGOs / institutions working with this category of vulnerable group.	Usually marginalized and discriminated.
vii) Workers and people under special circumstances [Military, police and special departments including prisoners]	Presence of special institutions concerned on the well being of this group. Some interventions started within special groups.	Some are not accessible to programmes Existence of some norms and regulations in some organisations, that delay marriage	Existence of plan for further interventions.	Negative criticism of safe sex. Levels of bias/ stigma and discrimination.
<u>Young people</u> **i) In school youths**	Presence of education structure that is able to collect/ meet with large population of young people.	Education system not adequately addressing HIV/AIDS issues in schools. Low availability of locally made curriculum, IEC materials. Low capacity and knowledge of teachers on HIV/AIDS	Education through school curriculum.	Leadership mind-set to change
ii) Out of school youths	Presence of some organized groups of peer educators Presence of family institutions and community organization.	Peer educators are not decentralized and not adequate. Lack of proper system to support young people when they complete their school. Weak families and community organization in taking their role of upbringing of youths.	Peer education through sports clubs and peer groups. Existence of vocational school training youths Existence of interventions and funding sources [e.g. Global funds] targeting young people.	Lack of capital for self-employment High levels of Unemployment. Cultural sensitivity on some aspects of HIV prevention

PIORITY AREAS	STRENGTH	WEAKNESESS	OPPORTUNITIES	THREATS
Gender	International conventions on gender are adopted. Sexual harassment act revised/updated. Presence of special ministry responsible for gender related issues.	Existing policy not good at addressing issues of men. Capacity constraints for various institutions on gender issues. Low involvement of men in SRH programme.	Presence of NGOs advocating gender issues Existence of gender sensitive action plan to implement women policy	Resistance by culture and religions to accept gender-advocating programmes. Willingness of men to change.
Treatment, Care and Support [health]				
i) Treatment	Existence of an organised institution (MoHSW) with vast experience Establishment of HBC Presence of trained and skilled personnel. Palliative care in place [manages OI]. HIV clinic established Established database. Basic monitoring tools in place Guidelines for clinical management of PLHAs in place.	Absence of HIV/AIDS health sector strategy. Routine screening not comprehensive. Limited access to drugs [e.g. ARVs] Unreliable/uncertain funding system and procedures. Weak/low quality assurance. Low human and other resource capacity at the periphery. System not decentralised Programmes functions vertically No defined coordination and collaboration mechanism with private sector No linkage with traditional healers	Presence of committed stakeholders. Evenly distribution of health care facilities that could assist HBC. Existence of a general health sector policy. Presence of District health management teams	Stigma and discrimination against PLHA Sustaining human resources pool Uncertain financial allocation. Presence of available/freely generic ARVs.

PIORITY AREAS	STRENGTH	WEAKNESESS	OPPORTUNITIES	THREATS
ii) Care	Existence of institutions dealing with care	Low capacities of institutions dealing with care and support Lack of policy/ guidelines Insufficient medical services.	Medical care available in public and private centres.	Some level of stigma & discrimination facing PLHA and AIDS orphans. Traditional and extended family systems for orphan support could be overloaded
iii). Support	Existence of institution providing support	Lack of policy/ guidelines No strategic/ planned system for supporting orphans/MVC.	Various NGOs willing to support AIDS orphan.	Some level of stigma & discrimination facing PLHA and AIDS orphans
Advocacy and Political commitment	Extensive use of media. Commitment of higher government leaders Regular airing of HIV/AIDS messages through presidential speeches. Establishment of ZAC. Presence of NGOs advocating HIV/AIDS.	Advocacy programmes are not well organized and coordinated. Absence of advocacy guidelines Some advocacy messages are culturally insensitive/ externally flavoured. Limited capacity of sectors and some ZAC staff Weak coordination at district and community levels.	Using the traditional and cultural beliefs in advocating HIV/AIDS. Willingness of leaders. CSOs and CBOs dealing with HIV/AIDS. Partnership with stakeholders and development partners. Media participation	Resistance to the negatively perceived advocacy messages by traditional, cultural and community. Absence/ delayed formulation of HIV/AIDS national policy. Low public risk perception. High level of denial. Inadequate allocation of internal resources

PIORITY AREAS	STRENGTH	WEAKNESESS	OPPORTUNITIES	THREATS
District and community Response.	Increased awareness of District HIV/AIDS interventions. NGO s initiatives at the District level.	Absence of decentralization policy. Low capacity (both financial and human) Absence of prioritised interventions at district level. Lack of district action plans on HIV/AIDS Poor Coordination of all actors including NGOs at the District level.	Encourage the establishment and use of the local HIV/AIDS committees Presence of DACOM in pilot Districts**.** Presence of other forms of HIV/AIDS initiatives at various levels in the district	Delayed and ineffective implementation of decentralization system. Uncertainty over sustainability of interventions at the district levels.
Resource Mobilization	Legal establishment of ZAC.	Limited budget line. No sectoral plans of activities on HIV/AIDS	MTEF to include HIV/AIDS activities Existence of Funding envelopes	Low absorption capacity**.** High dependency on donor assistance.
Coordination and Management	Establishment of ZAC. Presence of board of commissioners. Existence and experience of ZACP in the management of HIV/AIDS.	Lack of clear linkages with District and community levels. Lack of linkages with private and informal sectors Lack of an agreed management structure for ZAC	Existence of District and Shehia administrative structures Presence of NGOs and CBOs e.g. Inter-Faith based Forum, ZAPHA, ZANGOC	Placement of unskilled personnel in management coordination roles.

The SWOT analysis has identified most of the lessons learned from the past 17 years of MTPs as well as from the Situation and Response Analysis done earlier. At the same time, the analysis underlines what actions need to be taken in order to achieve the objectives that have been outlined in fulfilling the identified gaps. This HIV/AIDS Strategic Plan is designed on the basis of what actions need to be taken to control the spread of new infections from the identified vulnerable population groups to the entire population. Moreover, the strategic plan will ensure care and support to the infected and affected population groups.

CHAPTER THREE

3.0 ZANZIBAR NATIONAL HIV/AIDS STRATEGIC PLAN

3.1 Development of the Zanzibar National Strategic Plan (Process)

Zanzibar AIDS Commission and the Steering Committee that guided the Situation and Response Analysis mandated a group of five consultants to facilitate the formulation of the National HIV/AIDS Strategic Plan. For purposes of ensuring that all major stakeholders participate in the process, the team of consultants, with facilitation from ZAC, undertook consultations at national, sectoral, district, shehia and community levels as follows:

- All major sectors in the public sector.
- All major sectors in the private sector.
- The NGO community.
- International development partners.
- Several farming groups (seaweed and clove farmers).
- Several youth groups (urban and rural).
- Several women groups (urban and rural).
- Several political leaders (all levels).
- Several shehia level leaders.
- Several orphan groups, including those focusing on AIDS orphans.
- Several groups of people living with disability.
- Several religious groups.
- Groups of SW.
- Groups of substance/drug abusers.
- Groups of PLHA.
- Transport operators.
- Several groups of small business people (e.g. food vendors both men and women).
- Several groups of mobile populations (fishermen and petty traders).

In total, among these categories, the team held discussions with 1,150 people scattered all over Unguja and Pemba Islands. These various participants were subdivided in groups and led into focussed group discussions where the following key questions were the centre of discussions:

- ⌦ ***Identified the main risk/contributory factors fuelling up the epidemic***
- ⌦ ***What favours the existence of such factors?***
- ⌦ ***What are the existing gaps in the implementation of MTP III?***
- ⌦ ***What should be done?***
- ⌦ ***What is/are the priority areas of focus?***

These consultations focused on the priority areas identified in the Situation and Response Analysis Report. These priority areas were further consolidated through other consultations with the technical committee. The priority areas form the major themes of interventions in this Strategic Plan.

3.2 Rationale for Developing the Zanzibar National Strategic Plan

Zanzibar had been implementing a series of activities addressing HIV/AIDS under the popular Medium Term Plans since 1987. The latest plan was the MTP III, which was implemented from 1998 to the year 2002. In order to make a plan that is multi-sectoral and sustainable, the government has recognized the need to prepare a new Strategic Plan for 2003-2007 because of, among others, the following reasons:

- Zanzibar has committed herself to the Millennium Declaration and the Millennium Development Goals, which are spelled out in the declaration of commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS).
- Zanzibar has developed and launched the Poverty Reduction Strategy Plan, which has spelt out clearly the need for responses to the HIV/AIDS epidemic to be more multi-sectoral.
- There are newer challenges that are predisposing the population to HIV infection. The strategies that were put in place in the MTP III are outdated.
- Zanzibar has recommitted itself to implementing HIV/AIDS programmes by institutionalising the multi-sectoral approach through the establishment of the Zanzibar AIDS Commission.

It is for these reasons that the need to develop a new Strategic Plan was inevitable. The HIV/AIDS Strategic Plan would guide the translation of these commitments into reality and therefore help to shape efforts that should halt the spread of HIV in the islands.

It should be noted that the preparation of the Zanzibar National HIV/AIDS Strategic Plan has been ***highly involving and participatory*** and has evolved through the following stages:

⇒ Revisiting the gaps and recommendation of the situation and response analysis.
⇒ Information collection from various stakeholders.
⇒ Presenting the preliminary strategic plan framework [draft] to the technical committee for review.
⇒ Presentation of the updated draft at the stakeholders workshop for increased ownership.

3.3 Overview

The main objective of the Zanzibar National Strategic Plan is “to ensure that the HIV epidemic is contained through a multi-sectoral involvement of as many partners and actors as possible and also focus its attention to ***priority groups*** so as to reduce the impact of the epidemic and minimize the spread of HIV transmission to the general population”. As such the Vision, Mission, and overall objective are stated in the sections that follow.

3.3.1 Vision

To have a Zanzibar population which is free from the HIV/AIDS threat and which has a sense of caring and supporting all those citizens infected and affected by HIV/AIDS.

3.3.2 Mission

To provide coordination leadership to a national multi-sectoral response to HIV/AIDS, leading to the reduction of HIV infections and its consequential socio-economic impact as well as to the reduction of unfavourable socio-economic factors that fuel the epidemic.

3.3.3 The Overall Objective

The overall objective of this Strategic Plan is to reduce new HIV infections by 50% by 2007, and to provide treatment, care and support to People Living with HIV/AIDS and their affected families.

This main objective will be implemented through emphasis of strategies on prevention, access to treatment of STIs and treatment of opportunistic infections including the provision of anti-retroviral therapy. In addition, other forms of care and support in addressing HIV/AIDS impact on people infected and affected by HIV/AIDS as well as capacity [comprehensive] development will be provided.

The dynamics and nature of HIV/AIDS epidemic is such that there will be need to accurately monitor and evaluate closely the epidemic as it evolves. Concurrently, there is need to monitor the effectiveness of various interventions. The Strategic Plan includes strategies to accomplish this.

The Strategic plan has included strategies to ensure that there is commitment from government and all other sectors. Moreover, the Strategic Plan acknowledges the important role to be played by development partners including the UN agencies particularly in the implementation phase and to facilitate and promote coordination and support to various actors at all levels.

This Plan also aims at achieving more active involvement of districts, shehias and communities. The local authorities will also be more actively involved. The finalisation of Zanzibar National HIV/AIDS Strategic Plan [ZNSP] will form the basis /foundation for all sectors [public, private, NGOs etc] to develop their own sectoral plans. Although this strategy will remain in place for the five year period of 2003-2007, there will be need to review it periodically and update it as need arises. The Action Plan, which is the second volume of this strategic plan, will provide the means to review and update the plan.

3.4 Guiding Principles of the Zanzibar National HIV/AIDS Strategic Plan

The HIV/AIDS epidemic, by its nature is very complex. Several challenges have been identified and others will be uncovered in future. These challenges need to be addressed by all stakeholders because HIV/AIDS issues relate to socio-economic, good governance, legal, ethical, and human rights issues. In order to adequately address these issues, there is need for partnership and involvement of all relevant sectors. As such, many different organizations and agencies (public and private), individuals, including those directly affected by the epidemic, are essential to any attempts to mitigate the spread of HIV in Zanzibar.

It is for these reasons, that this Strategic Plan represents a shift in the development and execution of the National Response in Zanzibar. The leadership in Zanzibar recognize that they are at the crossroads. Based on the current prevalence rates [which are low compared to those documented in other sub-Saharan countries], it is possible to contain the epidemic as it is below 1%. However, if necessary actions are not taken to control the predisposing factors, Zanzibar could witness higher prevalence rates [once it reaches around 5% the increase tends to be exponential]. It is because of these reasons that Zanzibar wishes to put in place concerted, deliberate and well-targeted actions that will reduce new infections in all sections of the society.

In preparing this Strategic Plan, Zanzibar has taken into consideration several of the government's documents and instruments as well as international conventions and declarations which she is party to by virtue of being part of Tanzania. The conventions and documents, which have contributed and served as a guide to the preparation of this strategy include:

- UNGASS Declaration on HIV/AIDS agreed to in June 2001.
- Convention on the Elimination of all forms of Discrimination against Women.
- Convention on the Rights of Children.
- Education for All.
- Millennium development goals [MDG].
- Beijing platform.
- ILO Code of practice on HIV/AIDS in the World of Work.
- SADC Code of Conduct on HIV/AIDS and Employment.
- The Abudjah Declaration.
- The Constitution of Tanzania
- The Zanzibar Constitution
- Vision 2020
- The Zanzibar Poverty Reduction Strategy Plan.

The **guiding principles** that underpin this national strategy include the following:

1. A ***multi-sectoral approach and involvement***. The epidemic is complex and it affects all sections of society, individuals, families, institutions and social behaviour, and transcends far beyond the health sector, effective national responses must be multi-sectoral.

2. A multi-sectoral approach to planning, implementation, monitoring and evaluation.

3. As a sub-component of multi-sectoral approach and political commitment, ***Civil Society*** involvement is central to the response. There has to be meaningful participation of all segments of society if the response is to be adequate. In particular, such civil society groups as for example PLHA, need to be involved in policy and programme discussions and also in implementation.

4. The adverse effects of stigma and discrimination are increasingly recognised as barriers to combating the HIV epidemic. A commitment to ***reduce stigma and discrimination*** is a central guiding principle.

5. ***Creation of enabling environment*** is very critical for the expanded and scaled up response.
6. The ***Human Rights*** based approaches. Many international declarations refer to the absolute need to take strong human rights approaches for combating the HIV/AIDS epidemic. The main reasons for this are related to the fundamental rights to access to health care, information, and gender equity. Moreover, human rights approaches have powerful programmatic effects as they reduce vulnerability to HIV/AIDS.

7. It is well recognised that a key cornerstone in responding to HIV/AIDS is to adopt programmes that address all stages of the epidemic from ***prevention to care, support and treatment and impact mitigation.*** These are mutually reinforcing elements of an effective response. UNGASS emphasises "…that care, support and treatment can contribute to effective prevention through increased acceptance of voluntary and confidential counselling and testing by keeping PLHA and vulnerable groups in close contact with health care systems and facilitating their access to information, counselling and preventive supplies".

CHAPTER FOUR

4.0 PREVENTION OF HIV/AIDS TRANSMISSION AMONG THE VULNERABLE GROUPS AND THE GENERAL POPULATION

Currently, HIV/AIDS is concentrated in specific ***high-risk groups***. The prevalence in the general population is very low. The main thrust of the strategic plan is to concentrate efforts among the high-risk groups while implementing strategies that will prevent a generalised epidemic. The following sections outline the objectives and strategies that will limit a generalised epidemic by addressing issues identified in specific populations [vulnerable groups] and to the entire population. The chapter also deals with the issues of treatment care and support.

4.1 Prevention of HIV/AIDS Transmission among the Vulnerable Groups

This section outlines the rationale behind the vulnerability of each of the vulnerable groups, and the specific objectives and strategies needed to achieve the overall objective of reducing the new infection rate by 50%.

Vulnerability to HIV implies an increased likelihood of exposure to/ or infection with HIV and /or an increased likelihood of suffering from needless consequences of HIV infections and AIDS. Economic, cultural, religious, behavioural, political, demographic, biological and the nature of some occupations [that expose people to be far away from their families/sexual partners e.g. the mobile population such as the fishermen, clove pickers, mobile traders or people under special circumstances –the military, police, special departments and prisoners] can predispose and amplify the vulnerability of some population groups to casual sex [as was outlined in the Zanzibar Situation and Response Analysis]. The most important factor catalysing their vulnerability is the lack of access to appropriate information on STD/HIV/AIDS or on health services especially in areas of STD/HIV and even on accessing or affording the procurement of essential preventive tools such as condoms [male/female] and vaginal microbicides [as soon as they are on the market].

General objective on the vulnerable population

To increase access to care and positive sexual behavioural change targeting at reducing STD/HIV infections among the vulnerable population in Zanzibar.

Strategies

1. Develop special TOT programme for the vulnerable population.
2. Ensure access to comprehensive STD/VCT and preventive services inclusive of access to male/female condoms and vaginal microbicides.
3. Enhance and sustain HIV/AIDS peer education intervention programmes.
4. Organise/develop alternative income generating schemes.
5. Revisit/ update laws and regulations that mitigate substance and drug abuse/SW and HIV spread etc.
6. Produce and distribute appropriate IEC materials.
7. Conduct biological and behavioural surveillance among people serving under special circumstances.

8. Introduce dialogue platforms for experience sharing between the special departments and other institutions [public/CBO/ CSO] that deal with HIV/AIDS.

Special intervention groups

4.1.1 Workers and People Under Special Circumstances [military, police, special departments including prisoners]

Rationale

Vulnerability of people under special circumstances is practically based on the institutional governing laws/rules and regulations. The governing institutions have the right of transferring staff away from their families or sexual partners for long periods of time, and also set the minimum time for marriage [ranging from three to six years]. On the other hand, prisoners do not have access to sexual relationships with their normal/regular partners resulting in unprotected sexual relationship with fellow inmates while some, based on their young age, are coerced into sex [raped].

Objective

To increase STI knowledge [transmission, prevention and predisposing risks] among decision makers and people serving under special circumstances.

Strategies

1. Review guidelines/regulations of special departments that might fuel STI transmissions.
2. Advocate against the vulnerability of people serving under special circumstances to HIV infection by targeting the decision makers and the institutional staffs [including those in correction facilities].
3. Establish a sound education system on STD/HIV/AIDS for people serving under special circumstances [to enable them have power and means to act on the acquired knowledge].
4. Introduce peer education schemes among people serving under special circumstances.
5. Establish user-friendly STI clinics, VCT services and access to affordable preventive e supplies [such as condoms] for people under special conditions [including prisoners].
6. Introduce a sound STI policy framework that includes access to care and support to the affected people [PLHA] serving under special circumstances [including prisoners].
7. Conduct biological and behavioural surveillance among people serving under special circumstances.
8. Introduce dialogue platforms for experience sharing between the special departments and other institutions [public/CBO/ CSO] that deals with HIV/AIDS.

4.1.2 Sex Workers [SW] and their Clients

Sex working is operating in Zanzibar and it is increasing though not legalised and it is contrary to the cultural and social norms of the Zanzibar society. This results to stigmatisation and discrimination of SW by the general public, hence, minimises the potentiality of SW to freely access appropriate SRH/STI information and care. Furthermore, economic and social constraints aggravate the vulnerability of SW to STIs. Fluctuating condom use behaviour between SW and their clients [as the latter determine whether or not to use a condom], increases the risk of this group to acquire STI. The young age [below 16 years] of some SW, group sex, men having sex

with men (MSM), marked substance abuse and the reported sex tourism, which is on the rise, are among the additional driving forces that increase the vulnerability of this group to STIs.

Objective

To increase knowledge on prevention and promote positive sexual behavioural change in mitigating STI infections among Sex Workers and their clients.

Strategies

1. Strengthen capacity of SW in areas of sex negotiations skills, peer education and condom use.
2. Introduce alternative income generating schemes for SW.
3. Develop an integrated VCT/STD services incorporating harm reduction based education.
4. Strengthen existing laws and regulations that increase cultural/moral adherence and discourages sex working [for both males and females SW].
5. Introduce surveillance [behavioural] mechanism on SW and their clients together with establishing an interventions database.
6. Conduct periodic qualitative and quantitative research on SW and their clients on behavioural determinants.

4.1.3 Substance Abusers

Rationale

The magnitude of substance abuse in Zanzibar has been increasing with time. This has affected mostly the young generation. All forms of substance abuse are accessible in Zanzibar. Recent trends show that the prevalence of IDUs has been increasing. Needle sharing between IDUs is a common phenomenon as well as periodic unprotected penetrative sex. With such risks in place, the need to mitigate both demand and harm reductions becomes inevitable.

Objective

To introduce capacity building schemes to substance abusers on knowledge and prevention of harmful consequences of Substance abuse on the transmission of STD/HIV with special focus to IDUs.

Strategies

1. Introduce comprehensive rehabilitation centres with vocational training schemes for substance abusers.
2. Strengthen existing laws and regulations /policy framework for the implementation and scaling up of harm reduction, demand reduction and enforcing the laws against the illicit importation [infiltration] of drugs.
3. Scale up peer-education training and programming using ex-drug addicts as TOT/facilitators.
4. Increase HIV/AIDS education message for substance abusers
5. Develop an integrated VCT/STD services incorporating harm reduction based education.
6. Produce behavioural change packages [with IEC materials] targeting substance abusers and the general public.
7. Increase capacity of CSOs and CBOs that mitigate harm and demand reduction.

8. Establish monitoring and behavioural surveillance systems that will strengthen the referral caring systems for substance abusers focusing on pregnant IDUs.
9. Conduct periodic qualitative and quantitative research on substance abusers on STI.
10. Educate and promote community [positive] perceptions towards substance abusers and introduce community supportive schemes that discourage substance use.
11. Strengthen capacity of governmental institutions involved in the control of substance abuse on issues related to HIV/AIDS.

4.1.4 Mobile Traders

Rationale

There are various kinds and forms of mobile traders in Zanzibar. Some travel outside Tanzania while others trade between Tanzania mainland and Zanzibar. There are also mobile traders within Zanzibar who trade both in rural and urban settings.

A number of internal mobile traders have relatively substantial amount of money and thus, have the potential of either buying sex from women or somehow coerce/seduce or influence them into unsafe sex. This is commonly so particularly with women who live under difficult and desperate financial circumstances or those under uncertain food security. Generally, this category of the population is very sexually active. Results from the validation survey have revealed that 2.3% of traders to be HIV infected [positive] while 15.6% of them had been involved in sex with non-regular partner with more than 75% of them having had unprotected sexual encounters.

Women who sell food in public places on rental basis are sometimes coerced [indirectly] into sexual relationships with officers responsible for such places in order to ensure that they have guaranteed access to these limited spaces. There are also regular male customers who have sex with female traders. Such behaviours increase the possibility of contracting HIV infections.

Objectives

To reduce the risk of acquiring new STD/HIV infections among mobile traders.

Strategies

1. Introduce behavioural communication programme to mobile traders.
2. Organize training of trainers/peer educator's among the women traders at their working places.
3. Establish a clear policy and guidelines with a transparent system for allocating spaces for business.
4. Conduct second-generation behavioural surveillance.
5. Strengthen access to condom and STD/VCT services.
6. Promote early STD treatment seeking behaviour.

4.1.5 Clove Pickers and social events/gatherings[e.g. Uhuru torch rally, Mwaka Kogwa]

Rationale

Cloves remain the major cash crop in Zanzibar. Clove picking is an activity that involves a number of people camping together for a period of three to four months in a year, and in most cases twice a year. People from different areas of Tanzania, with different backgrounds and

attitudes gather together in various areas of Pemba and Unguja for clove picking. The pickers are usually young men, women [married/divorced/ widowed etc] of various ages. For those married, they leave behind their families, and go for camping at clove plantation areas. In most cases the families left behind by the husbands are provided with limited financial inputs to support them for the entire period, sometimes lasting between two to three months. Such predisposing environment creates a precedence of sexual exposures driven either by food /domestic needs or by male influences, resulting in penetrative casual sex, the majority of which is unprotected.

Women are also involved in picking, but the majority of them join the camps for the purpose of providing supportive services such as food vending. There is potential for men and women in camps to indulge themselves in casual sex. With the current level of *low risk perception*, tendencies of unprotected sex with multiple partners, the risk of being infected is high among these mobile populations. During the picking season, clove pickers accumulate a good amount of money some of which may be used to buy sex in camping areas and elsewhere.

On the other hand, there are certain annual festivals and events that necessitate gathering of people with various backgrounds and sexual behaviours. These include events such as Uhuru torch rally, Mwaka Kogwa etc. and are carried out day and night. The climaxes of most of these events occur at night and are commonly accompanied by rampant sexual mingling/interactions. Gatherings such as these are among the underlying predisposing conditions to unprotected sex.

Objective
To reduce the infection rate of STIs that may result from unsafe sex among clove pickers and other camping populations and their immediate families.
Strategies

1. Develop media behavioural communication change and advocacy campaigns before and during special events and gatherings such as clove picking seasons, Uhuru torch, Mwaka Kogwa etc.
2. Conduct periodic outreach HIV/AIDS education campaigns through various field actors and educators namely agricultural extension workers, SHACCOMS members etc.
3. Promote access to condoms through SHACCOMs and Community Based distribution mechanisms.

4.1.6 People with Disabilities

Rationale
Persons living with disability of any nature are featured among the vulnerable groups because of their inability to undertake certain activities on their own. They are vulnerable to harassment or sexual abuse because they are unable to negotiate sex. This increases their vulnerability to sexual transmitted infections. People under such circumstances could easily be sexually harassed, resulting into unwanted pregnancies, sexual transmitted diseases, as well as physical and psychological trauma. These people need to be protected in order to minimize the infection, as well as empower and assist them to manage their sexual lives properly.

Objective
To minimize new STD/HIV/ infection among people living with various disabilities in the society.

Strategies

1. Organise TOT on HIV/AIDS transmission and prevention to people living with disabilities;
2. Reinforcing the laws that protect the rights, interest and well-being of the disabled people against sexual harassment.
3. Build capacity of NGOs and other health care providers on special skills to provide VCT services to this population.
4. Develop specific TV and Radio programs to improve STD/HIV/AIDS knowledge for people with disability.
5. Introduce sexual negotiation skills/ programme [where possible] to people living with various disabilities.
6. Integrate HIV/AIDS in community based rehabilitation [CBR] activities.

4.1.7 Fishermen

Rationale

Fishing is a major activity for people living along the costal areas of Zanzibar islands. Men are usually engaged in fishing throughout the year. In order to make business more profitable, some fishermen leave their homes, move along the costal areas of East African region, camping and fishing for prolonged periods of time. Their fishing expeditions sometimes take them for more than three months, leaving their families and children at their homes. It is common for fishermen to involve themselves in casual and unprotected sexual affairs with women around the villages in which they camp. Many of the women left behind by their husbands, are faced with economic hardships, increasing the possibility of these women/spouses indulging in casual sex and thus predisposing them to STD/HIV infections.

Objective

To increase knowledge on the prevention of STI infections to fishermen and their families at homes.

Strategies

1. Organize peer education on training of trainers (ToT) on HIV transmission, prevention and household food and financial security of fishermen dependants.
2. Monitor BCC among the fishermen.
3. Promote safer sex practices among the fishing communities.
4. Conduct behavioural surveillance among people engaged in camping type of fishing.

4.1.8 Passengers transportation services

Rationale

The passenger transportation service is the biggest sector in Zanzibar that brings people/ mobile population in contact/together regularly. Passengers from one place to another use various means of transportation. The common modes of transport include Daladala, rural transport, boats, ships and air. The Daladala is the most common mode of internal transport.

Ships and boats have their regular visits to and from Tanzania mainland and Unguja/Pemba including night trips. The persistent contact between drivers, their assistants, and passengers is regarded as an important exposure to sexual relations and eventually predisposing them to STIs.

The population based validation study [2002] has revealed that 16.7% of drivers have been exposed to sex with non-regular partners. The majority of these sex encounters were unprotected.

Substance abuse has also been observed among Daladala workers ("*Wapiga debe*"). This acts, as a predisposing factor for HIV/AIDS infection. It is therefore important to put in place specific strategies for interventions targeting both the owners of Daladalas, employees and passengers.

Objective
Increase STI awareness and knowledge and promote the development of workplace interventions against HIV/AIDS.

Strategies
1. Design special education programme on HIV/AIDS for Daladala owners and operators.
2. Ensure legal environment on protection of workers and their rights based on ILO recommendations.
3. Promote HIV/AIDS campaigns on Daladala commuters by using various IEC materials (through posters, stickers and spot announcement on cassettes or speakers.)
4. Conduct behavioural surveillance for drivers and their assistants/conductors.
5. Promote safe sex practices (including access to quality condoms).

4.1.9 Out of School Youths

Rationale
The current education schemes enables most youths [14-24 years] to complete form two of their basic education early in their life. Unfortunately, the education system does not fully equip the youths on issues related to the transmission of STD/HIV or employment opportunities. Similarly, the existing cultural norms inhibit parents from discussing sexual matters/STI with their children. The majority of youth in this age group are unemployed. The source of their SRH/STI knowledge is from their peers whose SRH/STI knowledge is full of misconceptions. Also, the group has limited access to STD clinics or prevention services such as condoms. Such factors, together with the fact that the majority of the young people are idle because of unemployment, predisposes the group to a multitude of risky behaviours [sexual or substance abuse-IDUs] resulting in STI/HIV infections.

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

Strategies
1. Scale up vocational training, income generating programmes and employment opportunities for out of school youths.
2. Promote safe sexual norms and positive sexual behaviour among young people including the options of abstinence and delayed sexual activities, faithful partnership [marriage] and condom use.
3. Empower youths, especially young women, on decision making regarding their sexual reproductive lives through life skills approaches.
4. Protect out of school youths against substance abuse [primary prevention].

5. Promote family dialogues and cohesiveness in addressing STD/HIV and the risks facing young people in the communities.
6. Develop and implement programmes with full participation of young people in order to support young people's development and healthy life styles.
7. Promote culturally sensitive life skills education for youths, especially girls, so as to enhance their confidence, negotiation skills and decision-making.
8. Promote youth partnership in conceptualising, planning, implementing and monitoring of Youth Programmes
9. Educate the community on the importance of young people accessing appropriate STD/HIV/AIDS information in mitigating STI.
10. Strengthen the capacity of public and non-public institutions that provide services for young people in ways sensitive to their needs, particularly in areas of counselling, reproductive health and STD treatment, condoms etc.
11. Conduct second-generation surveillance in out of school youth.[This component is clearly outlined in the Global Fund Support]
12. Conduct qualitative and quantitative gender sensitive researches that can assist in designing SRH/STI interventions for young people.

4.1.10 Married Women and House Girls

Rationale

Women of all ages form the majority of the population. They are highly involved in many of the day-to-day social and economic activities including caring for the sick [PLHA] in the family. The majority of persons, who work as house attendants/servants, are teenage girls who are mostly sexually naive. There are numerous reports that indicate that these girls are being harassed by their male employers or elder male children within the households. Some are unable to refuse sex due to favours/gestures shown by their male employers resulting in long term multiple unprotected partner sexual relationships due to fear of being sacked from work [job insecurity]. Sexual exposures such as these increase the likelihood of contracting STD/HIV infections. The recently finalised population based validation survey [2002] has revealed that 0.8% and 3.8% of married women and house girls respectively to be HIV infected. Furthermore, the study also revealed that 3.6% and 9.1% of women and house girls respectively have been involved in sex with non-regular partners. The greater proportion of these non-regular sexual encounters did not involve the use of condom.

Objective

To increase capacity on STD/HIV/AIDS knowledge and sexual negotiation skills among women and house girls.

Strategies

1. Promote safe sexual norms and positive sexual behaviour among women and girls either through delayed sexual activities, or proper condom use.
2. Empower women, especially girls, on decision-making regarding their sexual behaviour.
3. Educate employers and husbands on protection of their spouses and house girls.
4. Scale up HIV/AIDS interventions in trade unions involved in protecting house girls and hotel workers.
5. Enforce the legal Act on harassment and abuse.

6. Develop behavioural change communication interventions involving and focussing on men.

4.2 HIV/AIDS Prevention in the General Population and at Work Places

4.2.1 Mainstreaming Gender and HIV/AIDS

Rationale

Zanzibar is predominantly a patriarchal society. The gender roles and expectations that have been culturally and socially accepted, and the gender power relations existing in the society, put Zanzibar women in a subordinate position vis a vis that of men. This situation is witnessed in both private and public spheres that women find themselves in their daily lives.

In the private sphere, the existing gender power relations affect women's autonomy in negotiating safer sex. In many cases women do not have power to make decisions on matters related to sexual relations. The dominant ideology of femininity and masculinity encourage men to seek multiple sexual partners and expect women to be submissive. Many times, men are having unsafe sex, as they are unwilling to use condoms. These situations multiply the risk of women as well as men themselves in contracting HIV infections. Moreover, sexual abuse and harassment [including gender based violence], which is on the increase in Zanzibar society, can add to the factors that speed up the infection rate among women.

On the other hand, unequal access and control on economic resources, limited economic opportunities for women and low income have increased the proportion of women who depend on men for their routine support and living. This is further compounded by the high levels of illiteracy rate and divorce rates [FHHD] which increase women vulnerability to STD/HIV/AIDS transmission. The absence of support to children maintenance aggravate women position and hence are among the factors that predispose women to engage in risk related sexual activities that result in higher HIV/AIDS infection rates compared to their male counterparts.

Objective

To address HIV/AIDS in a gender sensitive and responsive manner for the prevention of new infections among men and women.

Strategies

1. Improve economic and social status of women to reduce their vulnerability to HIV/AIDS.
2. Advocate for legal and policy frameworks that enhance gender equality to social and economic opportunities and amend laws and policies that discriminate women.
3. Enhance implementation of International Conventions such as CEDAW, Beijing and Dakar Platforms of Actions.
4. Review economic and social policies that hamper men and women's efforts towards poverty reduction.
5. Design a public education campaign to discourage cultural practices and gender stereotypes, at all national levels that increase men and women vulnerability.
6. Build the capacity of implementing agencies, including NGOs and religious leaders on gender dimensions and gender mainstreaming in HIV/AIDS interventions.
7. Ensure that national and sectoral HIV/AIDS Plans are gender sensitive and responsive.

8. Encourage active involvement and participation of men and women in the fight against STI/HIV/AIDS interventions.
9. Empower men and women to protect themselves from STI/HIV infections, including ensuring access to condoms.
10. Discourage violence against women; divorces among couples; and promote cultural and religious values that strengthen marriages. [This will be accomplished through family life education /marital counselling etc.]
11. Strengthen Policy and legal issues concerning the sexual rights of women, girls and boys
12. Build strong networking and identify mechanism for collaboration with other partners, NGOs, CBOs and FBOs.
13. Design gender sensitive indicators, and collect gender disaggregated data in relation to HIV/AIDS.
14. Allocate adequate resources for research and analysis on gender and STD/HIV/AIDS.

4.2.2 Protection of Children

Rationale

Mother to Child Transmission is documented as the main route for HIV transmission among children. However, if not well addressed, child sexual abuse that has been happening for years, mistreatment of children, and other forms of harassment are among the risk factors that fuel the epidemic on the part of children, both girls and boys. Most of the children who are sexually abused are mistreated in their early ages when they are unable to negotiate for safer sex. This factor not only affects the future lives of children but also increase their vulnerability.

Furthermore, early marriages and early sexual debut affect more girls than boys. This is due to the fact that usually girls are married off to men or have sex with men who are older than them and who already have had several sexual contacts before. There are also cases of girls who engage themselves in commercial sexual activities. This situation increases the chances for girls to be infected. In addition, there is a growing trend of child labour through which, in some cases, children become involved with groups of various backgrounds and behaviours resulting into earlier predisposition to sexual activities.

Objective

Reduce STI transmissions among children by protecting them from sexual abuse and early sexual contacts

Strategies

1. Reinforce the laws that protect the rights, interests and well being of children.
2. Develop awareness on child sexual abuse in families, communities and schools.
3. Enhance effective implementation of the child Protection and Development Policy, Convention on the Right of the Child (CRC), and African Charter on the Rights and Welfare of the Child.
4. Eliminate the worst forms of child labour from shehia to national level.
5. Educate parents and religious leaders on the adverse consequences of early marriages.
6. Encourage parents, pre schoolteachers, Madrasa, NGOs, FBOs to provide necessary information to children on sexual abuse and help them to avoid being abused.

7. Revive community responsibility of protecting children in their respective areas and re introduce communal upbringing of children.
8. Create conducive environment including parent's support for girls to complete their basic education and pursue higher learning and professional skills to support themselves.
9. Educate children, especially girls on negative consequences of engaging in early sex.
10. Strengthen collaboration with institutions dealing with children's well being and interests.

4.2.3 *Education Sector*

Rationale

The education sector is at the centre of one of the great challenges facing humanity because in winning the fight against HIV/AIDS, education furnishes the tools with which children and young people carve out their lives. In addition, education has a life sustaining power in the fight against AIDS, especially in HIV prevention, and in reducing both the risk of HIV infection and people's vulnerability to HIV.

The issues of HIV/AIDS need to be addressed by everyone: teachers, education administrators, school children, young people out of school, adult learners, and community leaders living in a world with AIDS.

HIV/AIDS also poses major threats to the broader goals for sustaining development and eliminating poverty set during the Millennium Summit, including those relating to universal access to primary education and to gender equality. Together with other sectors, education has a key role to play in ensuring that these goals, along with those set during the year 2001 United Nations General Assembly Special Session on HIV/AIDS, are met.

The UNGASS Declaration of Commitment 1 on HIV/AIDS sets the target of reducing HIV infection among 15-24 year-olds by 25 per cent in the most affected countries by 2005 and, globally, by 2010. It also calls upon governments to develop by 2003, and implement by 2005, national strategies to provide a supportive environment for orphans and children infected and affected by HIV/AIDS. It calls for vastly expanded access to the information and education, including youth-specific HIV/AIDS education, necessary to develop the life skills required to reduce risk and vulnerability to HIV infection.

Among its many provisions, the Dakar Framework for Action 2, adopted by the international education community during the World Education Forum (Dakar, Senegal), draws attention to the urgent need to combat HIV/AIDS if 'Education for All' (EFA) goals are to be achieved. It calls on governments to ensure that by 2015 all children, particularly girls, children in difficult circumstances and ethnic minorities, have access to and complete, free and compulsory primary education of good quality. Such a target is seriously threatened by the HIV/AIDS epidemic and its impact on the demand for, and supply of, education. Moreover, ensuring universal basic education will be one of the most powerful weapons in the fight to contain HIV/AIDS. Thus, all concerned have a responsibility to ensure that National EFA Plans of Action are prepared taking HIV/AIDS into account.

EFA goals and the Millennium Development Goal for Education 3 cannot be achieved without urgent attention to HIV/AIDS. UNGASS targets and the Millennium Development Goal for HIV/AIDS, Malaria and other diseases cannot be achieved without the active contribution of the education sector. In addition, there is need to utilise educational structures and institutions where the majority of adolescents and young people can be easily reached. Through the in-school youths and adolescents can acquire the right and accurate information on STD/HIV/AIDS and with emphasis on traditional/cultural and traditional values that are protective in mitigating the spread of HIV/AIDS.

Above all, children and young people have the right to knowledge and understanding, and therefore access to the full range of information and resources, including preventive measures, that will allow them to protect themselves and each other against infection. They need support in making behavioural choices that will ensure protection against HIV infection. Education ministries have a clear responsibility for ensuring that the right to know, and support for behavioural choices, are understood and brought about.

Objective: To prevent HIV infection through advocacy at all levels of education.

Strategies

In order to mitigate the impact of HIV/AIDS on the education sector, there is need for concerted action by the education systems to provide leadership in working together with the economic, health, agricultural, labour and social development sectors to alleviate the social and economic impact of the disease.

The following are the strategies to be implemented:

1. Undertake a Situation Analysis and prepare an HIV/AIDS Strategy for the sector.
2. Ensure that HIV/AIDS is addressed across the whole education sector; and incorporated as an important issue within the school curriculum.
3. Ensure that teachers are well prepared and supported in their teaching on HIV/AIDS through pre-service and in-service education and training;
4. Develop a cultural sensitive and scientifically-accurate, good-quality teaching and learning materials on HIV/AIDS communication and life skills;
5. Promote life skills and peer education with participation of children and young people, and among parents and teachers themselves;
6. Eliminate stigma and discrimination, with a view to respecting human rights and encouraging greater openness concerning the epidemic;
7. Support for school health programmes that addresses HIV/AIDS including health clubs
8. Mobilise resources and build capacity to facilitate the attainment of EFA goals.
9. Build strong networking and collaboration with other related institutions.
10. Educate the community /parents on the importance of HIV/AIDS education in schools.
11. Develop an advocacy position paper for MOECS on HIV/AIDS.
12. Promote policies and practices that favour access, gender equity, school attendance and effective learning.
13. Provide or facilitate understanding of the nature of the infection and how it is transmitted is the precondition for changing behaviours that facilitate transmission.
14. Provide knowledge on what behaviours to avoid, such as not engaging in unprotected sex and needle sharing among students

4.2.4 Agriculture

Rationale

Agriculture is a major sector in the economy of Zanzibar, employing more than 60% of the population most of them in rural areas. Farming, fishing and dairy keeping is practiced mostly by the older generation leaving youths and school leavers migrating into towns looking for employment in the public as well as in the private sector.

Women, especially female headed, widowed and elders are the majority of farmers in rural subsistence farming. They are short of money, inadequate farm inputs and do not have access to credit facilities. What they earn from farming is so minimal that it is not enough to sustain them even in one season. The absence of reliable household food security and prices for their cash and food crops predisposes some of the peasants and animal keepers into other income generating activities. Some of the farmers indicated [during the consultations] that they indulge themselves in extramarital sexual relationships in order to supplement their little incomes. Such practices could result into sexually transmitted infections such as HIV and other STDs.

In order to save this section of the poor population from these infections, awareness and education is needed, in order to change their behaviour and divert them to those practices that are lawful, safer and beneficial.

Objective

To prevent new HIV infections to farmers/peasants in rural communities.

Strategies

1. Mainstream HIV/AIDS in the policies, strategies and activities of the agricultural sector and related institutions.
2. Integrate HIV/AIDS programmes in the training curricula [agricultural school] for extension workers.
3. Training of peer educators on mitigating STD/HIV infections.
4. Develop periodic outreach STD/HIV education campaigns to the rural community by involving agricultural extension workers and SHACCOMS.

4.2.5 Promotion of Traditional, Culture and Religious Values

4.2.5.1 Faith Based Organizations (FBOs)

Rationale

Faith based organizations in Zanzibar can play a very important role in advocating and educating the community on HIV/AIDS. It is a fact that almost every person in the isles belongs to a religious domination; as such they are linked to some faith-based organizations in some way.

Religion has great influence on the human behaviour, there is a great potential for the faith based organizations to reshape individual behaviour and that of the community at large and hence they can be used as a very important institution in fighting HIV/AIDS in Zanzibar. The potential of religious classes are of paramount importance in mitigating HIV transmission.

Religious leaders are among the respected leaders of the community who influence people's way of life. The religious organizations have a big number of followers scattered everywhere up to the village level.

In the Islam religion, Muslims have an advantage of regular mass prayer five times a day. Likewise, in other religions mass congregation and prayers are common and obligatory phenomena. If HIV/AIDS messages could effectively be delivered during these prayer meetings, or other similar gatherings increases the potential of education messages to reach the majority of the population with least cost involvement.

Objective
To increase HIV/AIDS advocacy and effective campaign by FBOs in mitigating HIV/AIDS transmission to the entire community.

Strategies

1. Introduce comprehensive marriage life education prior wedlock and after marriage.
2. Reorganize faith based institutions at the grass root level to be able to work with them effectively.
3. Develop capacity of FBOs to advocate and mitigate STD/HIV transmission
4. Expand the intervention of faith-based organization in HIV/AIDS issues.
5. Promote abstinence from sexual contacts out side marriage and encourage being faithful to the legal partners.
6. Increase effective uses/utilization of religious classes and other religious gathering.
7. Set up religious administrative structure to strengthen FBO commitments on implementing intervention plans at all levels
8. Incorporate HIV/AIDS intervention in all religious gathering and issues.
9. Strengthen the Interfaith Committee on HIV/AIDS.

4.2.5.2 Culture

Rationale
The culture of a society includes all behaviours learnt through socialization, norms and values of society. Culture is expressed through routine behaviour, language, visual work and other form of symbolic representation (expressions).

For quite a long time, the community in Zanzibar has adhered to traditional culture and the exercising of social control using traditional values and norms. The good values experienced under traditional culture need to be encouraged in order to avoid negative consequences of cultural attrition, the result of which, has led to increased divorce rates and a common practice of having multiple extra marital partners in the community. These habits are among the predisposing factors for HIV infection.

The restoration of good and sound traditional Zanzibari culture, including collective responsibilities of the upbringing of children, respect to traditional and community leaders and leading roles of community organizations in maintaining customary norms and order are important dimensions to influence positive culture that will help to address HIV transmission.

Objective

To promote good and sound traditional Zanzibari culture that is sensitive to fight against the spread of HIV/AIDS infection and living positively with infected and affected population.

Strategies

1. Revive traditional system used to prevent immoral practices in the community.
2. Introduce effective family life education programme.
3. Using traditional and community leaders for HIV/AIDS campaign in the community/streets.
4. Introduce and promote National Family Day to influence restoration of good and positive traditional values.
5. Incorporate HIV/AIDS messages through special national events/days [ZIFF/Tamasha la Mzanzibari] and promote positive values and practices that can mitigate the transmission of STD/HIV.
6. Regulate the media and information technology.
7. Introduce periodic research/studies and dialogues on culture as part of monitoring, and evaluating influences of culture on HIV/AIDS.
8. Create conducive environment for promotion of care and support for infected and affected families at community level.

4.2.6 Workers and Employer Organisations

Rationale

Generally, workers in public and private sectors constitute a significant proportion of the national productive force. Currently, very little has been done to mitigate the effects of HIV/AIDS on workers. The employers associations have not been adequately sensitised and have not been able to scale up the institutionalisation of HIV/AIDS issues in employment places, neither have the trade unions been able to fight for the care and support of the affected workers.

Recent international initiatives [Douala-2000, Mombasa-2001, ILO Code of Conduct on HIV/AIDS in the World of Work] provide an important driving force in ensuring that high levels of commitment are institutionalised [in work places] to protect the workers from HIV infection and provision of care to those who are affected. All of this calls for high levels of advocacy to ensure that the laws currently being reviewed should incorporate HIV/AIDS issues especially on mitigation of workplace stigma and discrimination.

Objective

To develop capacity for HIV/AIDS workplace intervention campaigns on prevention, protection, care and support to the affected/and-infected workers.

Strategy

1. Introduce HIV/AIDS education for workers/employees.
2. Promote the provision of employment contracts with health benefits.
3. Establish health care schemes that would provide medical care/aid and hospital charges.
4. Ensure access to essential services namely: STD clinics/VCT and condom or vaginal microbicides.

5. Create platforms for experience sharing between various workers institutions and trade unions both in private and public set ups both on the local and international fora.
6. Review policy/regulations that discriminate HIV/AIDS employee and ensure protection on this category/sector

4.2.7 Tourism Sector

Rationale

The RGoZ acknowledges that Tourism is an important economic and developmental sector. Although, there are good intentions in expanding tourism, this sector has also witnessed a number of challenges. The major challenge is the emergence of various activities that increase the possibility of HIV/AIDS escalation. Worth noting is the notable rise on sex tourism [paedophiles, MSM, SW, etc.], which is currently at various developmental stages in Zanzibar [reference-interview with tour operators]. Based on current tourism trends in Zanzibar, there is potential for sex tourism to explode and increase the magnitude of the epidemic. Under these circumstances***, it is imperative that Zanzibar addresses these issues early*** in order to better mitigate its impact.

Objective

To mainstream HIV/AIDS responses [especially cultural sensitive tourism] in the tourism sector in Zanzibar.

Strategies

1. Develop a strategy and action plan for mainstreaming HIV/AIDS interventions in the tourism sector.
2. Educate the tourist commission, tour operators and those living around hotels on the transmission, prevention and predisposing factors favouring STD/HIV spread in Zanzibar.
3. Identify and promote cultural sensitive tourism.
4. Revisit and update laws and regulations that act to mitigate the spread of sex tourism.
5. Establish a coordination mechanism between ZAC and the tourist industry.
6. Monitor the negative impact of tourism and promptly introduce appropriate remedies.
7. Conduct periodic qualitative and quantitative surveillance to the people whose life [immediately] depends upon the tourist sector and where possible monitor the sero status of their clients.

4.2.8 Promotion of Condom and Vaginal Microbicides

Rationale

The positive roles of condoms in the prevention of HIV transmission when effectively used have been documented in many parts of the world [e.g. Thailand and Uganda]. The male condoms are the most effective barrier [preventive gadgets] as they are easy to use, affordable and can prevent the transmission of STD, HIV and unwanted pregnancies. The female condoms though on the market, are not evenly and easily available in Zanzibar.

The acceptability of all types of condoms is very low in Zanzibar. Female condoms are the least favoured of the condoms [even by SW] available in Zanzibar. The current gender relations and societal expectations on males and females on matters related to sex disempower women when it

involves sexual intercourse [negotiations], and this also extends even to SW. The need to introduce and promote vaginal microbicides [currently not on the market] that will mostly be controlled by women themselves and are easy to apply remains an alternative prevention tool that will reduce STD/HIV transmission to women [including SW].

Objective

Increase the availability and access to quality condoms [male and females] and vaginal microbicides to the general community, with special focus on the high risk groups.

Strategies

1. Educate the public on the appropriate and effective condom use.
2. Ensure routine quality control of imported and stored/shelved condoms [male and females] so as to protect the community.
3. Formulate condom promotion and utilisation guidelines.
4. Establish a sustainable and effective system of procurement and distribution of male and female condoms.
5. Ensure availability, affordability and accessibility of vaginal microbicides and marketing of various assorted brands of condoms.
6. Conduct periodic behavioural studies on condom use in special population groups.

4.3 The Health Sector [Prevention, Treatment, Care and Support]

Rationale

In the first seventeen years of the epidemic, the health sector [through ZACP] led all sectors in addressing and coordinating HIV/AIDS interventions in the country. This leadership role retarded the health sector from effectively orienting itself towards the health aspects of the response to HIV/AIDS. Moreover, the current existing interventions in the sector are practically inadequate.

A sound functional medical /health services is a pre-requisite to an effective response to HIV/AIDS mitigation in the country. The health systems should be tailored to positively respond and mitigate STI/HIV transmission and related factors, management of predisposing diseases and other related disease conditions, ensure continuum of care/ support and mitigate against stigma and discrimination to the affected population. The services must ensure that blood and environmental safety and effective surveillance and research on STI/HIV/AIDS are well coordinated.

Overall objective

Increase access to comprehensive services for HIV/AIDS prevention, treatment, continuum of quality of care and support to infected/affected people.

General Strategies

1. Strengthen health care delivery system through the formulation of the Health Sector HIV/AIDS Strategy Plan.
2. Develop health care HIV/AIDS policy guidelines/framework.
3. Establish sound coordination mechanisms for the health sector response.
4. Strengthen the monitoring and evaluation mechanism of the health sector response.

5. Advocate for an increased financial governmental commitment to the health sector for HIV/AIDS activities.
6. Introduce health sector HIV/AIDS workplace intervention programme.
7. Introduce post exposure prophylaxis [PEP] in all health care settings [public and private].
8. Introduce and strengthen PMTCT, VCT, treatment for Opportunistic infections and TB, ARV therapy and laboratory diagnostic services.
9. Ensure availability, affordability and accessibility of ARV therapy.
10. Design a pricing policy for ARV and other related drugs
11. Establish and strengthen epidemiology surveillance to monitor HIV/AIDS magnitude and trends over time.
12. Undertake research.

4.3.1 Voluntary HIV/AIDS Counselling and Testing Services [VCT]

Rationale

Voluntary confidential counselling and testing is an important milestone in the scaling up of care and support services and in mitigating stigma and discrimination of PLHAs. Furthermore, the evenly existence and accessibility of user-friendly VCT services help individuals to draw constructive decisions and to effectively plan for their future. The existence of comprehensive VCT centres that provide counselling, testing on site, diagnostic, treatment and a well-defined referral mechanism is essential to the public. The need to scale up counselling services and incorporate it in HBC or making it part and parcel of ARVs management is unavoidable.

Objective

To expand coverage of comprehensive user-friendly, voluntary and confidential HIV testing mechanism with pre- and post- test counselling services.

Strategies

1. Develop policy framework on the provision and management of VCT services.
2. Scale up VCT services to the periphery.
3. Educate the public on the importance of VCT and produce appropriate IEC materials.
4. Scale up counselling services available to the networks of PLHAs.
5. Build up capacities of public and private sector in counselling services for HBC.
6. Promote capacity development to health care providers [including traditional healers, TBAs, spiritual and local leaders] in areas of basic care and counselling.
7. Introduce family counselling programmes to the affected families and AIDS orphans.
8. Strengthen the VCT monitoring and evaluation mechanisms.

4.3.2 HIV Prevention from Mother to Child Transmission

Rationale

Various observations and studies have documented that HIV transmission from the female parent to the child can be prevented/minimised by medical intervention either during or immediately after delivery. About 4% of HIV transmission in Zanzibar is estimated to result from MTCT. Currently, the scope of accessibility to medication that would assist in reducing MTCT has been globally widened. This increases the chances of survival of babies and under-fives. With the current PMTCT formative study in place there is need to introduce PMTCT in Zanzibar.

Objective
To reduce HIV transmission from mother to child during intra-uterine life, delivery or while breast feeding.

Strategies
1. Strengthen the organisational and human capacity of the health sector so as to enable smooth introduction of community based Prevention of mother to Child Transmission of HIV (PMTCT)
2. Raise awareness and improve male participation in PMTCT in order to reduce stigma and promote dialogue within the community.
3. Promote partner /family involvement on decisions regarding PMTCT [advocate for].
4. Monitor and evaluate PMTCT and undertake research on long-term benefits of interventions.
5. Conduct periodic evaluation on client satisfaction [monitor quality of rendered services.]
6. Promote ANC routine comprehensive screening services [including scaling up of ANC sentinel surveillance].
7. Encourage comprehensive protection and support to child feeding practices for infants of HIV infected mothers in accordance with Global Policies for infant and Child Feeding and International Code of Marketing of Breast Milk Substitutes.
8. Formulate a PMTCT policy.

4.3.3 Promotion of Safety of Blood and Blood Product including Waste Management

Rationale
Generally, HIV transmission through blood and blood products in hospital settings is controlled through routine screening prior to transfusion or by ensuring that aseptic techniques are in place. However, in some instances accidents do happen and these account for a relatively low level of transmission. The risk of HIV transmission through traditional practices such as ear and skin piercing, male circumcision and uvulectomy may increase particularly when it involves sharing or using unsterile procedures.

On the other hand, improper disposal of waste [blood, tissues, organs or other body fluid contaminated appliances including used condoms and syringes] may increase the chances of the community [children in particular] to be infected by HIV.

Objective
To minimise the risk of HIV transmission through blood, blood products or invasive procedures in health and non-health care settings.

Strategies
1. Introduce functional blood banks in all major health care centres in Zanzibar.
2. Ensure access to comprehensive blood screening services [against HIV, syphilis and Hepatitis]
3. Develop and reinforce national hospital and dispensary waste management policy [public and private].

4. Educate care service providers [public and private, including traditional practitioners] on preventing blood borne transmission through sterile procedures.
5. Educate the public on proper hospital waste disposal/treatment.
6. Establish post-exposure prophylaxis services to professional groups at risks.
7. Conduct research on blood borne and other related risks to HIV transmission in Zanzibar

4.3.4 Treatment

4.3.4.1 Management of Sexually Transmitted Infections

Rationale

Effective management of STIs in the community has been acknowledged to be one of the important cornerstones in controlling the spread of HIV. Studies from various places have shown that reductions of STI in the population have resulted in the reduction of the reported new HIV infections. As outlined in the situation analysis, the numbers of reported HIV in STD clinic clients in Zanzibar has been documented and are on the rise. There is need to scale up STD prevention and curative services in the population.

Objective

To increase access to appropriate information and quality care for the management of STI.

Strategies

1. Scale up the introduction of user-friendly STI clinics to all [SW, prisoners, MSM, Mobile populations and the community].
2. Make STI services user friendly to adolescents and young people.
3. Strengthen the quality of STI management through capacity building, ensuring the availability of essential medicaments/drugs and supplies.
4. Undertake regular monitoring of drug resistance.
5. Promote partner notification.
6. Involve the private [medical] sector in the management and monitoring of STI.
7. Conduct regular surveillance [behavioural and clinical].
8. Promote the integration of STD services and management in MCH/FP clinics.
9. Strengthen behavioural change communication approach.
10. Promote early treatment seeking behaviour.
11. Promote condom use among STD clients and partners.

4.3.4.2 Management of Opportunistic Infections and Palliative Care

Rationale

The escalation of the epidemic, accompanied by the increased number of PLHA, increases the demand on the quality of medical care to this population. In a country like Zanzibar, where resources are extremely scarce, it is very difficult to ensure universal access to ARVs and to the management of certain other AIDS related conditions to all those in need. The current international efforts in addressing these demands, call for additional commitment in the area of care and future treatment options. Furthermore, intervention campaigns and stigma mitigation in the country will be strengthened by increasing the availability of low cost generic ARVs. This

is currently feasible due to the emergence and existence of various funding and supportive sources.

Objective
To increase the coverage and access of PLHA to adequate quality medical services and treatment including ARV therapy.

Strategies
1. Ensure accessibility and affordability of quality care for preventive/supportive care and treatment of opportunistic infections and AIDS conditions in the public and private settings including HBC.
2. Strengthen health care system [human, infrastructure, and equipment/supplies] to be able to effectively monitor treatment and support to the clinical progress of AIDS patients.
3. Design a supervisory and quality assurance system to monitor medical services [in relation to HIV/AIDS] both in public and private settings.
4. Strengthen linkages between TB and HIV/STD control programmes.
5. Scale up holistic counselling services to include adherence to ARVs regimens, psychotherapy and terminal care.
6. Educate and prepare the communities to support PLHA and AIDS supportive programmes.
7. Develop a user-friendly national policy guideline [comprehensive] for drug/ARVs and care to PLHA/AIDS patients that will address both the public and private settings including traditional healers.
8. Educate traditional practitioners on care and support.
9. Set up an effective collaboration and supportive mechanism with traditional practitioners and PLHAs network so as to encourage them to participate in treatment care and support services.
10. Ensure confidential services at all levels, through staff training [public, private and traditional healers] and regular monitoring.
11. Establish functional reporting and referral systems at all levels.
12. Promote research and research application to the clinical management of AIDS patients and in the planning process in general.
13. Promote collaboration with local [public, non-public and private] and international institutions in the area of treatment care and support.

4.3.5 Care and Support

4.3.5.1 People Living with HIV/AIDS

Rationale
People living with HIV/AIDS (PLHA) are highly stigmatised in many countries. This is also the case in Zanzibar. The fear of stigmatisation means that few individuals are willing to find out their status through HIV testing, and even when they know they are positive, they are unwilling to disclose their status. This means that those infected may continue to transmit the infection to others. They may also continue to suffer quietly while psychological and social support to improve their lives may be available. Active involvement of PLHA is widely recognised to offer benefits to PLHA and to mitigating the impact of HIV/AIDS

Objective
Reduce stigma and discrimination of PLHA through provision of access, inclusion, participation and greater involvement of PLHA.

Strategies
1. Assess the attitudes of service providers and sensitise them where necessary so as to reduce stigma and discrimination.
2. Review policies and procedures and overhaul those that stigmatise or discriminate against PLHA and women.
3. Ensure confidentiality of all PLHA.
4. Train and involve PLHA in outreach education.
5. Use counselling services as a starting point for empowering beneficiaries.
6. Encourage PLHAs to organise themselves and or join HIV/AIDS networks.
7. Provide infected [PLHA] and affected families with the opportunity to meet other PLHA either through peer counselling or support groups.
8. Encourage PLHA to go public.
9. Develop counselling strategies to help PLHA cope with perceived and actual experiences of stigma and discrimination.
10. Encourage public and private sector HIV testing services to offer information to PLHA about NGO services and to refer PLHA to respective NGOs as quickly as possible.
11. Work with stakeholders to reduce stigma and discrimination at community level by promoting tolerance and compassion, improving community knowledge and awareness about HIV/AIDS, sensitising community and religious leaders, and advocating for legal and human rights of PLHA.
12. Ensure that PLHA have free or low cost access to appropriate health care, including treatment for opportunistic infections.

4.3.5.2 Community Home Based Care and Support

Rationale
The need to ensure continuum of care requires a widened coverage that involves communities. In addition, with increase in the HIV magnitude in the country, the demand for care and support by PLHA in health care set ups will overburden the health care delivery system. The foundation for a successful community and home based care is based on the level of acceptance of those infected and affected together with the establishment of conducive environment. Currently, there is little participation of men in caring and supporting for the sick. Women are left with the major burden of care provision to the infected subjects. Although HBC services have been in place for some time, the services are neither comprehensive nor are they satisfying the needs of infected individuals and affected families.

Objective
To increase coverage and access to comprehensive quality home based care and support for PLHA.

Strategies

1. Develop HBC guidelines that will describe possible roles of families, communities and service providers.
2. Incorporate family counselling and other psychosocial interventions to the affected families.
3. Promote the scaling up of community and home based care programmes.
4. Establish an integrated package of care that will involve all health care providers [including traditional healers, traditional birth attendants, spiritual healers etc.].
5. Enhance the HBC collaboration mechanism between public, NGOs, FBOs in addressing HBC activities.
6. Strengthen referral systems that involve HBC.
7. Promote greater involvement of PLHA in planning and implementation of HBC.
8. Build community capacity on the provision of HBC to respond to the needs of PLHAs and their families and ensure sustainability.
9. Monitor and evaluate the quality of HBC and support.
10. Promote more male participation in providing care and support.

4.3.5.3 AIDS Orphans and Children in Difficult Circumstances

Rationale

Caring for AIDS orphans in Zanzibar is done through a communal kinship system in which women are the majority of the caretakers. Most of the orphans find themselves in female-headed households. Although the number of AIDS orphans is low, experience shows that there is significant shortage of support especially of basic needs such as education, food and clothing.

The Government, through the Ministry of Health's Department of Social Welfare, does provide some assistance to orphans. However, due to lack of policy guidelines on orphans, the department has done very little on caring for AIDS orphans.

Current intervention done by few organizations (NGOs, international organizations) and good Samaritans are on ad hoc basis, and not sustainable. Differences in defining orphan among different organization has influenced difficulty in supporting orphans and left many AIDS orphans without any support. In some cases AIDS orphans who are also living with HIV/AIDS are stigmatised and discriminated against by both the community as well as institutions.

Children who are living under difficult circumstances [those who cannot access daily basic requirements and other supportive environments] are also at risk of contracting STD/HIV infections. The inability or failure of their parents to meet their basic needs such as school materials, food or clothes predisposes them to sex in exchange of gifts or material gains. This situation increases the likelihood of acquiring STI in early ages.

Objective

Promote an effective and sustainable system of supporting and caring AIDS orphans.

Strategies

1. Develop a community based recording system for identification and registration of orphans and other MVC.

2. Introduce special sustainable programs to support AIDS orphans and most vulnerable children in the basic need especially education, health, food and clothing.
3. Develop guideline/policy on AIDS orphan care and support.
4. Develop a family-counselling programme during the caring of a sick person and after death in order to properly take care of AIDS orphans.
5. Promote capacity building/skill development for the grown up AIDS orphans to be capable for self-employment and establish basis for their independent life.
6. Introduce peer educator among orphans and MVC.
7. Conduct behavioural study for AIDS orphans.
8. Increase effective participation of NGOs in caring for AIDS orphans and MVC.
9. Introduce a system for AIDS orphans to start education early and be able to accomplish their education careers.

4.3.6 Surveillance and Health Research

Rationale

Effective surveillance is paramount to the successful interventions. A functional surveillance system assists in the detection of the underlying/ predisposing risk factors, infection trends and intervention outcomes. In addition effective monitoring and well-designed studies fills in the knowledge gaps, which are missed in the surveillance mechanisms.

Objective

To increase capacity and quality of surveillance, monitoring and research in STI.

Strategies

1. Develop training programmes on monitoring, surveillance and research.
2. Establish an institution that would promote ethically sound research.
3. Strengthen Health management information system.
4. Introduce second-generation surveillance system.
5. Strengthen the capacity of ZACP to manage and monitor effective second-generation surveillance system and sentinel surveillance of blood donors, STD clients, and other population groups.
6. Identify research areas and advocate for additional research.
7. Repackage surveillance information to enable district interventions.
8. Create platform for the dissemination of the research findings.
9. Establish a research/surveillance information centre.

CHAPTER FIVE

5.0 STRENGTHENING THE ORGANISATIONAL AND MANAGEMENT SYSTEM

Rationale
As stated earlier, the challenges for Zanzibar is to be able respond to the rapidly evolving HIV/AIDS epidemic. These challenges include a weak implementation capacity due to limited financial and manpower constraints both within the public and private sectors; structural weaknesses in terms of multi-sectoral involvement *due to the fact that many organizations do not yet view HIV/AIDS as a priority; a weak decentralized local government system at district level; and a lack of HIV/AIDS policy.*

It is for these reasons that Zanzibar has decided to take several steps to broaden and deepen the involvement of all stakeholders. Those managing the national response will have to sustain political and financial commitment and bring in (involve) new partners and stakeholders. More importantly, they will have to translate political commitment into action.

Another important issue that will facilitate implementation will be the creation of an enabling environment and promote ownership of the implementation process at all levels.

Some of the ways in which the management and implementation of the strategy will be managed are discussed in the following sections.

Overall objective:
To increase HIV/AIDS advocacy capacity of implementing institutions through the formulation of a national multi sectoral HIV/AIDS policy.

Strategies:
1. Formulate a national multi-sectoral HIV/AIDS policy.
2. Harmonise the drafted national HIV/AIDS policy to the ZNSP and ZAC act.
3. Promote the wide publicity of the National HIV/AIDS policy to the public and other stakeholders.
4. Promote the implementation of the policy, and where appropriate, through the formulation of various regulations and by laws.

5.1 Zanzibar AIDS Commission
Rationale
ZAC is a newly formed institution whose commissioners are derived from various institutions with different backgrounds. Though awareness on SRH/STI in this category is high, unequivocally there is need to increase their capacity and knowledge on STD/HIV/AIDS issues, transmission dynamics and intervention, and best practices. This in turn will boost up their advocacy capacity and effectively assist in the fight against the transmission of HIV in the country.

On the other hand, the majority of ZAC secretariat members have limited experience on issues related to HIV/AIDS, even though some have experience on the running of multi-sectoral

institutions. With this background, there is need to orient and develop capacity of ZAC secretariat in areas of advocacy, management, coordination, monitoring and evaluation, information packaging/re-packaging and dissemination.

This Strategic Plan has outlined strategies for MoHSW to give more attention to the health sector. This will mean that the staff of ZACP may not be able to provide all the necessary technical support to ZAC. There is need to review the current Act and ZAC structure to ensure that ZAC becomes more independent from ZACP. This will mean that a few technical positions [about two to three] will need to be added to ZAC. These additions will also have implications on additional office space. The current organisation chart, which will need to be reviewed, is shown on the following page as Figure 1.

Objectives

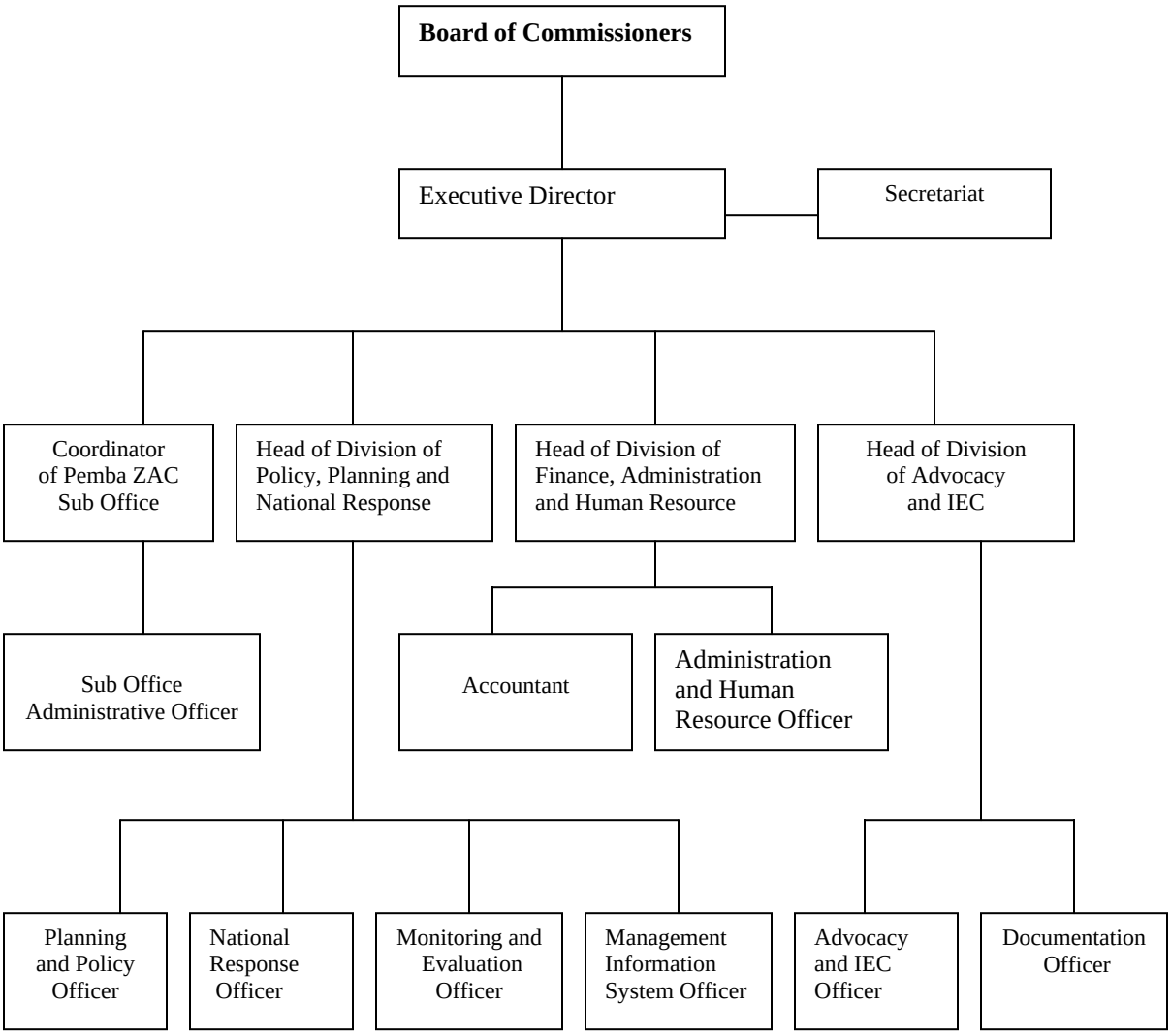
1. To increase knowledge and management capacity of ZAC commissioners and ZAC secretariat in mitigating STD/HIV in Zanzibar.
2. To mobilise and advocate for the involvement of all sectors in the society [political, religious and community leaders] in the fight against HIV/AIDS.

Strategies

1. Orient ZAC commissioners on advocacy on HIV/AIDS and related issues.
2. Design TOR for ZAC commissioners and orient them on their roles.
3. Organise orientation tours to successful countries/ countries with similar background to Zanzibar.
4. Organise short-term training for ZAC secretariat staffs in various specialities [e.g. management, coordination, monitoring and evaluation etc].
5. Facilitate and coordinate multi-sectoral plans for HIV/AIDS.
6. Facilitate mobilisation of resources and ensure an effective introduction of financial management and accountability systems.
7. Develop a coordination system at all levels [national, district and community].
8. Develop and implement a monitoring and evaluation system for a multi-sectoral response.
9. Establish consultative and coordination forums with various stakeholders.
10. Facilitate annual joint meetings with various players/stakeholders.
11. Facilitate ZAC capacity to be able to recruit staff with appropriate skills. ZAC should also have the capacity to fire staff.
12. Review the current Act and the ZAC structure to make ZAC more independent from ZACP by providing more positions for ZAC.
13. Support ZAC to develop human resource capacity requirement/recruitment [in terms of quality and quantity] in accordance with ZAC Act.
14. Prepare and update job descriptions for all staff at ZAC.
15. Provide additional office space to accommodate the available and future staff with suitable office accommodation.

Figure 1

ZANZIBAR AIDS COMMISSION (ZAC)
ORGANISATION CHART



5.2 Strengthening Capacity of HIV/AIDS Implementing Institutions [NGOs/FBOs/ Districts and Private Sectors]

Rationale

The escalation in the numbers of reported HIV/AIDS cases has been accompanied by an increased institutionalisation and scaling up of a number of actors ranging from the public to the civil institutions of various nature /background. The good intentions of these various actors are compromised by the absence of policy; presence of inexperienced operating staffs some with low academic/professional [administrative/health/financial/legal/welfare etc.] background in the areas of programme management. The existence of an umbrella institution that attempts to bridge

various NGOs to the central coordinating body [ZAC] becomes fruitless if the capacities of these institutions are not rectified.

Moreover, the uneven distribution and coverage to the rural areas, where they are greatly needed, remains a challenge to the equitable provision of essential services such as IEC, VCT, counselling, HBC, peer education and condom access. The existence of such low capacity results in duplication of activities, absence of long-term vision, improper coordination and vertical programme implementation accompanied by vertical programme monitoring and evaluation and absence of a solid platform for experience sharing and documenting best practices. The piloted intervention on District response initiatives [DRI by UNAIDS] is one of the essential milestones in addressing capacity at district level. With this background, the need to strengthen and scale up capacity of implementing institutions is of paramount importance in ensuring appropriate interventions of HIV/AIDS programmes by all.

Objective

To increase capacity and coverage of HIV/AIDS implementing institutions in advocacy, Treatment, care and support to PLHA, AIDS orphan and to the affected families at all levels with special focus on district or community levels.

Strategies

1. Conduct a capacity needs assessment.
2. Develop comprehensive training packages/modules on basic administration and management to include advocacy, project formulation, fund raising, care and support, supervision, monitoring and evaluation.
3. Encourage establishment of CSO/CBO and developmental committees that deal with HIV/AIDS in rural and peri-urban areas. [Decentralisation]
4. Promote the documentation and scaling up of best practices.
5. Encourage the establishment of intra-coordination platforms.
6. Strengthen the integration of advocacy campaigns.
7. Promote joint monitoring and evaluation of project implementations.
8. Strengthen information sharing platforms [meetings/website/newsletters]

CHAPTER SIX

6.0 CROSS CUTTING ISSUES

6.1 Advocacy

Rationale

Mitigating the HIV/AIDS transmission dynamics, care and support of the infected and affected populations requires well-harmonised [concerted] deliberate efforts from all walks of life, namely the public, non-public and civil society at large. The governmental commitment of placing HIV/AIDS as a national agenda becomes fruitless if all actors do not know what roles they have or what is anticipated from them. Henceforth, it is imperative for all main actors to be properly guided and knowledgeable enough on the subject matter if HIV/AIDS prevention and supportive campaigns have to be synchronised.

Various studies have documented wide gaps between HIV/AIDS awareness and translating this acquired information to the development of positive behavioural [sexual] changes as one of the significant pre-determining factors in curbing the spread of HIV in the society. The currently used advocacy mechanisms have in general produced limited notable success in changing the sexual behaviours of the Society/community. The undifferentiated stereotype messages aired/voiced by different leaders, CSO and Faith based leaders have not been effectively heeded, resulting into limited or no behavioural change. Although sufficient time is required prior to observing significant sexual behavioural changes, what has currently been documented, calls for marked advocacy [focused] campaigns. Similarly, due attention is required in advocating for changes/reviews of laws, policies and formulation of new laws and regulations.

Moreover, the marked levels of stigma, discrimination and denial in the general population and among some policy makers [Please refer to the HIV/AIDS situation and response analysis] on issues surrounding HIV/AIDS do compromise the intervention coverage. High levels of denial that exists in the country especially on associating the epidemics to people who are either not of Zanzibari origin, the promiscuous/adulterers are among the issues that need utmost attention. In addition, there is also the need to address and strongly fight against stigma and discrimination to people living with HIV/AIDS, AIDS orphans and affected families.

Objective

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

Strategies

1. Formulate an advocacy-guiding framework/tool that will clearly outline different levels of advocacy campaigns for the corresponding target group.
2. Promote involvement of FBO, Political parties, decision makers, influential and community leaders in the advocacy campaign.
3. Design and implement a comprehensive advocacy campaign to address stigma, denial and discrimination at all levels [national, district and community level].
4. Review and update [periodically], the advocacy strategies/ messages in use

5. Introduce advocacy platforms where senior leaders [high level politicians, decision makers, researchers/scientist, religious leaders, traditional healers etc] have an open dialogue on issues related to HIV/AIDS.
6. Establish a multisectoral advocacy platform to review the aired/ advocated messages.
7. ZAC, in collaboration with various stakeholders, should coordinate and repackage IEC packages.
8. Set up an advocacy hotline /website.
9. Develop capacities of decision makers on advocacy skills.

6.2 Zanzibar Poverty Reduction Plan (ZPRP)

Rationale

Poverty, especially the income poverty, has been cited as one of the pre-disposing factors that influences the spread of HIV/AIDS in the society. The Government of Zanzibar has prepared a Poverty Reduction Plan that has outlined the desire to reduce income and non-income poverty among the population, while at the same time improving human capabilities, survival and social well-being of the society while containing extreme vulnerability including various epidemics. It is estimated that more than 50% of the population live below the poverty line. The majority of them are women headed families living in rural areas.

ZPRP was designed as a social and economic multi-sectoral plan that will address all issues affecting people in their day to day life. The priority areas being education, health, water and environment, shelter, feeder roads, good governance etc. The government is trying to develop social and economic infrastructure throughout the islands in a move towards improving the living standard of the people. The newly introduced PER/MTEF system of budgeting and planning has seen the need for all sectors of the economy to rationalize HIV/AIDS issues into their planning processes, hence accord a special budget line to them. A special emphasis will be put in the coming financial year, where the Guidelines for the preparation of the Plan and Budget will outline the need for each sector of the economy to accord a special priority to the HIV/AIDS epidemic.

The plan has specifically targeted youths as the first intervention group of the population, while designing /developing a comprehensive multi-sectoral programs to combat HIV/AIDS. This could only be achieved through participation of top leadership in the campaign against the epidemic by involving more stakeholders such as the NGOs, CBOs, etc from national level to community level. Some of the strategies outlined in the ZPRP have been those of empowering the people, especially the rural and urban poor through improving their living standards.

Objective.

To make the ZPRP more responsive to HIV/AIDS epidemic by integrating HIV/AIDS interventions into main economic and social policies.

Strategies.

1. Develop Budget guidelines that will specifically identify HIV/AIDS areas of intervention to each public sector and their institutions.

2. Ensure adequate budget resource allocation and timely disbursement to accommodate programs planned for HIV/AIDS.
3. Install effective national budget monitoring mechanisms to ensure effective utilization of funds allocated for HIV/AIDS programs.
4. Review and mainstream HIV/AIDS into ZPRP, poverty monitoring process, PER and MTEF in order to mitigate issues related to poverty and HIV/AIDS in all sectors.

6.3 Mobilization of Public and Private Sectors

Rationale

The National Policy Frameworks (ZPRP, VISION 2020 etc) have narrowly translated the HIV/AIDS by not providing adequate strategic guidance to the planning of programs, projects and interventions by various stakeholders in the fight against HIV/AIDS. The two policy frameworks were expected to spell out the basic approaches and principles that would guide the national response and identify goals, objectives and strategies to each individual sector of the economy. The policy was required to guide all future programs and interventions by different stakeholders, and also outline a Monitoring and Evaluation system including the institutional, coordination and financial framework of the national response.

Stakeholders have the opportunity to focus on specific thematic areas, objectives, strategies in relation to their areas of comparative advantage and to develop appropriate programmes, projects and interventions. They are required to show how they can utilize their available capacity in undertaking various program activities.

The ZPRP is supposed to serve as a general document to advocate on HIV/AIDS issues, monitor and evaluate the national response with regards to progress against the established national goals.

The proposed Multi-Sectoral HIV/AIDS Strategic Plan aims to contribute to the realization of the national aspirations with respect to the ZPRP and Vision 2020. HIV/AIDS posses a serious threat to what has been achieved in reducing poverty and is an obstacle to the realization of national goals, hence a coordinated approach is required to ensure a systematic and sustainable results.

In order to have an effective HIV/AIDS implementation program, all public sectors must be coordinated effectively, monitored, assisted and guided towards a uniform and systematic approach to the required goal. ZAC will have the initial responsibility of national coordination, and monitoring of activities to ensure smooth implementation of HIV/AIDS activities [by all actors].

A national and sub-national institutional framework need to be installed to ensure proper lines and clear divisions of responsibilities to all people involved

Objective:

To increase awareness, involvement and commitment of private and public sectors in mitigating HIV/AIDS

Strategies:

1. Advocate for involvement and active participation of all sectors.
2. Enhance effective coordination on HIV/AIDS issues between private and public sectors
3. Establish an inter-sectoral functional body for experience sharing and information exchange.

6.4 Resource Mobilization

Rationale

Resources of all types {financial, manpower, goods and services or sometimes-termed physical} are important components towards the implementation of this plan. For HIV/AIDS activities earmarked in this plan, these resources are very crucial. Effective implementation, and better output will only be realized if programs/projects and their activities are well funded and supplied with adequate and capable manpower and physical resources throughout the plan period.

Successful implementation of this plan and its final achievement will depend on many social and economic factors, including macroeconomic stability, social development and adequate public resources and private sector participation. The government, public and private entities, including the community and NGOs are fully responsible for the funding of this plan. Public and private institutions, could mobilize these resources through different interventions and contributions. The government on its part has committed itself to fully support the plan and is ready to play its part by financing those areas where specific activities will be identified and appropriate costing made. The government will further continue to contribute and meet the manpower needs of the plan while at the same time sensitising the community to fully support the plan in their financial and physical contributions towards the fulfilment of the strategies set out in the Strategic Plan.

The government shall continue to provide guidelines to ministries, departments and commissions at the start of the yearly planning cycle to include HIV/AIDS in the sectoral budgets. The government will specifically insist on each sector and institution to create a budget line for the implementation of HIV/AIDS activities in their areas of responsibility. Through its manpower planning unit of MoFEA, the government will make sure that manpower needs for HIV/AIDS implementation are looked into, so that the long term goals of the plan are adequately addressed.

Donor assistance through multilateral, bilateral and international NGOs will form part of the financing package. The role of development partners in the assistance towards this plan cannot be overemphasized. The government through ZAC will continue to mobilize these resources throughout the Strategic Plan period. Donor agencies will be encouraged to participate fully in supporting the implementation of this plan. Their roles in financial terms and in the supply of physical and technical support are highly welcome. The demands from the plan are very high, and the government, with limited resources cannot meet the resource requirements; hence external resources will need to be mobilized.

Objective

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

Strategies

1. Sensitise public and private entities including the community to contribute and participate fully in the fight against HIV/AIDS.
2. Formulating affordable and cost effective programs to make donors contribute in the designed activities.
3. Seek alternative funding sources through the formulation of multiple project proposals through various funding institutions in place such as Global funding, rapid funding envelopes, research funding institutions, bilateral and multilateral partners.
4. Mainstream HIV/AIDS financing into the MTEF/PER with social welfare development-vote allocations to all public sectors and institutions.

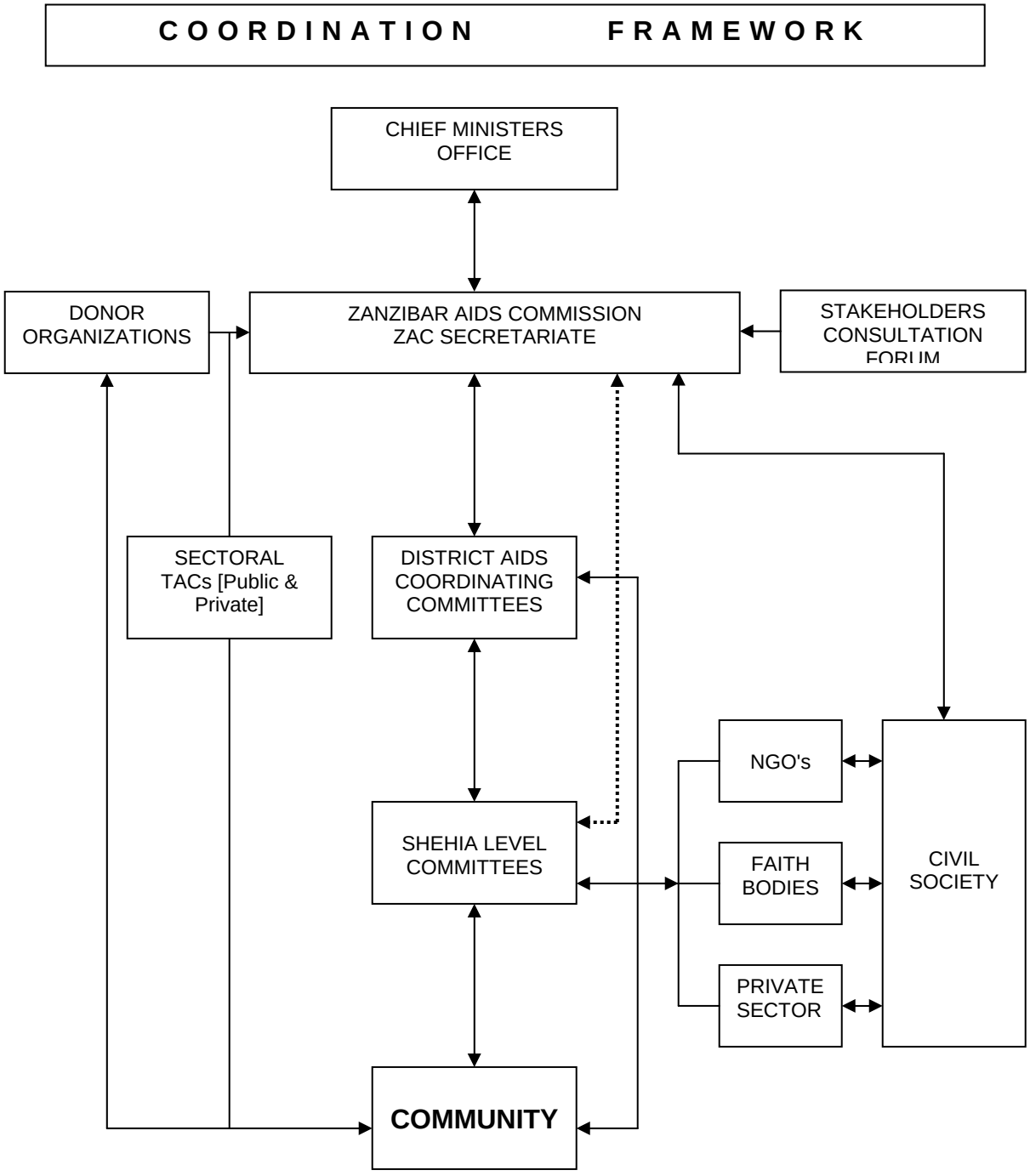
6.5 Coordination and Management

Proper **coordination** and **management** of the national response is very important if a unified response to the epidemic is to be assured. This is important if the Strategic Plan is to serve its intended purpose. If the Strategic Plan is to be successfully implemented, certain decisions and steps are to be undertaken. This section presents the institutional coordination framework and then discusses the various committees that should be put in place in order to facilitate the national response. Figure 2 on the following page is Coordination Framework to illustrate the anticipated coordination mechanisms and the major stakeholders.

Coordinating mechanisms, which form part of the framework, include:

- Quarterly meetings of ZAC commissioners
- Principal Secretaries committee on HIV/AIDS
- Public Sector Technical Committee meetings.
- Consultative stakeholders meeting.
- A technical committee that involves various actors from public and non-public sectors.
- A technical platform between various stakeholders including the UN agencies and international NGOs.
- Meetings and activities of ZANGOC.

Figure 2


COORDINATION FRAMEWORK
CHIEF MINISTERS OFFICE
DONOR ORGANIZATIONS
ZANZIBAR AIDS COMMISSION ZAC SECRETARIATE
STAKEHOLDERS CONSULTATION FORUM
SECTORAL TACs [Public & Private]
DISTRICT AIDS COORDINATING COMMITTEES
NGO's
SHEHIA LEVEL COMMITTEES
FAITH BODIES
CIVIL SOCIETY
PRIVATE SECTOR
COMMUNITY

6.5.1 Quarterly Meetings of the ZAC Commissioners

To show Government commitment, the Revolutionary Government of Zanzibar has established the Zanzibar AIDS Commission and its secretariat. ZAC is required to focus on management, strategic planning, coordination, advocacy, monitoring and evaluation of the national response to HIV/AIDS. ZAC has been structured to provide oversight over public organisations, international and local Non-governmental Organizations (NGOs), Community Based Organizations (CBOs), and Faith Based Organizations (FBOs) that are actively involved in HIV/AIDS prevention and mitigation activities.

At the district level, the District AIDS coordinating committees are supposed to facilitate the interface from the top to the community level and also manage the initiatives from the bottom. These meetings will accord opportunities for coordination, as the commissioners will bring up issues from different sectors.

6.5.2 Public Sector Steering Committee on HIV/AIDS (PSSC)

Principal Secretaries meet once a month to discuss issues of management. It is proposed that once every six months the meeting should be on HIV/AIDS. There are many issues that can be discussed at this level. One major advantage of this committee is that the issue of HIV/AIDS will be kept current on the national agenda. The first few meetings may need to be more frequent than what is proposed here in order to familiarize the principal secretaries on the roles they should play on HIV/AIDS as heads of the public civil service in their respective ministries. This in turn will hasten HIV/AIDS mainstreaming process within the public sector. The terms of reference for this committee should be to:

- Provide policy guidance on HIV mainstreaming in the public sector.
- Ensure mechanisms for monitoring and evaluating the impact of HIV/AIDS in the work place.
- Ensure that resources that have been mobilised for HIV/AIDS activities are properly utilised.

6.5.3 The Chief Minister's Office

HIV/AIDS is a multidimensional issue that requires not just a multi-sectoral response but also sustained political will and direction. At present, ZAC is under the Chief Minister's Office. It is hoped that the Chief Minister's Office will act as the pivot institution on HIV/AIDS programmes. This office would continue to ensure, amongst others tasks:

- ***The development and implementation of the National HIV/AIDS Policy;***
- ***The mobilization of resources in consultation with Ministry of Finance.***
- ***Spearheading advocacy and social mobilization on HIV/AIDS in all sectors at all levels.***

6.5.4 The Ministry of Health and Social Welfare

The Ministry of Health and Social Welfare is responsible to coordinate the health sector (public and private) response in the implementation of bio-medical interventions. The ministry created the ZACP to assume responsibility for coordinating the implementation of the health sector response to HIV/AIDS. This includes: surveillance, voluntary counselling and testing (VCT),

clinical care, prevention of mother to child transmission (PMTCT), home-based care, and other initiatives namely:-

- Health sector HIV/AIDS strategic plan formulation.
- Formulation of health sector monitoring and evaluation mechanism and supervision of on the job training and guidance.
- Define the roles and responsibilities of traditional medicine in care provision.
- Create platform for experience sharing on care and support for PLHAs.

6.5.5 The Department of Human Resources

The Department of Human Resources should be responsible to coordinate the public sector response to the epidemic. This is necessary because this is the department that deals with issues relating to the management of human resources in the public sectors. This department will ensure that mainstreaming of HIV/AIDS issues in all human resource management functions is undertaken. The department will also take the lead role in reviewing human resource management policies, practices and procedures in the public sector in light of the HIV/AIDS crisis. This is necessary in order to reduce employee and institutional vulnerability to the epidemic and to help improve human capacity development for an effective response to HIV/AIDS in the public sector.

6.5.6 Other Line Ministries/Institutions

All other Line Ministries/institutions will ensure that their institutional response to HIV/AIDS is properly coordinated and strategised. They will, accordingly, put in place mechanisms and systems that will enable them deal effectively with the epidemic. As they come up with institution-specific responses, Line Ministries or institutions will take cognisance of the need for a multi-sectoral approach to the epidemic. Each ministry will establish an HIV/AIDS Committee.

6.5.7 The Public Sector Technical Committee on HIV/AIDS **[PSTC]**

It is necessary to set up a **Public Sector Technical Committee (PSTC) on HIV/AIDS** to facilitate coordination of all HIV/AIDS activities being undertaken in the various institutions of the public sector. This committee will provide initial technical inputs on specific institutional proposals as well as those issues that are crosscutting in nature. This committee will meet once every three months. Its decisions and recommendations will be brought to the Public Sector Steering Committee on HIV/AIDS (PSSC) meeting for noting and/or guidance.

The members of the PSTC should be all those who are designated as HIV/AIDS Coordinators (focal persons). It is **recommended** that the ZAC should facilitate the meetings of this committee. The terms of reference for this committee should be to:

- Provide technical advice and support to the PSSC in the implementation of the HIV/AIDS programmes;
- Review annual HIV/AIDS work plans of ministries to ensure proper coordination and implementation, and provide budget allocations through MTEF.
- Monitor and evaluate progress in the implementation of the HIV/AIDS program in the public sector;

- Map out strategies and ensure timeliness in the public sector for the development of appropriate capacity building initiatives, systems and policy related strategies;
- Hold regular meetings to identify opportunity for synergy and discuss issues relating to program implementation;
- Receive and review reports from various institutions in the public sector;
- Review policies, procedures and practices that promote HIV transmission;
- Design HIV/AIDS programme for participation of private sector and businesses.

6.5.8 Institutional HIV/AIDS Committee

There will also be an **Institutional Committee (IC) on HIV/AIDS** for each public sector institution so that HIV/AIDS issues are effectively mainstreamed, implemented, and progress reviewed from time to time. The institution's Principal Secretary/Head of Department/Chief Executive will chair the proceedings of the IC on HIV/AIDS. Records of proceedings of the meetings shall be sent to the Department of Human Resources for subsequent noting and observations by the PSTC on HIV/AIDS.

The secretariat services to the IC on HIV/AIDS will be provided by the institution's HIV/AIDS Coordinator [focal person]. The terms of reference for the IC on HIV/AIDS will be to:-

- Provide HIV/AIDS prevention and impact mitigation IEC materials and messages.
- Ensure timely implementation of the institutional HIV/AIDS activities.
- Conduct risk assessment of HIV/AIDS in the institution.
- Provide VCT services.
- Submit quarterly reports on HIV/AIDS activities to the PSTC.
- Undertake periodic HIV/AIDS social mobilization and advocacy campaigns in the respective institution.
- Provide leadership and guidance to the HIV/AIDS Coordinator on all matters of HIV/AIDS in the institution.

6.5.9 Institutional HIV/AIDS Coordinators [focal persons]

Most ministries and departments had appointed focal persons. But most of these have not been functional. It is recommended that these be resuscitated. This will ensure that HIV/AIDS issues receive the attention they deserve. This will also facilitate institutional memory and provide secretarial services to HIVAIDS activities that will take place in each ministry/department.

The HIV/AIDS Coordinator's terms of reference shall be to:-

- Facilitate HIV/AIDS activities in the institution.
- Initiate actions for HIV/AIDS prevention in the institution.
- Ensure access to I.E.C. materials/ messages and condoms.
- Conduct training sessions on HIV/AIDS for the institution.
- Liase with ZAC on HIV/AIDS issues.
- Promote networking, linkages and partnerships with other players in areas relating to HIV/AIDS.
- Participate in national and international fora on HIV/AIDS.

- Engage in resource mobilization activities for HIV/AIDS in the institution.
- Documentation of HIV/AIDS issues.

6.5.10 Coordination of HIV/AIDS at District and Community Level

The need for districts and community involvement and participation is of paramount importance if the national HIV/AIDS response is to be scaled up and be successful. This fact makes it a prerequisite to establish and strengthen the mechanism that will facilitate the implementation as well as coordination of HIV/AIDS activities at various levels: National–District–Shehia.

Though the decentralization reform process is not yet fully realized, the use of the existing district structures is the only available option on how best to work with communities. Hence, at the district level, ***District AIDS Coordination Committees***, will continue to be responsible for implementing, coordinating and reporting on HIV/AIDS activities that take place at that level.

In few areas, Shehia AIDS Coordinating Committees (SHACCOM) have been established. There is need of extending the establishment of these Committees in other shehias after the evaluation. These committees will have the responsibility of coordinating and implementing all activities that occur in the shehias and work with other institutions at community level. In addition the committees will be responsible to DACCOMs in order to ease the coordination process at these two levels.

Both DACCOMs and SHACCOMs should be multisectoral so as to involve representative members from different sectors. Terms of References for these two committees have already been designed. There is a need to familiarise the members of these committees, during training sessions, on their roles. However, in order for these committees to fulfil their extended functions, it is necessary to empower them technically as well as financially. Resources will be needed to initiate STD/HIV/AIDS interventions. It is therefore important for the Government to commit itself financially because dependence on external financial sources might slow down the implementation of interventions. Close collaboration between DACCOMs and SHACCOMs should be promoted. In addition, periodic platforms between the two for information sharing will facilitate the process. It is highly recommended to involve and inform regional administrative structures so as to smooth the implementation, especially on advocacy issues.

The Ministry for Regional Administration and Special Departments will be responsible for coordination of the HIV/AIDS activities implemented in the 10 districts of Unguja and Pemba. The MoRASD, in collaboration with the MoFEA, will also ensure that HIV/AIDS activities for the districts receive financial allocations as part of the Ministry's annual budget. In addition, districts should play a significant role in mobilising resources for their respective areas. The District Response Initiatives Program (DRI), which started in the districts of Mkoani and Central, need to be strengthened, scaled up and effectively monitored.

6.7 Monitoring and Evaluation

Rationale:

An important national strategy such as this one must have a monitoring and evaluation component. This is necessary because such a tool helps to enhance the effectiveness of the resources being put into the programme by establishing clear links between past, present and future interventions and results. Monitoring and evaluation will help the Zanzibar AIDS Commission extract from past and ongoing activities, relevant information that can be used as the basis for fine-tuning, reorientation and planning. Monitoring and evaluation mechanisms or systems will help to determine if the national response is heading into the right direction and whether success can be claimed and how to direct or improve future efforts.

The main focus of monitoring this strategic plan will be to:

- Enhance ZAC, the government and its partners in organisational and development learning of the epidemic;
- Ensure that informed decision making on HIV/AIDS issues is properly undertaken;
- Ensure that there is accountability for the resources that are put into programmes and if necessary, reorient the strategic plan;
- Ensure that there is ongoing capacity building on monitoring and evaluation for the national response.

For these reasons therefore it will be important that monitoring primarily focus on major issues.

It is very important that the HIV/AIDS Committees outlined in this strategic plan be established and made functional. After these committees are functional, they will act as instruments for coordination, monitoring and implementation of the Plan in the following ways:

- The fact that all sections of the public sector will be actively involved in HIV/AIDS activities will promote accountability and ensure that there is continuous consultation;
- In addition, due to the diverse nature of the committees, there will be deliberate actions to ensure gender balance on the committee members. This will also contribute to the effectiveness of the national response.
- The monthly, quarterly and annual reports should be shared with as many people as possible to promote learning and sharing of experiences. The focal point persons will be very instrumental in this process.

This Strategic Plan has a second volume The Zanzibar National HIV/AIDS Action Plan for 2003-2007. The information that is necessary for monitoring and evaluation is contained therein. The annual planning of activities by various programmes will contribute to monitoring of the ZNSP implementation.

However, in order to facilitate the accomplishment of monitoring and evaluation activities outlined above, certain steps need to be undertaken. What follows is an outline of an objective and strategies.

Objective

To develop a national HIV/AIDS monitoring and evaluation plan.

Strategies

1. Prepare a national HIV/AIDS Monitoring and Evaluation Plan based on the ZNSP.
2. Prepare an Activity Reporting System for HIV interventions, which should include among other things, indicators and data sources.

CHAPTER SEVEN

7.0 WAY FORWARD

Although most of the issues in this Strategic Plan are a priority, there are, however, some activities, which are central and urgent to start the implementation and/or consolidation of the Strategic Plan. These are as follows:

- To institutionalise and strengthen the coordination mechanisms for the National response to HIV/AIDS.
- To build capacity of the Public, and private sector as well as CSOs to respond effectively to the epidemic.
- To strengthen networking and information sharing activities among and between the CSOs, Public and Private Sectors institutions.
- To create a conducive environment for the National response to HIV/AIDS.
- To develop capacity and stronger commitment/involvement of private sector in mitigating HIV/AIDS.
- To mainstream HIV/AIDS and introduce workplace programs.

7.1 Urgent Activities

A number of activities will have to be implemented in order to achieve the objectives outlined above. Specific activities are outlined as follows:

	Objectives	**Activity/ Strategies**	**Output**
1	*To formulate the national multisectoral HIV/AIDS policy*	*Organise consultative process for the formulation of a comprehensive national HIV/AIDS policy*	• *National Multisectoral HIV/AIDS policy formulated.*
2	*To institutionalise and strengthen the coordination mechanisms for the National response to HIV/AIDS.*	(i) Quick review of HIV/AIDS Focal Points to determine competencies and gaps; and finalize their TORs.	• Competencies defined. • TORs for HIV/AIDS coordinators finalised.
		(ii)Identify and train Institutional HIV/AIDS Coordinators.	• Institutional HIV/AIDS Coordinators trained.
3	*To build Capacity of the Public, Private Sectors and CSOs to respond effectively to the epidemic.*	(i) Build Capacity of Institutional HIV/AIDS Committees.	• Committees trained and equipped.
		(ii) Build the capacity of human resource managers to coordinate the Public Sector response.	• Human resource personnel equipped.
		(iii) Train AIDS Coordinators (focal point personnel) on tools for Impact Assessment.	• Coordinators trained.
		(iv) Conduct institutional HIV/AIDS sensitisation campaign.	• Sensitisation campaign conducted.

		(v) Identify capacity gaps that need to be addressed in institutions.	• Capacity gaps identified.
4.	*To strengthen Networking and information sharing activities among and between the CSOs, Public and Private Sector institutions.*	(i) Conduct quarterly meetings for the Public Sector Technical Committee	• Quarterly meetings conducted.
		(ii) Conduct semi annual meetings of the Public Sector Steering Committee	• Semi annual meetings conducted.
		(iii) Undertake Networking and information sharing activities.	• Information sharing activities undertaken.
5.	*To create a conducive environment for the National response to HIV/AIDS*	(i) Develop HIV/AIDS Training Manuals for the CSOs, Private and Public Sector.	• Training Manuals produced.
		(ii) Review the Public Service Regulations.	• Regulations reviewed.

Proposed schedule of Committee meetings

In order to raise and sustain momentum in the implementation of the proposed activities, it is important that meetings be held for the various Committees. It is therefore **proposed** that meetings be held as follows:

- Semi- annual meetings for the **Public Sector Steering Committee** are to take place in January 2004, June 2004 etc.
- The quarterly meetings of the **Public Sector Technical Committee** to take place in January, 2004 **April**, 2004, July 2004, October 2004.
- The Institution Committee on HIV/AIDS to take place quarterly

7.2 Mainstreaming HIV/AIDS

Some of the earlier sections of this plan briefly discussed mainstreaming of HIV/AIDS. In this section a brief introduction of mainstreaming is presented and thereafter a few ministries are selected as institutions where deliberate efforts should be made to commence and/or consolidate mainstreaming. This will provide the public sectors with experience that should be useful in helping to mainstream HIV/AIDS in the private sector.

There are broadly three phases of the mainstreaming process namely:

Integration: this is an initial phase where HIV/AIDS is ***"added on"*** to the core business of government and other sectors at all levels. Institutional arrangements are put in place so as to elevate the profile of HIV/AIDS and promote political commitment and a heightened focus on addressing the epidemic and its impacts.

Institutionalisation: this is a phase where the mechanisms and practices are put in place to address the epidemic while still being ***"added on"*** to become more normal and accepted. The roles and responsibilities of various stakeholders are clarified and regularised.

Mainstreaming: this is a more advanced evolution of the ministry's/department's HIV/AIDS ***responses*** and represents a stage where the mechanisms, structures and practices are put in place to put HIV/AIDS on the agenda, so that they begin to become less pronounced and the functions they sought to perform are just another facet of the core business of the ministry/department.

Although this Strategic Plan has outlined several objectives and strategies to achieve mainstreaming in various sectors, six ministries and one Department are presented below for deliberate mainstreaming efforts. These Ministries / Department have been selected based on the vulnerability factors as regards the working environment and clients they are serving as well as their potential impact in terms of reaching the majority of the population. Other ministries can be added to this list as soon as possible, based on the discussions of the various committees that should be set up. The institutions to commence and or consolidate mainstreaming are as follows:

Institutions to Start HIV/AIDS Mainstreaming

	Institution/Ministry	**Justification**
1.	Ministry of Health and social welfare	• This institution has to coordinate the Health Sector response to HIV/AIDS. • There is some data that can accelerate mainstreaming.
2 3	Ministry of Education, Culture and Sports. Ministry of Agriculture, Natural Resources, Environment and Cooperatives	• These institutions cover a very high percentage of the Zanzibar Public Service establishment. • These institutions also cover a big proportion of the population.
4	Department of Civil Service	• This department deals with human resource management and development issues, it is in the best position to coordinate the Public Sector response.
5	Ministry of Finance and Economic Affairs	• This ministry is very central in its role in resource mobilization and allocation.
6	Ministry of Youth, Employment, Women, Children and Development	• In order to cover issues that deal with out of school youths, children, gender and development.
7	Ministry of regional administration and special departments	• This institution has to coordinate the district response initiatives.

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