



Zanzibar Key Stakeholders Priorities Charter

An Advocacy Roadmap for the Global Fund to fight AIDS, Tuberculosis and Malaria
New Funding Model

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AIDSAccountability
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#1 Priority – Treatment Care and Support

Top Priority – Availability and Accessibility of Antiretroviral Drugs (ARVs)

The availability and accessibility of ARVs remains a big challenge for many people in Zanzibar. Evidence shows that only 65% of people living with HIV (PLHIV) in Zanzibar who are eligible for anti-retroviral treatment (ART) are receiving appropriate care and treatment (Zanzibar AIDS Commission [2014] Report of the Mid-Term Review of the Zanzibar National HIV and AIDS Strategic Plan II, 2011-2016 [hereafter referred to as ZNSP II MTR, 2014]). This is shy of the national target of 80% coverage by 2016. Improving the availability and accessibility of ARVs is crucial, particularly to upscale treatment as prevention. Strong measures must be taken to reduce the costs and distance to reach ART centres. There is a need to upgrade voluntary counselling and testing (VCT) sites through public-private partnerships to enable them to provide care and treatment. In order to invest for impact, the ART strategy must align with the new guidelines from the World Health Organization and make treatment available for all people with a CD4 count of ≤ 500 . Special focus must be placed in the Central and Western districts of Unguja, targeting key populations in urban areas. The implementation period should be from 2015-2018, and should be led by partners such as the Ministry of Health (MoH), Ministry of Finance (MoF), the Zanzibar AIDS Commission (ZAC) and the National Tuberculosis & Leprosy Programme, in partnership with civil society organizations (CSOs). The expected outcomes are the reduction of morbidity and mortality rates, a rise in uptake of ART services and also a clear decrease in new HIV infections.

Secondary Priority – Promotion of Positive Culture

There is an urgent need to launch a programme that will promote income generating support activities which will benefit PLHIV. Sustainable livelihoods are closely linked with treatment retention, which is a high priority in Zanzibar since the ART retention rate after 12 months is only 78.7% in Zanzibar (ZNSP II MTR, 2014, p. 30). In order to prevent further loss within the treatment cascade, key stakeholders propose supportive environments which promote positive health, dignity and prevention among PLHIV. This is particularly important for care givers of children living with HIV. Specifically, PLHIV need capacity building around economic activities through entrepreneurship and easier access to loans from micro-finance institutions. This strategy must be implemented through organizations and networks that are led by PLHIV themselves, and should be rolled out at the district and Shehia levels from 2015-2018. The key implementing partners must include the private sector, office of the Vice President, ZAC, MESYWC, and other CSOs. The expected outcomes for this activity are a decrease in new infections, improvement of economic status and health of PLHIV.

#2 Priority – Behaviour Change

Top Priority – Raising Awareness on HIV Prevention

Key stakeholders have identified the need for a sustainable campaign aiming to raise awareness to the general population on HIV prevention strategies and to promote uptake of VCT services. Current trends show that many people are still engaging in risky behaviour, particularly men. The most recent evidence shows that 8.5% of men report HIV risk behaviour, compared to only 2.3% of women (ZNSP II MTR, 2014, p. 15). Further, there is a challenge in ensuring that those that do go for VCT make it to treatment centres after learning their HIV status. The awareness campaign must be implemented through peer educators, mass media, social activities, and support for recovery houses (sober houses). The campaign should target out-of-school youth, as well as orphans and vulnerable children (OVCs). This activity should strategically target social gathering and leisure centres such as Maskani and Vijiwe, recovery houses, fishing centres (Dago), and religious houses, and should be implemented during the period between January 2015 and December 2017 to align with the Global Fund New Funding Model. Organizations with comparative advantage to implement include non-governmental organizations (NGOs), faith-based organizations (FBOs), academia, and government institutions. The expected key outcomes will include a reduction of risky behaviours, such as a reduction in multiple concurrent partnerships, harm reduction for injecting drug users and an increase in the number of people who attend care and treatment centres.

Secondary Priority – Promotion of Parent-Child Communication on HIV/SRHR and Drug Abuse

An area that is often neglected in behaviour change programming is the promotion of parent-to-child communication on HIV/SRHR and drug abuse. Evidence shows that the use of clean injecting equipment among drug users in Zanzibar has increased substantially, from 10% to 42% (ZNSP II MTR, 2014, p. 23), but key stakeholders think that this kind of harm reduction can have even greater coverage if education begins within the family unit. For effective behaviour change interventions, the issues need to be discussed starting at family level, as part of the engagement of the whole family unit around HIV prevention. This intervention can be spearheaded by the engagement of CSOs and faith-based leaders for advocacy on parent-to-child communication, awareness raising campaign, mass media, and social activities. The campaigns should also target Shehias and wards, and be rolled out between January 2015 and December 2017. NGOs and FBOs are in the best position to lead this activity, in partnership with academia and government institutions. The key outcomes must include improved parental communication with their children, increased attendance to YFS centres, and reduced risky behaviour among youths. The key measurement of progress must be a clear decrease in new HIV infections, teenage pregnancies, STIs and drug abuse.

#3 Priority – Health Systems Strengthening

Top Priority – Increase the Availability of Skilled Staff, Equipment and Supplies at Primary Level

Health threats related to HIV, TB, malaria and maternal mortality are exacerbated in Zanzibar by problems such as stock-outs of supplies, lack of equipment and unqualified staff. For example, 70% of health facilities in Zanzibar need training on STI diagnosis and treatment (ZNSP II MTR, 2014, p. 9). One of the major reasons for these health challenges is a weak health system that needs support in a variety of ways. To improve this, key stakeholders in Zanzibar suggest increasing the availability of skilled staff, equipment and supplies at primary health care level. In particular, efforts must also be made to address the problem of equitable distribution of staff between rural and urban areas. There is need to develop a staff retention strategy, introducing induction courses for graduates, and also to ensure adequate essential supplies and equipment. This can be done by strengthening public-private partnership strategies and also to include the eight districts which are not under performance-based financing (see Secondary Priority for Health Systems Strengthening). The implementation should be between 2015 and 2018, and key implementing partners should include the Human Resources Department and the Procurement Department at the MoH, in collaboration with various public-private partnerships. The key expected outcomes include a clear increase in availability of essential health care services and human resources, increase of quality services utilization at primary health care level, retention of staff and also the equitable distribution of staff between rural and urban areas.

Secondary Priority – Scale up Performance-Based Financing

Another key strategy needed for health system strengthening in Zanzibar is scaling up of performance-based financing (PBF). Currently, in the two PBF districts there is an increase of performance by up to 70%. For instance, HIV treatment uptake in these areas increased from 20% to 90%. Based on this evidence, key stakeholders in Zanzibar propose scaling up PBF from two districts, to include all ten. As such, efforts must be made to increase the funding level of PBF health service providers to enable them to also cover the other eight districts. This should be rolled out between 2015 and 2017, to align with the Global Fund New Funding Model, and be led by the PBF unit and Planning Unit at the Ministry of Health. The key outcomes of this initiative will be measured by a clear increase of quality service utilization at primary health care level, as well as the retention and equal distribution of health care practitioners at all areas. The key measurement of progress must be a clear increase in the availability of essential health care services.

#4 Priority – Prevention of Mother-to-Child Transmission

Top Priority – Test 100% of Pregnant Women and Start 100% of Pregnant Women on Option B+

Key stakeholders in Zanzibar prioritize fully promoting PMTCT strategies in order to reduce HIV prevalence. Data shows that HIV testing for pregnant women in Zanzibar has increased tremendously over the past few years: “The proportion of pregnant women who received an HIV test and know their results has increased significantly from 5% in 2005 to 85% in 2012” (ZNSP II MTR, 2014, p. 8). However, though Zanzibar adopted Option B+ in December 2012, only 68% of pregnant women are initiated on treatment as of 2013. This may be related to low ARV access (ZNSP II MTR, 2014, p. 29). As such, the target must be to test 100% of all expectant mothers for HIV and ensure that 100% are offered treatment initiation under Option B+. Efforts must be made to educate and promote HIV testing and delivery at health facilities and in Shehias, including traditional birth attendants. In addition, key stakeholders prioritize ensuring regular supply of ARVs for those on Option B+, along with outreach services for HIV testing. This campaign must target all expectant mothers at the health facilities (both private and public). The implementation period should start in July 2015, and be led by partners with experience in this area, particularly health care workers at health facilities and Village Health Committees. The key outcomes of this activity will include targets of 100% expectant mothers tested for HIV and entered into the HMIS, as well as 100% of expectant mothers living with HIV on Option B+.

Secondary Priority – Immediate HIV Testing of all Family Members of Pregnant Women, Particularly Newborns

In addition to Option B+, PMTCT should be scaled up to include strategies around testing all immediate family members of HIV+ expectant mothers, particularly the newly born children. National level data shows that early infant diagnosis for exposed infants is currently only at 53% coverage, indicating the importance of this intervention as a priority (ZNSP II MTR, 2014, p. 30). Key stakeholders propose implementing this activity by educating and promoting HIV testing and delivery at health facilities including traditional birth attendants. This can be achieved through outreach services for HIV testing and treatment at the household level, also promoting male involvement. This is in line with the target in ZNSP II which aims to see 80% percent of pregnant women accessing quality hospital based PMTCT services by 2016. Strategy 1 under this objective in ZNSP II is to “promote greater male involvement in PMTCT services” (ZNSP II MTR, 2014, p. 29). The areas to be targeted must include all the health facilities, households (outreach) and special Shehia testing days. As with the top priority, this activity should begin to be rolled out in July 2015, with Village Health Committees taking the lead, with support from health care workers at facility level. The targets of this activity are universal coverage, with 100% newly born children of HIV+ mothers tested for HIV, and also 100% of immediate family members related to HIV+ mothers tested for HIV at health facilities or during outreaches.

#5 Priority – Malaria Prevention and Treatment

Top Priority – Community Awareness

Zanzibar has made great progress towards controlling malaria, with the malaria infection level dropping from 10% in 2005, to less than 2% in 2010 (Zanzibar Malaria Control Program, 2011, “Zanzibar Malaria Program Performance Review: Strengthening health systems and community based malaria control and elimination” [hereafter referred to as ZMCP, 2011]). There is need to reduce the prevalence rates of malaria by promoting community awareness on its prevention and treatment strategies. Currently there is insufficient knowledge about malaria among many people (less than 40%). While uptake of the use of long-lasting insecticide treated nets among pregnant women has increased from 73% in 2007, to 80% in 2010, increased awareness is needed to get this coverage to 100% (ZMCP, 2011, p. 11). Efforts must be made to improve facilities for conducting training of trainers (ToT) and community awareness within the villages and at schools level. This can be done through the community and school health committees. The target areas must include hot spots areas and schools, especially Micheweni, Tumbatu, Kojani, Fundo, 7/33 of the Shehias of Mkoani, Cheju, Ndijani, Miwani, Uzi and Ndagoni. The implementation period must be from 2015 to 2018. The District Health Management Teams are in the best position to be leading this initiative, but this must be done in partnership with community-based organizations, faith-based organizations and non-governmental organizations. The outcomes will include targets of increased community understanding and awareness of malaria prevention strategies.

Secondary Priority – Improved Case Management

Along with prevention strategies, rates of malaria can be reduced through improving case management processes. Currently there is a scarcity of diagnostic tools, medicines and reliable resources. Further, the government notes challenges associated with the fact that “there is no functioning national case management technical working group or committee to advise the program on changing malaria case management issues” (ZMCP, 2011, p. 5). Efforts must be made to procure diagnostic tools and recommended anti-malaria medicines with other equipment. High burden areas should be strategically targeted for improved case management techniques, in order to maximize efficiency. Health Management Teams are well-placed to target health centres and hospitals, which should be done for a period of three years (2015-2018). Key implementing partners should include the District Health Management Teams, health centres and hospitals. In the short term, progress will be measured against the Zanzibar Malaria Control Program’s target to “ensure that all malaria cases are parasitologically confirmed and notified within 24 hours for mapping and investigation for outbreak containment” (ZMCP, 2011, p. 5). In the long term, this will result in a reduction of malaria cases (< 1%) at national level according to district status.

#6 Priority – Community Systems Strengthening

Top Priority - Strengthening Decentralization and Self-Autonomy at the Community Level

Community systems can be strengthened in Zanzibar through decentralization and self-autonomy at the community level. Currently, the decentralization framework is already there but it is not effectively functioning due to lack of structures at the community level. This priority is in line with the targets of the ZNPS II, which aims to ensure that “capacity strengthening of all strategic partners is done to align them with the proposed programmatic shift including health and community systems strengthening and a greater focus on key populations” (ZNPS II MTR, 2014, p. 44). The Mid-Term review of the Zanzibar National HIV and AIDS Strategic Plan II also emphasizes the need for peer educators to replace NGO workers for outreach functions in order to support efforts of community systems strengthening by bolstering existing community outreach structures (ZNPS II, 2011-2016, p. 9). As such, efforts must be made to have formal structures that are legally supported in all the ten districts of Zanzibar, which will require certain legislative changes to take place. This process can be led by both Government institutions and community-based institutions, in collaboration with development partners for technical support and assistance. The time period for this intervention should be from 2015 to 2017, to align with the Global Fund New Funding Model. The key expected outcomes must include improved communication and dissemination of information.

Secondary Priority - Strengthen Co-ordination among Key Stakeholders

Along with strengthening community systems through decentralization, co-ordination among all key stakeholders is a second priority for CSS in Zanzibar. This is needed if the targets of the Zanzibar National Strategic Plan are to be reached by 2016, particularly to reduce HIV prevalence by 33% (ZNPS II MTR, 2014, p. 20). Part of the problem is related to translating policy into practice: According to the ZNPS II Mid-Term Review, “Integration and mainstreaming of HIV/AIDS in general and sector development plans is very limited. It remains mostly on paper and very little is put into practice” (ZNPS II, 2011-2016, p. 48). Currently, there is poor co-ordination between and among sectors, with minimum community involvement and participation. Efforts must be made to formalize inter-sectoral co-ordination mechanisms through a bottom-up approach. This must target all the ten districts of Zanzibar. This process must be facilitated by both the Government and community based institutions. The implementation period must be from 2015 to 2017. As with the top priority for CSS, the key implementation partners must include Government sectors, but communities based organizations are integral to the success of the programme. In addition, development partners can be brought on board for technical support. One of the key outcomes of this activity will be the successful implementation of community plans based on their priority needs.

#7 Priority – Key Populations

Top Priority - Access to Health Education

Access to health care services for key populations in Zanzibar is a high priority. This can be achieved by the promotion of access to health education based on HIV, malaria and TB stigma, religion, culture, discrimination and marginalization. The educational programme should begin with meetings with religious leaders, mass media programme, workshops and festivals. Using data for advocacy will be a key element of promoting access to health, as key stakeholders in Zanzibar note that understanding the different epidemics among different key populations is necessary. For instance, HIV prevalence has fallen among some key populations in the last five years, while it has risen in others. HIV prevalence among men who have sex with men (MSM) has fallen from 12.3% to 2.6% from 2007 to 2012. It has also fallen among injecting drug users (IDUs) - from 16% to 11.3% - over the same time period. However, HIV prevalence has risen among female sex workers (from 10.8% to 19.3%) and youth aged 15-24 (from 0.2% to 0.3%) from 2007 to 2012 (ZNSP II MTR, 2014, p. 33). For this reason, female sex workers and youth will be prioritized for this intervention. The target areas, starting in July 2015, should focus on concentrated places such as schools, colleges, universities, hotels, bars, guest houses, beaches or seaside areas, fishermen camps and other hot spots. The key implementation partners must include the Government institutions, in close partnership with NGOs. The target for this intervention will be increased awareness of HIV prevention among key populations.

Secondary Priority - Improvement of Accessible and Friendly Services

There is an opportunity for significant improvement in health service provision for key populations in Zanzibar under the Global Fund New Funding Model, since 15-20% of the support from the Global Fund's envelope for Zanzibar (US \$5.2 million for HIV and US \$5.2 million for TB) could be allocated towards key populations (ZNSP II MTR, 2014, p. 16). This is especially vital since HIV prevalence among key population is much higher than in the general populations: 19.9% among sex workers, 12.5% among IDUs and 2.4% among MSM. Currently the friendly service centres are very few in number, there is also a shortage of peer counsellors and professionals. Efforts must be made to provide training for peer counsellors, increase number of friendly services and expertise on the field. The target groups must include sex workers, IDUs, MSM and people in correctional facilities, as well as people with disabilities and transgender individuals. This should be implemented through all the available treatment care centres. The key implementation partners must include Government institutions with partner NGOs and KP networks. The key expected outcomes include a clear increase in the number of health centres offering key population-friendly services, as well as an increase in the uptake of services by key populations.

#8 Priority – Tuberculosis Prevention and Treatment

Top Priority - Community Awareness

There is a need to improve TB prevention and treatment strategies through community level awareness campaigns. Currently, most people are not aware of signs and symptoms of TB. The problem is further complicated by misleading traditional beliefs. In addition, there is a lack of knowledge around TB treatment, and how defaulting affects one's health. As such, there is a need for robust adherence support since stigma is a very serious impediment towards retention to care which causes high loss to follow-up rates (ZNSP II MTR, 2014, p. 12). Efforts must be made to reduce the transmission rate and deaths related to TB in the country. This can be achieved by conducting community meetings, the formation of TB clubs, the use of mass media, and also by promoting TB as a cross-cutting health issue. Populations which should be prioritized for this intervention include young people, care givers, traditional healers, as well as prison populations, and as such the target areas for this activity should include schools, Shehias, hospitals, prisons and camps. The implementation period should begin in July 2015, aligning with the funding cycle of the Global Fund New Funding Model. To promote community awareness, NGOs and FBOs are in the best position to lead this activity, since communities know and trust them. However, close partnerships with Government should be fostered throughout, for sustainability purposes. The success of this programme will be measured by an increase in community awareness and a marked decrease in the TB burden in Zanzibar.

Secondary Priority - Availability of Facilities

Key stakeholders in Zanzibar note that levels of HIV-TB co-infection are currently high, at 16% (ZNSP II MTR, 2014). As such, HIV/TB integration through various activities is needed to improve diagnosis and treatment coverage of both HIV and TB. There is a need to improve TB prevention and treatment strategies, particularly through increasing the availability of facilities. This priority will strategically endeavor to increase the availability of facilities in prisons, in line with the Zanzibar National HIV and AIDS Strategic Plan (2011-2016) Mid-Term review, which highlights how correctional facilities in particular lack availability of TB/HIV services (ZNSP II MTR, 2014, p. 11). Currently, there is a shortage of staff, especially those trained in early TB diagnosis. To maximize impact, efforts must be made to ensure the supply of enough microscopes, x-rays, reagent, adequate knowledge for staff and care givers. The target area must be all public hospitals, with a special focus on correctional institutions. Since prisons are a key target, the public sector is in the best position to lead this, but development partners and civil society need to play a key supporting role. Starting in July 2015, this programme will set targets to achieve comprehensive management of TB, and to increase in coverage of TB case identification capabilities.

#9 Priority – Voluntary Counselling and Testing

Top Priority - Community Awareness Creation

In order to increase the uptake of voluntary testing and counselling services, community awareness creation is a necessary first step. The involvement of confidential outreach programmes can help contribute to this objective. The need for this is clear, since current HIV counselling and testing levels among key populations are particularly low: 19.9% for female sex workers, 18.4% for men who have sex with men, and 12.5% for injecting drug users (ZNSP II MTR, 2014, p. 9). Further, partner testing is even lower, at only 3.3% (ZNSP II MTR, 2014, p. 28). Challenges include inadequate education and cultural norms and stigma which discourage VCT. As such, efforts must be made to improve the use of different media, strengthening mobile approach, youth bonanzas, and the initiation of a curriculum programme. The target groups must include key populations such as sex workers, IDUs, MSM, as well as couples and youth (ages 15-24). Youth are a strategic target since HIV prevalence among young (15-24) persons has increased from 0.2% (2007) to 0.3% (2012) (ZNSP II MTR, 2014, p. 33). The target area must be at all levels, though particular focus should be on specific Shehias, health facilities, district/zone, work places, school health programmes and Madrasa health programmes. The implementation period should begin in March 2015 and run for three years. Civil society is in a particularly strong position to lead this activity, with organizations such as ZANGOC, ZAYADESSA, ZIHTLP, ABCZ, ZBC, ZATUC, and the media, though the DHMT and Community Health Committees need to also be involved. The targets for this intervention will be measured by the numbers going for VCT, as well as outreach areas covered and media programmes.

Secondary Priority - Stigma and Discrimination

Along with awareness, a second barrier to increasing VCT coverage in Zanzibar is the issue of stigma and discrimination. This is especially true for key populations, which, as highlighted above, have very low rates of HIV counselling and testing. Currently there are a lot of myths and misleading assumptions. Efforts must be made to create awareness at all levels of care. This process must be led by all health service providers, community members such as Shehe, Padri and Madrasa teachers, workers at workplaces. The target areas must be at all levels, but strategically focused at community level within the Shehia, health facilities, district/zone, workplaces, school health programmes and Madrasa health programmes. The implementation period should begin in March 2015 and be a three year programme, running to March 2018. Again, civil society has comparative advantage to implement this activity, with strong organizations such as the following taking the lead: ZANGOC, ZAYADESA, ZIADA, ZIHTLP, ABCZ, ZBC, ZATUC, and the media. The short term targets will be to increase the number of people going for VCT – particularly key populations - and the long term outcomes will be a reduction of HIV prevalence, and an increase in enrolment of patients to care treatment centres.

#10 Priority – Gender Equality

Top Priority - Generation and Dissemination of Gender-Responsive Evidence-Based Information and Data

There is also a need to promote gender equality by the generation and dissemination of gender responsive evidence-based information and data. The rationale behind scaling up gender-based and gender-informed programming is clear, since the burden of the HIV epidemic in Zanzibar is disproportionately borne by women, with HIV prevalence among women at 1.1%, compared to 0.9% among men (ZNSP II MTR, 2014, p. 15). Further, the prevalence of HIV among single women and widows is 3-10 times higher than among the general population, highlighting further gender inequality issues associated with the epidemic. Currently, there is a problem of inadequate gender sensitive information and facts to support programming processes. Efforts must be made to conduct gender responsive research and assessments, collect desegregated routine data, produce popular versions of findings to be shared with relevant groups. The target groups must focus on people with high prevalence rates, key populations and vulnerable groups, in areas of Zanzibar with high HIV, TB and malaria prevalence rates. The implementation period should be from 2015 to 2017, to align with the Global Fund New Funding Model. Academic and research institutions are in a strong position to lead the work around creating a stronger evidence-based for gender-informed programmes, in partnership with CSOs. The key outcomes must include successful implementation of gender responsive plans and gender responsive research conducted (through M&E indicators).

Secondary Priority - Gender Mainstreaming in HIV, TB and Malaria

One of the key issues within Zanzibar's HIV, TB and malaria responses is to do with inadequate interventions which address needs and concerns of different gender groups in society. This includes women and girls, as well as transgender individuals, who are equally prioritized for gender-sensitive interventions within the Zanzibar National HIV and AIDS Strategic Plan (ZNSP II MTR, 2014, p. 13). In order to address this, key stakeholders in Zanzibar propose conducting skills development training and gender mainstreaming in HIV, TB and Malaria programmes, preparing guidelines and checklist for mainstreaming gender and providing technical assistance and financial support to mainstream gender in HIV, TB and Malaria programmes. From a policy and programmatic level, ZAC is well placed to lead the work on this activity, in partnership with the TB and malaria unites (ZHTLP, ZMCP) and CSOs working in the three diseases. This should be a three year programme to align with the Global Fund New Funding Model. Impact and successes of this activity can be measured by the number of staff within the relevant government units trained on gender mainstreaming and the number of staff with capacity to implement gender responsive plans.

#11 Priority – Human Rights

Top Priority - Right to Access Information for Most Vulnerable Groups

There is need to improve the right to access to information for most vulnerable groups. Currently, most of the key population in Zanzibar struggle to access information about their right to health and how they can access services. This is due to factors such as cultural challenges and inadequate communication materials which specifically target the needs of most vulnerable groups. As such, efforts must be made to introduce specific programmes for specific target groups. This can be done by sharing of SBCC programme/material and conduct of community dialogue forums and workshops. The target groups must include people with disabilities, women (particularly those based in rural areas), young girls, youth and key populations. Targeting youth is strategic towards achieving the objective in the ZNSP II that “80% of young people aged 10-24yrs in-school & out of school [...] are provided with knowledge and skills to make informed decisions and choices about their sexual behaviours” (ZNSP II MTR, 2014, p. 26). The target areas must include tourist zone of Unguja and Pemba, and all ten districts of Zanzibar for IDUs. The implementation period must start from 2015 till 2017, and be led by partners in the media, policy makers, legal organizations, advocacy organizations including CSOs and DPOs. The key outcomes must include a clear increase in knowledge among most vulnerable and high risk groups, and progress could be measured by conducting knowledge studies among key populations.

Secondary Priority - Stigma and Discrimination

There is also a need to fully address the challenge of stigma and discrimination that is currently hindering access to services and other rights (including education and justice). This is also affecting access to HIV/TB and malaria services, since “Stigma & discrimination and violence against KPs by Health Care workers is reported” (ZNSP II MTR, 2014, p. 9). Efforts to improve this should include activities around publicizing and promoting information on HIV, TB and malaria. There is also a need to launch an awareness creation programme focusing on strong anti-stigma messages. This can be facilitated by the community, service providers, media, people living with HIV, key populations and faith-based leaders. The target areas must include all service delivery centres, media houses, selected communities and legal institutions. The implementation should begin in 2015 and run until 2017 to align with the Global Fund New Funding Model. Faith-based organizations have strategic advantage to lead this activity along with the MoH, media, and other CSOs, including DPOs, and PLHIV networks are also key partners. Success will be measured by assessing reduced levels of stigma and discrimination of PLHIV in the community and at service delivery centres, as well as an increase in the number of PLHIV and key populations accessing quality health services. In the long term, progress could be measured by the improvement of results of the Stigma Index.

#12 Priority – Condom Promotion

Top Priority - Strategic Awareness

Condom use in Zanzibar is one of the biggest challenges which key stakeholders have identified. Through the implementation of strategic awareness campaigns, the current levels of condom use may be improved. The most recent available data shows that there is inadequate use of condoms, especially among key populations. However, condom use among some key populations is comparatively higher than others, with condom use among female sex workers at 78.9%, as compared with 39.7% among MSM and only 10.5% among IDUs (ZNSP II MTR, 2014, p. 8-9). Despite this variation, key stakeholders in Zanzibar say condom use among key populations should be 100%, indicating that efforts must be made to increase awareness especially among focus groups and key populations. This can be achieved via mass campaigns targeting key populations in particular. These populations are strategic in terms of achieving the expected prevention outcomes in ZNSP II, particularly the objective to achieve the target of “50% of mobile and vulnerable populations embrace safe sex practices” (ZNSP II MTR, 2014, p. 20). The target areas must include hot spot areas of key populations such as bars, parties and discos. For this to have maximum impact, NGOs should partner with the public sector from 2015 to 2017 to reach the most people. Key stakeholders propose conducting a baseline survey among key populations to establish base levels of condom use awareness, then measure impact and successes by raising awareness levels.

Secondary Priority - Accessibility and Affordability

While awareness is a barrier to condom use, a second challenge faced is their accessibility and affordability to most people. Currently, ZANGOC data shows that condoms are not easily available in most places and the prices are too high. The other problem is challenges posed by cultural and religious attitudes. The areas to be targeted must include all pharmacies and DTL shops, guest houses, hotels and other hot spots who should sell condoms at affordable prices, or alternatively (and preferably) make them available for free. The target groups must include key populations, particularly sex workers, IDUs, MSM, but also higher learning students, and general population. This campaign could be implemented through pharmacies, health facilities, OTC, local shops and youth friendly facilities. The implementation period must be from 2015 to 2017 to align with the Global Fund New Funding Model, and the key implementation partners must include private and public sectors, non-governmental organizations and other civil society organizations. A reduction in HIV prevalence rates by the end of the project period will be the target objective for this activity.

Partner Organizations

Zanzibar School of Journalism
AidNet Zanzibar
Aids Business Coalition for Zanzibar (ABCZ)
Care and Share (Pemba)
Chama cha Viziwi Zanzibar' (CHAVIZA)
College of Health Sciences Zanzibar (CHS)
Danish International Development Agency (DANIDA)
District Health Management Team - Central
District Health Management Team - Micheweni
District Organization for AIDS Control and Orphans Rights (DOACO)
Drug Free Zanzibar (DFZ)
Faith-Based Constituency
First Vice President's Office, Zanzibar
JUH UWAMA
Jumuiya ya maendeleo ya vijana na hifadhi ya mazingira Bububu (BYDECOI)
Karume Institute of Science and Technology (KIST)
Kikosi Maalum cha Kuzuia Magendo Football Club (KMKM)
Key Populations Network
Local Government - Chake Chake
Local Government - Kati
Local Government - Kojani
Local Government - Micheweni
Local Government - Mjini
Local Government - Mkoani
Local Government - Tumbatu
Local Government - West District
Local Government - Wete
Local Government - Wilaya Mjini
MEDWYWC
MICTS
Ministry of Finance
Ministry of Health (Pemba)
Ministry of Health (Planning Unit)
Ministry of Health (Unguja)
Ministry of Health (Zanzibar Malaria Elimination Program)
Ministry of Justice and Constitutional Affairs (Office of Mufti)

MKUPE (Pemba)
OMPR
Pemba Herbalists Cooperation (PEHECO)
Pemba Island Relief Organization (PIRO)
Police
Rahaleo Development Association (RADEA)
Recovery Community
Rehabilitation Homes (Prisons)
Second Vice President's Office of Zanzibar (SVPO)
Sheha - Chake Chake (Pemba)
Sheha - M/OLE (Pemba)
Sheha - Micheweni
Sheha - Mkoani (Pemba)
Sheha - Tasani Kusini
Tanzania Media Women's Association (TAMWA)
The International Center for AIDS Care and Treatment Programs (ICAP) (ICAP-CU)
UMUZA
UNAIDS
UNICEF
University College of Education Zanzibar(UCEZ)
WAKF
WAMATA
WKS
Women's Sober House
Zanzibar Professional Counsellors Association (ZAPCA)
Zanzibar AIDS Commission (ZAC)
Zanzibar Association for People with Developmental Disabilities (ZAPDD)
Zanzibar Association of People Living with HIV/AIDS (ZAPHA+)
Zanzibar Association of Tour Operators (ZATO)
Zanzibar Centre for Disability and Inclusive Development (ZACDID)
Zanzibar Global Fund Country Coordinating Mechanism (ZGFCCM)
Zanzibar Institute for Tourism Development (ZIToD)
Zanzibar Muslim Academy
Zanzibar Muslim Women's AIDS Supporting Organization (ZAMWASO)
Zanzibar Non-Governmental Organization Cluster (ZANGOC)
Zanzibar Psychosis Association (ZPA).
Zanzibar School of Journalism
Zanzibar Social Improvement Charitable Company (ZASICCO)
Zanzibar Youth Education Environment Development Support Association (ZAYEDESAS)
Zanzibar Integrated HIV, TB and Leprosy Programme (ZIHTLP)
ZOTWUZNZ

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