Zanzibar's National PMTCT and ART Program

Initial Assessment and Start-up Communication Plan

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DRAFT

The Zanzibar AIDS Control Programme (ZACP)
of the Ministry of Health and Social Welfare Zanzibar

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LIST OF ABBREVIATIONS

AIDS	**Acquired Immune Deficiency Syndrome**
AKF	**Aga Khan Foundation**
ANC	**Antenatal Care**
ARVs	**Antiretroviral drugs**
BCC	**Behavior Change Communication**
CCP	**Johns Hopkins Bloomberg School of Public Health Center for Communication Programs**
CDC	**Centers for Disease Control and Prevention**
CTC	**Care and Treatment Clinic**
DHMT	**District Health Management Teams**
FBO	**Faith-based Organization**
HBC	**Home-based Care**
HC	**Health Center**
HIV	**Human Immunodeficiency Virus**
IEC	**Information, Education and Communication**
IRH	**Integrated Reproductive Health**
MCH	**Maternal and Child Health**
MDM	**Medicos del Mundo (Doctor's of the World – Spain)**
MOH	**Ministry of Health**
MTCT	**Mother–to-Child Transmission of HIV**
NGO	**Nongovernmental Organization**
PLHA	**People Living with HIV and AIDS**
PMTCT	**Prevention of Mother-to-Child Transmission of HIV**
PSI	**Population Services International**
RMO	**Regional Medical Officer**
STI	**Sexually Transmitted Infection**
TB	**Tuberculosis**
TBA	**Traditional Birth Attendant**
TOT	**Trainer of Trainers**
UNICEF	**United Nations Children's Fund**
USAID	**United States Agency for International Development**
VCT	**Voluntary Counseling and Testing**
WHO	**World Health Organization**
ZAC	**Zanzibar AIDS Commission**
ZACP	**Zanzibar AIDS Control Programme**
ZANGOC	**Zanzibar NGO Cluster**
ZIFF	**Zanzibar International Film Festival**

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EXECUTIVE SUMMARY

At the request of the Zanzibar National AIDS Control Programme (ZACP) of the Zanzibar Ministry of Health and Social Welfare and the Centers for Disease Control and Prevention (CDC) Tanzania, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP) conducted a needs assessment of behavior change communication for the prevention of mother–to-child transmission of HIV (PMTCT) and promotion of access to HIV/AIDS treatment and care in Zanzibar.

Accompanied by different members of the ZACP team, Ms. Uttara Bharath Kumar visited PMTCT, Anti-Retroviral Therapy (ART), and Voluntary Counseling and Testing (VCT) sites; interviewed representatives of programs actively involved in PMTCT; talked with NGOs involved in working with VCT promotion and HIV/AIDS prevention; met with the association of people living with HIV/AIDS (PLHA); and reviewed documents and materials concerning HIV/AIDS, PMTCT, and ART in Zanzibar.

Background

Despite very low rates, an increasing trend in HIV prevalence has been observed in Zanzibar since 1986 when the first case was identified. Infection rates among VCT attendees increased from 0.6% in 2002 to 5.6% in 2003.[1] Statistics from the MDM clinic data also indicated that infection rates among women were (as predicted) higher than among men.

The government of Zanzibar introduced PMTCT and ART services in Zanzibar in April 2005 to help reduce viral load and subsequently lower the rate of transmission of HIV in the country. These services are offered at limited sites in both Pemba and Uguja, the two islands that make up Zanzibar. (see Attachment B for health service structure).

Findings

To date, very little PMTCT or ART-related communication or service promotion has taken place. There is a general lack of printed materials, provider/counselor guidelines for community or client education, visual aids, or electronic media focused on PMTCT or ART. In some areas, community mobilization activities using drama and music and initiated by NGOs are taking place. A much more comprehensive approach, however, is needed to increase service utilization, treatment literacy, quality counseling, and referral.

Previously, communication for PMTCT and ART education and service promotion was used cautiously for fear of creating demand for services that did not yet exist. Now with the program in place (even in limited locations), a wide range of stakeholders believe it is time for some comprehensive communication and education about these services.

[1] Situation and Response Analysis of HIV/AIDS in Zanzibar (Aug 2003)

The assessment also found that stigma and discrimination against PLHA is still common and cited by many as being "very real." Fear of rejection by community and family members is a major deterrent to effective utilization of PMTCT and ART programs. Fear prevents individuals from seeking to learn their HIV status; prevents HIV-positive mothers from disclosing their results to their partners; and prevents men and women from protecting themselves and their partners ("do you have something to hide?").

Finally, the assessment revealed that no health sector communication strategy exists for HIV and AIDS, under which a communication strategy for PMTCT, and Care and Treatment would fall. At the very least, a communication strategy for PMTCT, ART, and perhaps VCT is urgently needed. This strategy could later be expanded to include other aspects of HIV/AIDS communication, ideally integrating it with home-based care, integrated reproductive health (IRH), and tuberculosis communication. The initial communication strategy should at least make reference to these links.

Advantages

Given the small size of Zanzibar, the relatively low prevalence of HIV/AIDS, and small population, communication interventions should reach far and wide. Since both PMTCT and ART programs are very new, people do not have much information, but they also do not have a lot of misinformation. This is an opportunity to "do it correctly from the start." In general, health workers seem committed, willing, and able to get involved in communication activities about PMTCT and ART. They appear not as overwhelmed and overworked as their continental counterparts. Another possible advantage is the low rate of women (4-5%) opting out of MCH testing as part of PMTCT, indicating either a willingness to get tested or perhaps a lack of information on the opt-out option.

Assessment participants also said they believed that with more information about VCT, PMTCT, and ART, and wider uptake, people may want to know their HIV status, leading to a possible reduction in stigma as well.

Recommendations

1. Develop Communication Strategy immediately on VCT, PMTCT, and ART.
2. Empower clinical staff, home-based care providers, peer educators, and others with guidelines and teaching tools to assess client needs and provide clear, correct, and consistent information.
3. Involve as much as possible faith-based organizations and people living with HIV/AIDS to ensure maximum acceptance and credibility of communication.
4. Solicit wide buy-in for the communication strategy by all PMTCT and ART stakeholders in Zanzibar.
5. Promote MTCT Plus. To effectively prevent MTCT, behavior change communication should not be limited to promoting PMTCT services. It should also promote practices likely to reduce MTCT such as:

- Primary HIV prevention
- VCT and risk reduction planning among young couples
- Family planning among HIV-positive pregnant women
- Exclusive breastfeeding up to six months or exclusive replacement feeding to reduce the risk of HIV transmission among women who are HIV positive or whose status is unknown
- ART and care for positive mothers

6. Involve mothers — as well as grandmothers and other family members that influence her infant feeding decisions — when developing the communication strategies.
7. Develop realistic approaches that communicate to men the benefits of knowing their HIV status, protecting their partners, their babies, and themselves from HIV infection, and creating a supportive environment for PMTCT practices.
8. Use existing community structures and actively promote community-based approaches.
9. Identify, train, retrain and consistently supervise and support good peer educators.
10. Ensure better coordination and harmonization of communication interventions and messages.
11. Increase research on Zanzibari social values, stigma, and how they impact infant feeding practices, HIV testing, and care and treatment seeking behavior. This will better inform communication interventions.

Prior to developing the communication strategy, it is recommended that focus group discussions (FGD) be conducted at least among PMTCT, VCT, and ART providers, PLHA, and pregnant mothers. These FGDs should explore some of the observations made in this report and test the suggested framework. The results of this assessment should be used when developing communication strategies and action plans for Zanzibar.

BACKGROUND

Zanzibar is part of the United Republic of Tanzania and is comprised of two islands — Unguja and Pemba — with a population of 984,625 with females accounting for about 51%[2]. Zanzibar is estimated to have an annual population growth rate of 3.1% and a population density of 400 persons per square kilometer, which is considered one of the densest in sub- Saharan Africa.

Summary of Socio-demographic Indicators for Zanzibar[3]

Population	984,625
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	45 years
Functional illiteracy rate percentage	35-40
Per Capita income	US$250

The first three HIV/AIDS cases in Zanzibar were diagnosed in 1986 at Mnazi Mmoja hospital. Since then, reported numbers and the rates of HIV-infected people have escalated markedly (cumulative from three in 1986 to 2,500 by the end of 2002). Currently HIV prevalence in the general population is estimated at **0.6%**[4] . Zanzibar is considered to be a low prevalence country (LPC), compared to the HIV/AIDS epidemic currently ravaging most of sub-Saharan Africa. However, women show infection rates about four times higher than their male counterparts.

While the major mode of transmission remains heterosexual, mother-to-child transmission has become significant,

Mnazi Mmoja Hospital in Zanibar

accounting for up to 4% of the overall infections. It is estimated that more than 600 Zanzibaris have died of AIDS

[2] Source: August 2002 National census
[3] Source: Ministry of Finance and Economic Affairs, 2002
[4] Source: Validation Survey, 2003

since the first case was identified in 1986. Nearly 500 AIDS-related 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. For more data about HIV/AIDS and STIs in Zanzibar, see Attachment F.

Mother-to-Child HIV Transmission in Zanzibar

Transmission of HIV from mother to child is a growing problem in Zanzibar. The Ministry of Health (MOH) estimates that approximately 1% to 2% of pregnant women are infected with HIV and 40% of these mothers will transmit the virus to their babies if appropriate preventive actions are not taken to lower the risk.

Despite high awareness of HIV and AIDS among women and men of child-bearing age, few know their sero-status or have adopted risk reduction practices. According to ZACP estimates, with no hard evidence available, less than 10% of men and women in Zanzibar have been tested for HIV and know their status. In general, 65% of the assessment respondents perceived condoms to be socially unacceptable and this perception was markedly higher in Pemba [82%] when compared to Unguja [54%].[5]

Zanzibari mothers and infants

The first step in PMTCT is prevention of unplanned pregnancies — whether or not a woman knows her HIV status. The next step is for women to find out their HIV status and be aware of all the risks before deciding to get pregnant. Currently there is no PMTCT-related counseling linked to family planning.

If a pregnant woman knows she is HIV positive, is given Nevirapine during labor and her newborn also gets Nevirapine, the risk of transmitting the virus to her baby will be greatly reduced. If, in addition, she delivers safely at a health facility and exclusively breastfeeds with rapid cessation at four to six months or exclusively and safely feeds her baby with infant formula or other replacement feedings, she can reduce the risk of transmission by as much as 50%. After delivery, the HIV-positive mother should be linked to care and treatment services.

PMTCT services are currently offered at the Mnazi Mmoja Referral Hospital and Mwembeladu Maternity Hospital in Unguja and the Chake Chake District Hospital in Pemba. Antenatal counseling is offered and opt-out testing for HIV is routine at these sites, while further PMTCT services are made available to positive mothers. The refusal rate for antenatal testing is as low as 4% to5%. Based on the most recent three months of antenatal testing data, HIV prevalence was about 2.5% among pregnant

[5] Zanzibar HIV/AIDS Validation Survey, 2003

women.[6] Currently nine positive mothers have come through ANC since the program started and three more were referred to MCH from the Care and Treatment Clinic.

Anti-Retroviral Therapy in Zanzibar

The HIV prevalence of 4.02%[7] in admitting clinics[8] at any given point in time in Zanzibar means at least 33 beds in all major public hospitals are being utilized or occupied by a PLHA. This has ongoing implications for cost, care, and medication in the health care system, and affects the livelihood of affected families and dependents and their capacity for support and care. Because of the potential increase in the economic and social impact through an upsurge of HIV prevalence in the general population, the government of Zanzibar decided to introduce HIV prevention measures as well as care and treatment measures.

Care and Treatment (Anti-Retroviral Therapy) services are currently only available at the Mnazi Mmoja Hospital in Unguja. One District Hospital in Pemba is scheduled to be on board with Care and Treatment by the end of August 2005. The Care and Treatment services include treatment of opportunistic infections, monitoring CD4 count, general counseling on positive living, and provision of ARVs when the client becomes eligible. Zanzibar receives its medical supplies from the mainland while the Clinton Foundation is also currently supporting the ARV drug supply. Only the first-line drugs for adults are currently available and there is enough supply to treat 400 patients per year. Currently only 60 PLHA are on treatment.

Zanzibar recently applied for round 5 funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. If awarded, more ARVs will be available in about 21 months in addition to the supply the health system currently receives from the mainland.

All of the above services **are available free** to the people of Zanzibar, including CD4 tests. Blood samples are currently sent to the mainland for CD4 counts but equipment will soon be available in Unguja for the testing.

While current PMTCT and ART services will likely form the service delivery landscape for the next two years, peri-urban and then rural clinical services for PMTCT and ART will be added later.

Implementation Partners and Scope of Work

Partners involved in PMTCT and ART programs in Zanzibar include the Clinton Foundation (Care and Treatment), Columbia University (PMTCT), the U.S. Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), Global Fund Round 2, UNICEF, and Medicos del Mundo (MDM).

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[6] Antenatal clinic data from Maternity Clinic at Mnazi Moyo Hospital in Unguja, April – June 2005.
[7] Situation and Response Analysis of HIV/AIDS in Zanzibar, 2003
[8] Apart from OPD and other clinics

CDC/Tanzania and the PMTCT Secretariat asked Johns Hopkins Bloomberg School of Public Health's Center for Communication Programs (CCP) to conduct a communication needs assessment as a precursor to developing communication strategies to increase uptake of PMTCT practices and services as well as ART. As a first step, CCP and ZACP Officers visited PMTCT, ART, and VCT sites, interviewed representatives of programs actively involved in PMTCT, talked with NGOs involved in working with VCT promotion and prevention, met with the association of PLHA, and reviewed documents and materials concerning HIV/AIDS, PMTCT, and ART in Zanzibar (see Attachment D for a list of documents reviewed).

The PMTCT/ART assessment team

This report summarizes the findings of this assessment, makes some recommendations, and outlines a proposed framework for developing communication strategies for PMTCT and ART.

COMMUNICATION STRATEGY CONSIDERATIONS

Language and Literacy

Swahili is the official language of Zanzibar and is spoken throughout. The people of Zanzibar are very proud of their "high quality" Swahili. As people here say only in half-jest, "Swahili was born in Zanzibar, grew up in Tanzania, got sick in Kenya, and died in Uganda."

Some Swahili words are unique to Zanzibar and different from the mainland and quite different from Kenya and other Swahili-speaking countries. There is some resistance, therefore, to just using materials developed in the mainland or in other Swahili-speaking country. Materials, especially pictures, would need to be adapted because, for example, most Zanzibari women cover their heads and that is not true on the mainland.

Literacy in Zanzibar is reported to be quite high at 60-65% although Zanzibaris admit that people actually do not read a lot. "Even if people can read, it is not a reading culture." English is only spoken or used in writing with non-Zanzibaris.

Media Habits and Materials

This section takes a combined look at what channels of communication exist in Zanzibar and what, if anything, is currently being implemented using those channels.

Print

Other than some mainland Tanzania newspapers, Zanzibar Leo (Today) is the Government- owned daily most widely read by Zanzibaris. Men especially read this paper and women do too, but prefer the comics and serial stories that appear. Zanzibar Wiki Hii (this week) is also important, but not as popular as Zanzibar Leo.

During the assessment, respondents frequently talked about the need for more print "IEC materials" as a necessary part of communication. The only HIV/AIDS-related print materials currently available in Zanzibar were produced or sourced and distributed by MDM. Other existing materials include home-based care and stigma reduction leaflets from the home-based care program..

MDM will close up their activities by the end of 2005 but is currently developing — in partnership with ZACP — an illustrated, simple, comic-style leaflet to promote accessing PMTCT services as a couple.

Femina HIP in Tanzania is working on an illustrated, magazine-style book called 'Knowing more about HIV/AIDS." This Swahili adaptation of a Soul City comic book by the same name is targeted for the mainland. It is being considered for Zanzibar but clearly needs more pre-testing for appropriateness of content, language, and visuals.

Rafiki is a magazine designed for youth.

Zanzibar has some design and printing capability, such as:

- Multi Colour Printer
- Stone Town Printers
- Government Press
- Al Habib Press

Nevertheless, most printing is apparently still done on the mainland. It will be important to explore local print shops as it is always easier to work with a vendor nearby for changes, reviews etc.

Television/ Video

Zanzibar does not have known media statistics on TV ownership or viewership. According to assessment respondents, the one main government television channel (Zanzibar TV-Z) is watched by the majority of people. More affluent people have cable television that shows M-Net and other channels. News and sports are very popular among men, especially football. The popular television program called TV-Z Doctor may be a good vehicle to include information about PMTCT and ART.

Government: Television Zanzibar

Private: Furaha Cable, Zanzibar Cable

Video or TV production capacity exists at the TV stations. Otherwise visual media is produced in or with assistance from the mainland. MDM mentioned good experiences in collaborating with a documentary producer called Rajab that has been involved with magazines as well.

Radio

Zanzibar has a variety of government and privately run radio stations:

- Radio Zanzibar plays news and Tarab music and is preferred by older people
- Spice FM, Coconut FM, Zanzi FM, Karafu FM, Sauti ya Zanzibar, East African Melody play Zanzibar hip hop, Zanzibar Flavour as popular kinds of music and are favoured by the youth
- People in general like to listen to rural kiSwahili on the radio. Kimakunduchi, Kitumbatu, Kipemba (other local language/dialects)

For radio production (spots, drama, etc.) collaboration can be sought with:

Government radio

1. Sauti ya Tanzania, Zanzibar
2. Spice FM

Privately run radio

1. Coconut FM

2. Zenji FM

Music, Community Media, and Other

As stated in the radio section, music is widely listened to and popular in Zanzibar. MDM used famous artists in "Music for Life" as a tool to talk about HIV and VCT.

A number of festivals and events are on the Zanzibari calendar throughout the year, including the Makunduchi Festival and the Zanzibar International Film Festival (ZIFF). These events are being used — and should be used more — to create awareness of testing, care, and treatment among the public.

Many NGOs train and perform drama at the community level. Topics include stigma and discrimination, personal responsibility, HIV testing, safer sex practices etc. Because it has been proven effective elsewhere, this could be an effective tool to raise community awareness. ZANGOC and MDM have experience working with community drama NGO.

Zanzibar has two resource centers: The NGO Resource Centre, a project of the Aga Khan Foundation, and the Madrasa Resource Centre. In the absence of an HIV/AIDS Resource Centre, these two should be used to stock relevant HIV/AIDS communication materials so more people can access them, and both could be linked up with other HIV/AIDS resource centers in the region.

Finally, PLHA testimonies help people see the reality of HIV. Even in treatment and PMTCT, they can be a powerful tool.

Faith and Community Mobilization[9]

More than 97% of Zanzibaris are Muslim. Imams and other religious leaders have the power to influence the general public through their lectures not only at mosques but also at social and religious gatherings, such as marriage ceremonies. Their potential to address issues such as faithfulness, responsibility, and protection of the family, as well as gender issues, compassion for the sick, and other social norms is profound. Interviews showed that religious leaders need to be "fully" involved in HIV/AIDS-related activities right from the beginning to plan together and take action together. According to the assessment, religious leaders felt they had not been involved and were being approached in the last minute.

In light of this, the Zanzibar AIDS Commission (ZAC) decided to hire a Coordinator to work with and coordinate the HIV/AIDS activities of faith-based organizations (FBOs) on HIV/AIDS. Since then, an inter-faith committee (Islam, Christian, and Hindu) has been formed. Mr. Hamid, the FBO coordinator is a member and the secretary of this association. He is knowledgeable, approachable, and seems to have a good rapport with the religious leaders.

[9] From interview on July 12, 2005 with Mr. Hamid S. Nassor at the Zanzibar AIDS Commission

An assessment and mapping was conducted to have a proper record of leaders and FBOs and their geographic reach[10]. The assessment found that faith leaders are incredibly influential in their communities. While Imams usually lead the prayer, in Zanzibar an Imam performs many functions, including holding weddings, conducting funerals, developing messages, performing rituals, and giving sermons. He is a powerful source of information, particularly for men. The assessment found two female religious leaders. Some leaders can only read Arabic not Swahili, but they may be able to read Swahili written in the Arabic alphabet. Madrasa teachers, however, are key for reaching women.

The assessment revealed a major problem with FBO capacity, knowledge, and resources. Madrasa teachers clearly need workshops and trainings. Religious leaders given opportunities to travel to other Islamic countries can see for themselves how faith communities have taken leadership roles in the fight against HIV/AIDS. Senegal, Nigeria, and Uganda could be part of the exchange to inspire Zanzibar's faith leaders, open their minds, and narrow the gap.

The approach taken by FBOs toward HIV/AIDS has been in combination with IRH. FBOs also felt that their role should be more than just distributing the results of "science" (public health). They believe they can help influence norms and promote desirable behaviors supported by quotations from religious books and teachings.

Many religious leaders may be ready to speak out, on radio and elsewhere, to encourage their followers to understand more about HIV/AIDS. Faith leaders should not have problems discussing topics such as treatment and PMTCT, which are more removed from the sexual aspects of HIV/AIDS.

Religious leaders can also be very helpful in a "know your status" campaign to motivate people to go for HIV testing. As for stigma reduction, they can be extremely influential in discouraging blame and finger pointing once the status is known.

Condom Promotion

Condom use is still very controversial but most Imams said while they will not promote condoms, they also will not stop people from using them. Condoms, in their view, should only be used when absolutely necessary, for example under a doctor's advice Condom use for positive people or discordant couples is clearly endorsed, however condoms should not be discussed or advertised in public. Most religious leaders will not condone it, nor will they condemn it. Most condom discussion and distribution happens through bars, hotels, night clubs, and peer educators.

Due to general stigma and religious beliefs, some health care workers and also conservative community members tend not to promote condoms. Even in counseling and treatment services, there are a few health workers who have problems promoting

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10 Zanzibar Faith Based Organisations Implementation Report, 2004-05, Printed in June 2005, H.S.Nassar, FBO Coordinator, ZAC

condoms in that context. This is true especially, in the more traditional Pemba, although some say that this is slowly changing.

After Medicos del Mundo (MDM) procured condoms from PSI and distributed them through selected outlets listed below, demand has steadily increased. Maria Roura, Project Director of MDM, said, "Condom discussion has to happen with the knowledge of whom you are talking to and how far you can go. Give general HIV/AIDS info and then slowly start talking about condoms."

Last month nearly 70,000 condoms were distributed through

- Peer educators at bars, clubs, guest houses, military camps
- Clinics
- MDM office
- General requests
- ZACP Pemba
- NGOs (especially the female condom)
- ZAPHA+

Not surprisingly, Pemba condom distribution of 10,000 to 30,000 monthly is much lower than Unguja**.** It is even difficult to distribute condoms in health facilities, mostly because health workers are afraid that communities will say they are promoting sex. MDM is putting boxes discreetly in non-public places.

The following chart represents condom use reported by sex workers (distributed through MDM[11]). In 2003, 252 sex workers were interviewed in Unguja and in 2004, 240. For more information on the assessment of commercial sex workers, see Attachment G.

	2003	**2004**
Female condom use	3%	18%
Condom use with client	51%	63%
Condom use with partner also	47%	58%
Can a healthy person have HIV?	8%	4%

In December 2005, MDM will finish project implementation and then have three months to wrap up activities. The Global Fund has been asked to finance continuing activities under ZACP. A decision will be made by September and money could start flowing again in June 2006. If this funding is not awarded, a big gap in condom availability and risk

[11] MDM Service and distribution statistics

reduction/prevention communication is expected. MDM will leave a one-year supply of condoms as well as some promotional spots for broadcast behind when they leave.

Peer Education

Peer educators are an effective way to reach audiences with information and counseling, since they are considered credible and trustworthy sources that people can identify with. Training these peer educators to deliver messages can widen the network of information dissemination.

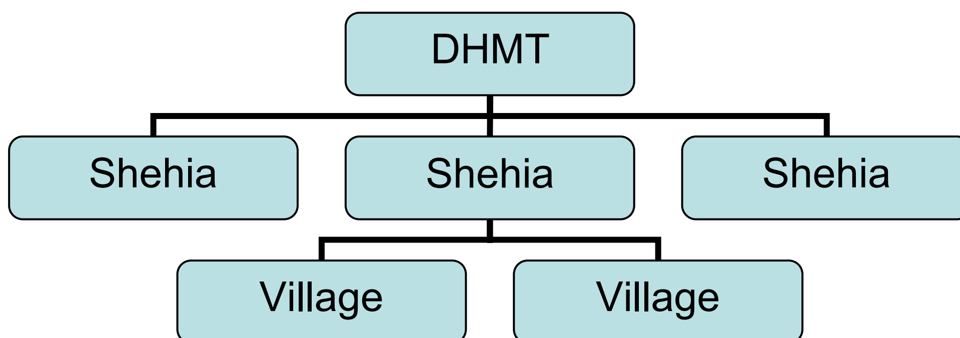
ZANGOC has a network of peer educators (PE) who are voluntary NGO members. They were trained in life skills which included a starter pack of information. This material needs to be reviewed, revised, and made more user-friendly.

MDM also trains PLHA PE through ZAPHA+ as well as sex worker PEs. Altogether, 15 junior peer educators were trained. There are four senior PE trained in HIV/AIDS and condom use with one leader. There is clearly a need for additional peer educators to be trained for the care and treatment clinics as well as PMTCT.

Community Health Committees

Zanzibar's community health committee structure offers great potential for collaboration in the area of PMTCT and community preparedness for ART.

The Health Education Unit of the MOHSW currently receives German funding to revive the existing community health promotion structure[12]. They work with DHMTs to formulate a health committee with equal male and female members, and include one TBA. There is a selected representative from each village at this health committee that sits at the Shehia level. Shehia leaders are very influential and it is critical to involve them in any plan for community-level work.



[12] Interview with Mr. Mtumna Kassim Iddi, Health Education Unit of the MOHSW

This health committee has its own bylaws that can sustain the committee. Income generating projects provide the funds. The health committees:

- Identify and prioritize health problems
- Hold regular meetings
- Learn from other communities – exchange visits
- Initiate income generation activities
- Do health promotion

Only a few of these districts right now have active health committees. These started as pilot programs and need to be revived.

Infant Feeding Practices

It is common for mothers to practice mixed feeding. Often times they can begin mixing foods as soon as the baby is one week old. Sometimes they give water immediately because they think the baby is thirsty and needs water as well as breast milk. The government has made an effort by to promote exclusive breastfeeding, however the Baby Friendly Hospital Initiative has not been so successful because none of the nine hospitals have yet qualified.

Even if a mother wants to exclusively breastfeed, the family will put pressure on her to introduce other foods because it is believed that breast milk is not enough for the baby to grow well and big. Grandmothers and mothers-in-law are factors in feeding decisions. Mothers also think breast milk is not enough, especially during fasting. Even though they are exempt from fasting as feeding mothers, they still take part.

Instead of an exclusive breastfeeding effort, the nutrition experts at the MOHSW, Nutrition Unit felt that simple, locally available, cheap replacement options are needed. These options are more realistic than exclusive breastfeeding for HIV-positive mothers.

A UNICEF study[13] showed that 21% of mothers exclusively breastfeed babies under three months. Informants, however, felt that this number was probably overestimated because mixed feeding is so common and mothers may not think water counts as mixing.

Many babies born in Zanzibar are given honey and something bitter when they are born to know the sweetness and bitterness of life. This happens before the baby has any breast milk at all. This practice occurs in the North B district but also other parts of Zanzibar.

Respondents felt that promoting the practice of expressing milk is almost impossible because mothers will be unwilling in Zanzibar. Many of them work, sell things, and are

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[13] Baseline Health Facility Needs Assessment and Community KAP Study for Piloting PMTCT in Zanzibar, Aziza Mwisongo and Emmanuel Mkundi, UNICEF, June 2003

busy during the day, making expressing milk not a convenient option. Also women do not like to express milk.

Babies are usually left with other caregivers that feed them porridge, cows milk, formula, etc. Mothers usually breastfeed the baby at night and in the morning.

MCH and maternity staff need more training to explain feeding options better. In support of breastfeeding, the government allows mothers to use one extra hour during the workday for breastfeeding. This regulation is currently not used very much. Currently, there are no other serious breastfeeding promotion activities in Zanzibar.

VCT

The ZACP estimates, without hard data available, that less than 10% of Zanzibaris know their HIV status (see Attachment E for list of VCT sites around the country). VCT services (see appendix for list of sites and services) are offered by NGOs, FBOs (Christian Missions and Islamic Health Centres), military clinics, and private clinics. The government hospitals and health care units are the most widespread with a number of primary health care units offering the services.

Group PMTCT counseling before individual counseling

In many government clinics VCT, STI, and Skin Clinics all seem to be located together in a distinct part of the clinic. So if one is seen going there, there is a lot of stigma.

Many people first go to a private VCT centre and, if they test positive, go to a government site to confirm the result. In private VCT clinics, pre and posttest counseling is thought to be poor or non-existent.

People access VCT for two broad reasons:

1. Worry about their status due to repeated or prolonged illnesses. Either the individual worried about himself/herself or was referred by other clinics like VCT, TB, STI etc This also means people usually go for testing rather late in the development of the disease — often too late for treatment to be effective.
2. Upcoming marriage

Promotion and uptake of premarital VCT happens and VCT uptake is high, especially during the "marriage months." VCT is commonly quite acceptable before marriage with 4-5% of those getting tested found positive. Prevalence among women is much higher at around 8% than men at around 4%[14]. Women are not exactly blamed, but women

[14] MDM Service and distribution statistics

from "Tanga" (mainland) are often accused of bringing the infection. Although premarital testing is a large reason for VCT in Zanzibar, it has its own drawbacks in terms of the stigma and discrimination the individual or couple faces if testing positive.

Polygamy is prevalent in Zanzibar. A Muslim man can have up to four wives. It is most common for a man in Zanzibar to have two or three. This results in a problem when the man discloses his status to his wives and the ones tested later start blaming the first one. This is not a new problem. It always existed, even with STDs.

At Chake Chake hospital, VCT can be as low as two or three clients a day but can increase to 11 couples a day during the marriage season. MDM provides technical support to several clinics on both islands. Sometimes they do mobile VCT around special events and special days. Referral is still weak between private testing sites and government treatment services. Referral is also poor from private clinics (for other illnesses) and VCT.

Treatment

The Care and Treatment Clinic began seeing clients in March 2005, and some are referred there from various VCT sites. Most referrals to care and treatment seem to be from government VCT sites and not private due to lack of awareness and knowledge of treatment services among private providers. Even referral from government sites is not seen to be working that well.

When they first arrive, new patients are enrolled, seen by the clinician, treated for opportunistic infections and put on ARVs when necessary, and scheduled for CD4 testing. After CD4 testing, medical eligibility status is defined and eligible patients receive group counseling on ART. They then have at least two further individual counseling sessions with a treatment partner before they actually start ART. A doctor, adherence counselor, and a pharmacist all provide support and information to the client.

This is the ideal pattern and works well now only because of the low patient load. But bringing a treatment partner does not seem to work for everyone (see next section on disclosure). Training of the staff in care and treatment, including adherence, is going to be repeated next month. About 60–65% of those currently on treatment are women. Chronic HIV patients are given Septrin prophylaxis and their opportunistic infections are treated.

So far clients appear to be complying with treatment and not stopping because of side effects. Only one patient with severe side effects had to have their regimen changed by the physician. Some do not believe ARVs work because they start too late and get worse after they start. Some myths surrounding ARVs include that they are a cure for HIV, once you start ARVs it is safe to have babies, and you need special foods when you are on ARVs. Clients also tend to start looking for all sorts of support, like food, transport, money etc. They feel that since they are receiving treatment, they should receive every other support as well.

Disclosure of HIV Status

Only a few clients on treatment disclose their HIV status to their partners and even fewer couples are being treated. Clients need support to stay in treatment, so disclosure is a big issue. Support partners are most often a parent or a close family member, not the client's partner.

Sometimes clients bring in a support partner "in name" because it is required. It may be a friend or someone who is just there or someone who lives too far away to be useful in reminding and supporting the client on drugs. This is also difficult because support partners are supposed to call the clinic if the client is unwell and bring them in for treatment, etc.

Home-Based Care

Home-based care (HBC) in Zanzibar is provided not only for people with AIDS but any chronic illness like diabetes, stroke, high blood pressure, asthma, or epilepsy.

There are 154 HBC providers in the primary health care units and hospitals in Zanzibar. All have undergone 21 days of training, with 30 trained by the Zanzibar nurses association and the rest trained by ZACP with WHO-OPEC and Belgium support. They are all part-time, however, and have other jobs. This often results in poor availability and commitment.

Many clients have trouble accessing HBC because of disclosure. They don't want people coming to their homes and revealing to their families that they are HIV positive.

In June 2005, CTC met with HBC providers to improve links and develop a list of all the HBC providers by district so clients can be referred to the one in their district. Registration cards have to be signed by a HBC provider so the CTC knows they have been seen.

Support Groups

Support groups play a critical role in the success of ART and PMTCT programs. HIV-positive people get together to support each other, and share experiences, advice, and problems. In an environment where stigma and discrimination are still high, support groups are vital. They can also be instrumental in treatment adherence and positive living.

ZAPHA+ offices in Stone Town

As of now, the only known support groups for PLHA in Zanzibar are ZAPHA+ in Unguja and WAMATA in Pemba. Within ZAPHA+ there is a sub-group for treatment support and that meeting is assisted by a trained nurse.

Some other organizations were mentioned as helpful

places to get support even if they were not actually support groups.

- Association of parents. (WAZAZI). Each district has one.
- Umati is a good group active in youth, HIV/AIDS issues.
- Right now all the people on treatment are referred to ZAPHA+ for additional support.
- No support groups exist as yet for PMTCT but those would be useful.

CHALLENGES

Individual behavior, not only with regard to PMTCT and HIV/AIDS testing and treatment, depends on a number of key factors beyond just self, many of which form key challenges to behavior change. It would be naïve to assume that if a person only has the right information and knows what to do, they will do it.

Below is a diagram that outlines the various factors that influence individual's actions.

Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs 2003

A group of 28 clinicians, providers, and counselors involved in PMTCT and Care and Treatment from both Unguja and Pemba gathered to discuss and brainstorm

communication gaps and challenges in this area of HIV/AIDS work (see Attachment C for participant list).

After some introduction on the basics of Behavior Change Communication (BCC), the group collectively agreed that:

- Behavior change is a process and it is not easy
- Different audiences have different needs for information, motivation, and skills
- Just having information is not enough. It has to be the right information at the right time and place
- An individual's behavior is dependant on many factors, including key people and values that influence the individual

The group then looked at what the goals are for the PMTCT and ART programs, developed a quick list of some barriers to reaching those goals, and, as per the diagram above, what influences these barriers. The group then split into two to discuss these issues in depth and a brief outline of those discussions follow.

PMTCT (Facilitated by Dr. Farhat)

Goal: All pregnant women using PMTCT program/services

Barriers	Influenced by
1. Preventing HIV Infection	
People don't believe HIV is a problem in Zanzibar	Information/ Community
Drinking alcohol and taking drugs	Peers
Beliefs around condoms: - No satisfaction - Do not work/ protect - Not publicly promoted/ not personally used for religious reasons	Partners but mostly male Information Values
2. Preventing Unintended Pregnancy	
Misconceptions around FP methods - Can't have children (permanent sterility) - Cause cancer - Loss of libido	Peers Information

Beliefs and customs against use of family planning	Parents/ Community Values
3. Knowing HIV Status	
Fear of stigma and discrimination – will be seen as promiscuous/ immoral	Community/ Family
Women fear to be tested without husband's knowledge/ him knowing his status – afraid of divorce	Husband/ Family Values
DURING PREGNANCY Taking Nevirapine - Need a real life story to believe - Widely known that HIV has no cure. How can Nevirapine prevent transmission?	Community/ self information
DURING CHILDBIRTH Delivering at a health facility low, home delivery is still widely practiced because - Transport difficulties: living far from health facilities that offer these services - Better care at home/ what is conventionally done - Can't afford to buy the requirements for delivery at the health facility (gloves, napkins etc)	Self/ family Ability to act Enabling environment
FEEDING OPTIONS - Mixed feeding early, even as soon as a week or two weeks after delivery due to belief that breast milk is not enough for the baby, baby will be thirsty etc. - Stigma if you don't breastfeed - Poverty, can't afford formula - If she does not breastfeed at least sometime, mother feels she is not giving tender loving care to the baby	Self Family Community Information Enabling environment
4. Care, Support and Treatment	
Treatment is lifelong	Self/ Information
Stigma and discrimination	Family/ Community Values Enabling environment

Misconceptions about treatment, effectiveness etc	Peers/ Community/ Self Information

<u>ART</u> (Facilitated by Dr. Ahmed)

Goal: All eligible patients on ARVs

Barriers	**Influenced by**
1. Knowing HIV Status	
Inadequate knowledge of HIV, transmission methods and self assessment of risk	Self Information
Stigma	Family, community Enabling environment Values
Worry that knowing status will not do any good (no knowledge about positive living or treatment)	Self, Information Motivation
2. Treatment of Opportunistic Infections (OIs)	
Go first to traditional healers	Peers, community Information Values
Do not know about seriousness of OIs if someone is HIV+ (special vulnerability)	Self, information
Do not know where to go for treatment	Information
Poor availability of some treatment drugs and stock outs	Enabling environment
Financial constraints – high costs of private drugs	Enabling environment
3. Seeking Timely Treatment at CTC	
Lack of information about clinic	Information
Distance to the CTC and lack of transport due to financial constraints	Enabling environment
Stigma of being seen at CTC	Community/ self Values Enabling environment
4. Disclosure	
Fear of divorce	Partner/ Family/ Values

Stigma	Family/ Community Enabling environment Values
Worry about losing employment	Enabling environment
4. Prevention of re-infection	
Lack of disclosure of sero status to partner	Self/ partner/ Family Information Motivation Ability to act
Lack if information about the need for safe sex in sero discordant and concordant couples	Self/ Partner Information
No policy to guide those who are purposely re-infecting others	Enabling environment
5. Adherence	
Lack of treatment partner who can support and remind. This is often due to lack of disclosure	Self/ family/ community Ability to act
Side effects	Self Information Motivation
Transport constraints due to financial ability and distance from CTC	Self

CONCLUSION

Key Findings

1. Communication Strategy**:** With the expansion of HIV/AIDS services (PMTCT, ARV access, home-based care), there will be a need to promote and explain each service. Currently, the health sector lacks an overall strategy for HIV/AIDS communication. Without such a strategy, there is a danger of confusing the public and duplicating resources. No health sector communication strategy for HIV and AIDS exists, under which a communication strategy for PMTCT and Care and Treatment would fall. At the very least, a communication strategy for VCT, PMTCT and ART is urgently needed. Perhaps as a later step, this strategy could be expanded to include other aspects of HIV/AIDS communication. Ideally PMTCT and ART communication should be integrated with HBC, IRH, and TB communication. This communication strategy should make reference to the links.
2. Stigma and discrimination against people living with HIV and AIDS are still common and cited by many as being "very real." Fear of rejection by community and family members is a major deterrent to effective PMTCT and ART programs. Fear prevents individuals from learning their HIV status; prevents HIV-positive mothers from disclosing their results to their partners; and prevents men and women from protecting themselves and their partners (do you have something to hide?). People believe that with wider information about and uptake of PMTCT and ART, more people will want to know their HIV status (will see some hope) and stigma may also be reduced because HIV/AIDS can be presented as a chronic disease, rather than a death sentence.
3. Male involvement is critical. Health decisions are largely influenced by men. However, it appears most men do not share responsibility with their partners for preventing MTCT of HIV. It seems that this has two main causes. First, many women are not ready to disclose their HIV results to their partners. Secondly, many men are not willing to get tested nor do they see the benefits for them or their families to become involved in their wives' maternity care. Treatment is also dependent on knowing one's status.
4. Faith-based organizations are very influential in Zanzibari society and could influence key barriers in the community and between men and women. Faith leader training, support materials, and networking with, for example, the International Muslim Leaders conference on AIDS or other ongoing activities is crucial. Faith leaders must be involved from the start so that they feel committed and consulted.
5. Care seeking behavior in Zanzibar often involves first going to a traditional healer and then going to a clinic only when someone starts to feel worse or is not getting any better. There is still a lot of faith in traditional cures.
6. Behavior change always occurs in a social context. Much greater community involvement is needed in order to change social norms towards testing, treatment, care and support.

7. Family planning is a critical piece of PMTCT. Increasing use of modern family planning methods will reduce MTCT.
8. Widespread mixed feeding practices for infants in Zanzibar will be a huge communication challenge for the PMTCT communication strategy.
9. MTCT Plus is needed to follow up on positive mothers after they have delivered and to monitor their infant feeding though "buddy" support and/or home-based care visits. Also follow up and link these mothers to treatment.
10. The health system will become increasingly burdened by the number of people on treatment and the number of positive pregnant mothers in the PMTCT program. Without an increase in trained clinical staff to provide adequate counseling and support, demand could outstrip service delivery.

Recommendations

1. **Immediately develop a communication strategy on VCT, PMTCT, and ART**. Prior to developing the communication strategy, it is recommended that some focus group discussions be conducted among PMTCT, VCT, and ART providers, PLHA, and pregnant mothers at the very least. These FGDs should explore some of the observations made in this report and test the suggested framework. The results of this assessment should be used when developing communication strategies and action plans.
2. **Combine mass media and interpersonal communication approaches for PMTCT and ART**. PMTCT and ART involve a complex set of practices that require a good understanding of HIV/AIDS, transmission, prevention and treatment.
   - Mass media should be used to provide more general education about MTCT and ART and how to reduce the risk of transmission through primary prevention, family planning to avoid unplanned pregnancy among HIV-positive men and women, prevention and early treatment of opportunistic infections, treatment and adherence support for those on ART, and compassion and caring for people living with HIV and AIDS.
   - Interpersonal communication supported by client materials like brochures, posters, and booklets that are more detailed for those who need the services.
3. **Empower clinical staff, home-based care providers, peer educators, and others** with guidelines and teaching tools to assess client needs and provide clear, correct, and consistent information.
4. **Outline clear points of action in all communication materials.** What do you want the reader/listener/viewer to do with the information he/she has received?

5. **Involve as much as possible faith-based organizations and people living with HIV/AIDS** to ensure maximum acceptance and credibility of communication activities and materials. Faith leaders are also an extremely effective channel for reaching audiences in Zanzibar and can be used to impact a variety of issues.
6. **Solicit wide buy-in for the communication strategy by all PMTCT and ART stakeholders in Zanzibar**. Any materials or communication interventions on PMTCT and ART produced or undertaken in Zanzibar should fit in with the communication strategy and other partners should be aware of it. This will ensure wider acceptability and less duplication of communication interventions.
7. **Promote MTCT Plus** to more effectively prevent mother-to-child transmission of HIV. Communication activities should not only promote PMTCT services, but also:
    - Primary HIV prevention
    - VCT and risk reduction planning among young couples
    - Family planning among HIV-positive pregnant women
    - Exclusive breastfeeding or exclusive replacement feeding to reduce the risk of HIV transmission among women who are HIV positive or whose status is unknown
    - ART and care for positive mothers
8. **Involve mothers, grandmothers, and other family members that may influence infant feeding decisions in developing communication strategies**. Mothers who choose not to breastfeed are stigmatized and mixed feeding is a common practice. In light of these realities, realistic communication solutions need to be found.
9. **Develop approaches that help men understand the benefits of knowing their HIV status**; protecting their partners, babies, and selves from HIV infection; and creating a supportive environment for PMTCT practices. Even before PMTCT services were available, men did not normally attend antenatal services. It is unrealistic to demand that men attend antenatal services in order to receive VCT and discuss results with their partners. Men should be encouraged to learn their HIV status, discuss their status with their partners, protect themselves and their partners from HIV, and support partners who are HIV-positive to take action that will prevent transmission to their infants.
10. **Actively promote community-based approaches** that are more interactive, responsive to individual information needs and community contexts, and provide an opportunity for men and women to voice their concerns.
11. **Use existing community structures and resource persons** such as Shehia-level Health Committees, TBAs, traditional healers, home-based care providers,

and peer educators with standardized approaches and materials so information is accurate and consistent.

12. **Identify and train good peer educators** who can do peer counseling for PMTCT and ART. At some point, the burden of counseling will become great for the clinical officers in addition to their work administering treatment. They will need some help. PLHA that are good communicators with a clear understanding of HIV/AIDS, treatment, and care should be identified. These peer educators should be well trained in peer education skills and in information about care and treatment. They will then be able to do pre-counseling and refer clients to the clinical officers only for the major issues. Clients will also be more open and comfortable with peers for certain kinds of questions.
13. **Communication capacity building**: The communication capacity is currently low as medical response is the greater priority. It would be important to build capacity for communication within the existing NGOs and current health care system.
14. **Ensure better coordination and harmonization of communication interventions and messages**. Apparently, the Health Education unit once played that role in Zanzibar but, by its own admission, has been unable to do so in the last 10 years since Danida withdrew support for that activity. Perhaps this is something that can fall under the ZAC IEC officer in conjunction with the ZACP IEC Officer.
15. **Conduct more research on Zanzibari social values and stigma**, and how they impact infant feeding practices, HIV testing, and care and treatment seeking behavior. This will better inform communication interventions.

Developing a Strategic Communication Plan

The following are suggested outline and guidelines to be used when developing communication strategies. These strategies should be vetted with stakeholders and adapted to the Zanzibar context. There are merely suggestions as to how the strategies could be organized.

Any strategy developed should adhere to the following general principles:

1. Be a research-based and audience-centered approach
2. Offer an integrated approach to VCT, PMTCT and ART
3. Focus on BCC and not just information giving
4. Allow for community ownership and participation
5. Recognize that partnership and coordination is key among stakeholders
6. Use multiple channels of communication
7. Respond to the dynamic nature of HIV/AIDS information

PMTCT Communication Goal:

Empower individuals, families, and communities to make informed choices to prevent HIV transmission, prevent unintended pregnancies, use PMTCT services, and access care and support through effective BCC strategies.

- Objective 1: Increase knowledge and awareness of PMTCT. Increase service utilization, including PMTCT Plus
- Objective2: Increase community action, ownership, and partnership for PMTCT
- Objective 3: Encourage male involvement in PMTCT
- Objective 4: Strengthen Health Worker's knowledge and communication skills to promote and provide the PMTCT Plus package

.

ART Communication Goal:

Empower individuals, families, and communities to make informed choices to prevent HIV transmission, know their HIV status, prevent and seek early treatment for opportunistic infections, seek and use ART services, and access care and support through effective BCC strategies.

- Objective 1: Increase knowledge and awareness of ART(treatment literacy but also client empowerment).
- Objective 2: Increase community preparedness for ART services, increased service utilisation, ownership, and partnership for ART
- Objective 3: Encourage disclosure and partner testing.
- Objective 4: Encourage proper adherence to ART and OI medication
- Objective 4: Strengthen Health Worker's knowledge and communication skills to promote and provide the ART package

Under each of the objectives, specific strategies should be developed (three or four per objective) and each strategy should be organized as follows:

Audience:

Communication Channels:

Key Messages:

Illustrative Activities:

Indicators:

- # of
- # of
- # of

Attachment A: HIV Prevalence among VCT Clients in Zanzibar:
HIV prevalence among VCT clients: distribution of HIV infection patterns in VCT in public facilities -March; April and June 2003 [May Data not available]

Age groups [Years]	HIV positive subjects		Number tested	Percentages positive [%}
	Male	Females		
0-14	0	2	9	22
15-24	4	6	288	3.5
25-29	5	10	271	5.5
30-34	8	13	213	9.8
35-39	10	5	152	9.9
40+	8	6	117	12
Total	35 [3.3%]	42 [4%]	1050	7.3%

HIV prevalence among VCT clients: distribution of HIV infection patterns in VCT in non-public facilities between 2001-2002

Age groups [Years]	HIV positive subjects		Number tested	Percentages Positive [%}
	Male	Females		
0-14	6	4	23	43.5
15-24	28	7	521	6.7
25-29	29	17	420	10.95
30-34	21	12	243	13.58
35-39	12	13	150	16.67
40+*	4	8	211	5.69
Total	100 [18.6%]	61[6.1%]	1568	10.27

- There are 3 HIV positive subjects in this category whose sex was not recorded.

Overall: total number of males: 538; total females: 1002. Undefined sex: 28

Attachment B: List of Contacts from Meetings

Organization	Contact	Title	Phone number/ e-mail	Function of Organization
ZACP	Dr. Dahoma Dr. Farhat Khalid Dr. Ahmed M. Khatib Hamida O. Bungalah Tatu Bilal Ali Kailu Ameir Nassor Ramadhan Hassan	Director National PMTCT Coordinator National Treatment Coordinator PMTCT Coordinator Unguja HBC and VCT Coordinator IEC Coordinator STI Coordinator	 0748-585860	ZACP is the coordinator for the health sector HIV/AIDS response. - Provides technical support to ZAC - Advocates for counseling, testing and treatment - Ensures that quality services are made accessible to the Zanzibar people - Mobilise resources - Build health sector HR capacity - Solicit for equipment
Clinton HIV/AIDS Initiative	Heidi Becher	Project Manager	0744-222503 heidi.becher@t-online.de	Technical assistance to ZACP in the setting up of the treatment and care programme.
ZANGOC	Asha Ahmed Othman Mr. Kai Bashir	Secretary Steering Committee Member Nurse Counselor, VCT	0747-416032 zangoc@zanlink.com	NGO cluster or an umbrella body for 24 NGOs (currently) and coordinates their HIV activities although they may have other activities as well
MDM	Maria Roura, Ph.D Ramadhan Issa Hassan	Programme Coordinator STI Coordinator	0747-435207 mdmzanzibar@zanlinkl.com 0747-459215 ramadhai@yahoo.com	Spanish NGO with mandate to STI reduction, VCT and PMTCT. Only NGO producing materials of any quality and volume for Zanzibar
MOH/ HEU	Mr. Mtumna Kassim Iddi	MOH Health Education Unit	0747-438928 223-5547	Coordination of communication activities of MOH
MOH/ Nutrition	Mr. Abu Hamadi Juma Ms. Amina Saleh Ms. Asha Hassan Shemsa Mselem	Director Nutrition Officers	0747-422660 0748-430996	Infant feeding Nutrition
ZAC	Asha Abdallah	Executive Director		Coordinating HIV/AIDS Activities in Zanzibar, and providing advocacy,

	Mr. Hamid Mr. Chande Moumin	FBO Coordinator Administrator		planning, capacity building and fund-raising assistance to NGOs, FBOs and others
MMH/ IRH	Ms. Azzah Amin	Assistant Programme Manager Integrated Reproductive Health	0741299347	Family planning and safe motherhood at the Mnazi Mmoja hospital
MMH/ MCH	Sharifa A. Said	PMTCT Nurse Counselor		PMTCT services in MMH within the MCH Clinic. One of the three sites in Zanzibar where this service is offered
Mafunzo PHCU	Haji Hamdu Omar	Clinical Officer, VCT Counselor, Home Based Care Provider		One of the PHCUs providing VCT – Government site
ZAPHA+	Consulata John Catherine Sutton	Chairperson Coordinator, PLHA Volunteer		Support group for PLHA in Unguja.
Femina HIP	Minou Foglesang		0744-55411 femina-hip@raha.com	
Aga Khan Foundation NGO Resource Centre	Secretary		+255-24-223-0696 ngorc@zanzinet.com	Working for advancement of civil society through capacity building, training, policy and advocacy.
UNICEF				United Nations Children’s Fund

Attachment C: List of Participants in PMTCT and ART Communication Meeting

Name	Title	Organization
Uttara Bharath Kumar	Regional Communication Advisor	CCP
Dr. Farhat Khalid	National PMTCT Coordinator	ZACP
Dr. Ahmed M. Khatib	National Care and Treatment Coordinator	ZACP
Hamida O. Bungalah	PMTCT Coordinator Unguja Zone	ZACP
Consolata John	Chairperson	ZAPHA +
Amour Ahmada	Vice Chairperson	ZAPHA +
Samola Brashi	Member	ZAPHA +
Tatu Bilal Ali	HBC and VCT Coordinator	ZACP
Kailu Ambir Nassor	IEC Coordinator	ZACP
Hussein Salim	Member	ZAPHA +
Ramadhan Ali	Audio Visual Tech	ZACP
Dr. Mariam	Care and Treatment Clinician	MMH
Heidi Becher	Project Coordinator	Clinton HIV/AIDS Initiative
Tatu Magaga		ZACP
Rukia Suleiman Saleh	STI/CTC Clinician	MMH
Siti Makame	STI/ CTC Clinician	Pemba
Wahida J. Nahoda	STI Pharmaceutical Assistant	MMH
Mwikhanus Issa	Nurse Counsellor STI/CTC	MMH
Abdilahi Nassoro	Member	ZAPHA +
Asha Abdallah	Nurse Counsellor CTC	Pemba
Time N. Khamis	Nurse Counselor	MMH
Sharifa A. Said	MCH Clinic PMTCT Counselor	MMH
Hidaya M. Hamad	Lab Technician	MMH
Said Salim Maalim	Pharmacy Technician	ChakeChake Hospital – Pemba
Rabia M. Makame	Pharmacy Assistant	MMH
Muhera Homoud Mohid	Pharmacy Assistant	MMH
Nahya Kassim Nasor	Lab Tech	MMH
Rahmata Mzee Said	Nurse Midwife	MMH
Rukia Suleima Vua	O/H	MMH
Ramadhan Hassan	STI Coordinator	ZACP

Attachment D: Documents Reviewed

1. Baseline Health Facility Needs Assessment and Community KAP Study for Piloting PMTCT in Zanzibar, Aziza Mwisongo and Emmanuel Mkundi, UNICEF, June 2003
2. Zanzibar National HIV/AIDS Strategic Plan 2003-2007
3. Situation Analysis and Response Analysis of HIV/AIDS in Zanzibar, August 2003
4. Validation Survey (MOHSW) Report on the Population Based Survey to estimate HIV Prevalence in Zanzibar, January 2003
5. Zanzibar Faith Based Organisations Implementation Report, 2004-05, Printed in June 2005, H.S.Nassar, FBO Coordinator, ZAC
6. HIV and Infant Feeding: technical update, Dr. Chewe Luo, 4-6 February 2004
7. Prevention of Mother to Child Transmission of HIV in Tanzania: Behaviour Change Communication, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, May 2005
8. Draft Zanzibar National Multi-Sectoral HIV/AIDS Policy, Zanzibar AIDS Commission, June 2005
9. Anti-Retroviral Therapy (ART) Communication Strategy for the Joint Clinical Research Centre (JCRC) with assistance from the Health Communication Partnership
10. National PMTCT Communication Strategy of Zambia, November 2004

Attachment E: Health Care Delivery Structure in Zanzibar

Type of Institution	Number	Where
Referral Hospital (includes general, maternity and mental hospitals)	1	Mnazi Moyo Hospital in Unguja.
District Hospitals	3	Pemba
Cottage Hospitals	4	2 each in Unguja and Pemba
Primary Health Care Units (PHCU)	130	Distributes in both islands

The PHCU, which is the lowest level of health delivery, is usually staffed by a Clinical Officer and/or Nurse, a Community Health Nurse a midwife and other clinic support staff. VCT services are offered in some PHCUs, some offer counseling only and others offer neither. Where VCT is offered, the staff went through a 6 week training conducted by WHO. Often the PHCU is involved in community mobilization activities along with local organizations and NGOs.

List of sites and services in Unguja and Pemba

Name	Type	Counseling	Testing	PMTCT	ART	HBC	STI	TB/ Leprosy
UNGUJA								
Urban District								
Mnazi Mmoja CTC	Hospital	Yes	Yes		Yes	5	Yes	Yes
Mnazi Mmoja MCH Clinic	Hospital	Yes		Yes	Yes	-		
Rahaleo	PHCU	Yes	Yes			2	Yes	Yes
ZANGOC (Mpendae, M/Kwerekwe)	NGO	Yes	Yes			-		
Zayadesa	NGO	Yes	Yes			-		
Bavuai	Military Clinic					-	Yes	
Ubago	Military Clinic					-	Yes	
Mwembe Ladu	Maternity Hospital	Yes		Yes		2		
Sebleni	PHCU	Yes				2	Yes	Yes
Chumbuni	PHCU	Yes				2	Yes	
Mental Hospital						2		
Mafunzo	Dispensary	Yes	Yes			2	Yes	Yes
Marie Stopes	Private Clinic	Yes	Yes			1		
Ziwani	Police Clinic					2	Yes	
Migombani	Military Clinic					1		
Al Rahma	Private Hospital	Yes	Yes			1		
Rahaleo	Aga Khan Clinic					2	Yes	Yes
SDA Meya	Mission Clinic					1		
JKU Saateni	Military Clinic					2	Yes	
Shauri Moyo	PHCU					1		
West District								
Magogoni	PHCU					2		
Fuoni	PHCU	Yes				2	Yes	
Fuoni Kibondeni	PHCU					1		

Name	Type	Counseling	Testing	PMTCT	ART	HBC	STI	TB/ Leprosy
K/Samaki	PHCU	Yes				2		
Kombeni	PHCU	Yes				1	Yes	
Shakani	PHCU					1		
Bwefumu	PHCU					1		Yes
Mbweni	PHCU					1		
Kizimbani	PHCU	Yes				2		
K.M.K.M. (Kibweni)	Dispensary	Yes	Yes			3	Yes	Yes
Bububu (Jeshini)	Military Hospital	Yes	Yes			2	Yes	Yes
Selem	PHCU	Yes				2		
Beit-Ras	PHCU	Yes				1		
St. Camillas	Mission Clinic					1		
North A District								
Kivunge	Cottage Hospital	Yes	Yes			1	Yes	Yes
Mkokotoni	PHCU					1		Yes
Nungwi	PHCU					2	Yes	Yes
Kidoti	PHCU					1		
Tazari	PHCU					-		
Chani Kubwa	PHCU					1		
Chani Masingini	PHCU					1		Yes
Matemwe	PHCU					2	Yes	
Pwani Mchangani	PHCU					1		
Tumbutu jongowe	PHCU					1		
TUmbatu Gomani	PHCU					1	Yes	
Gamba	PHCU					1		
Kijini	PHCU					-		
Central District								
Mwera	PHCU					1	Yes	
Dunga	PHCU					1		
Tunguu	PHCU					1		
Machui – St. Lukes	Mission Dispensary	Yes	Yes			1		

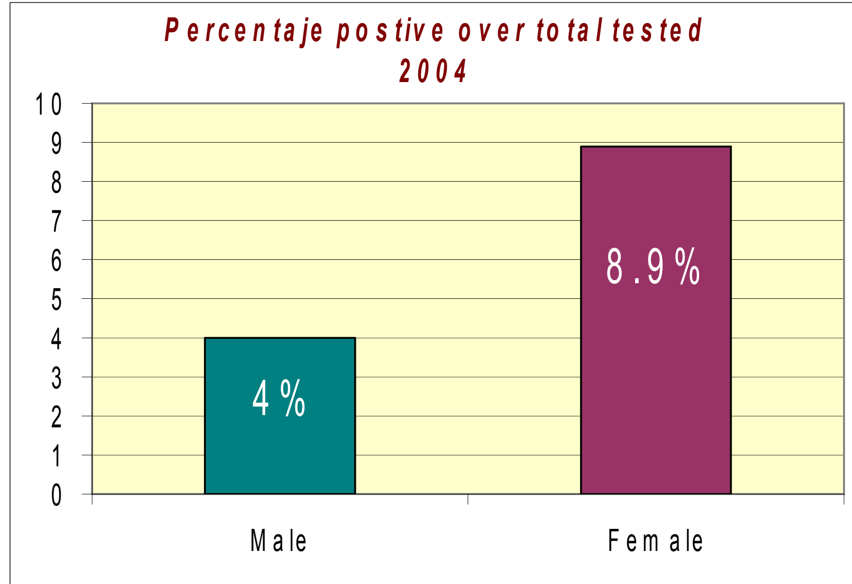
Name	Type	Counseling	Testing	PMTCT	ART	HBC	STI	TB/ Leprosy
Machui	PHCU					1		
Kiboje	PHCU					1		Yes
Ndijani Mseweni	PHCU					-		
Ndijani Kwabaniani	PHCU					1		
Michamvi	PHCU					1		
Unguja Ukuu	PHCU	Yes	Yes			1		
Uzi	PHCI					1		
Uzini	PHCU					1	Yes	Yes
Pongwe	PHCU					1		
Chwaka	PHCU					-		Yes
Uroa	PHCU					-	Yes	
Charawe	PHCU					-		
Mchangani	PHCU					-		Yes
Miwani	PHCU					-		
Ukongoroni	PHCI					-		
North B District								
Misufini	PHCU					1		
Mahonda	PHCU					1	Yes	Yes
Kiwengwa	PHCU					1	Yes	
Donge Vijibweni	PHCU					-		Yes
Donge Mchangani	PHCU					-		Yes
Fujoni	PHCU					-		
Kiyomba Mvua	PHCU					-		
Upenja	PHCU					-		
Makoba	PHCU					-		
South District								
Makunduchi	Cottage Hospital	Yes	Yes			3	Yes	Yes
Mtende	PHCU					1		Yes
Jambiani	PHCU	Yes	Yes			1	Yes	
Bwejuu	PHCU					1	Yes	

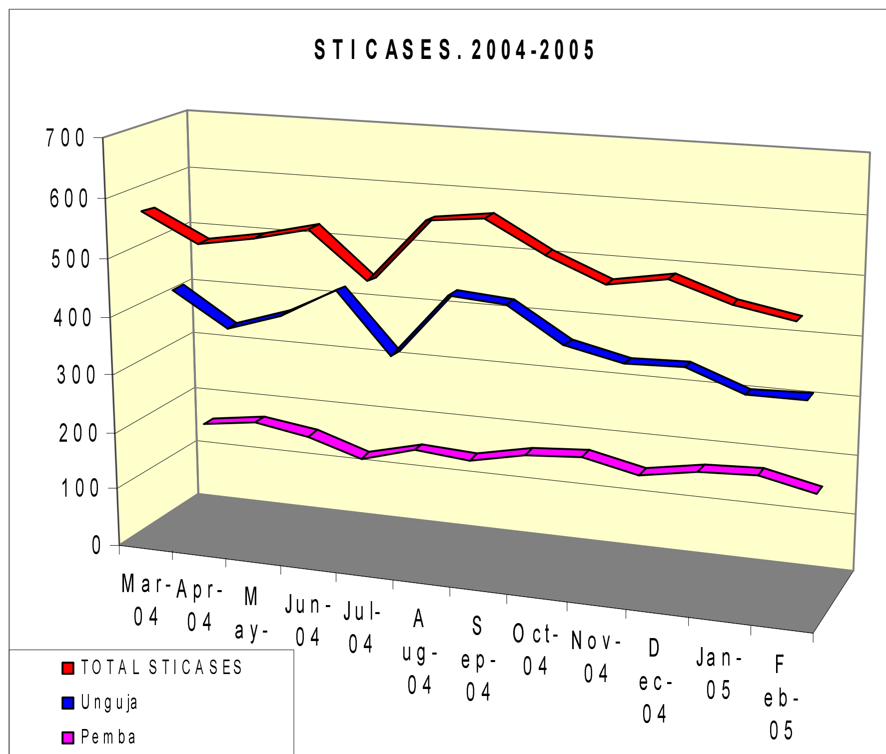
Name	Type	Counseling	Testing	PMTCT	ART	HBC	STI	TB/ Leprosy
Paje	PHCU					1		
Kitogani	PHCU					1		
Muyuni	PHCU					1		
Kizimkazi Mkunguni	PHCU					-	Yes	Yes
Kizimkazi Dimbani	PHCU					1		Yes
PEMBA								
Chake Chake District								
Chake Chake	Hospital	Yes	Yes	Yes	Soon	4	Yes	
Chonga	PHCU					2		
Shungi	PHCU					1		
Tundauwa	PHCU					1	Yes	
Ndagoni	PHCU					1		
Al Khamis Camp	PHCU					1	Yes	
Ziwani	PHCU					1		
Vitongoji	Cottage Hospital	Yes	Yes			1	Yes	
Uwandani	PHCU					2		
Pujini	PHCU					1		
Mabaoni	PHCU					-		
Gombani	PHCU					2		
Mkoani District								
Mkoani	Hospital	Yes	Yes			1	Yes	
Mkoani Hospital	Hospital					3		
Mkoani Wilayani	Private	Yes	Yes			-		
Kisiwa Panza	PHCU					1		
Makongwe	PHCU					-		
Makobmeni	PHCU					1		
Bogowa	PHCU					1		
Wambaa	PHCU					1		
Mtambile	PHCU					1		
						1		

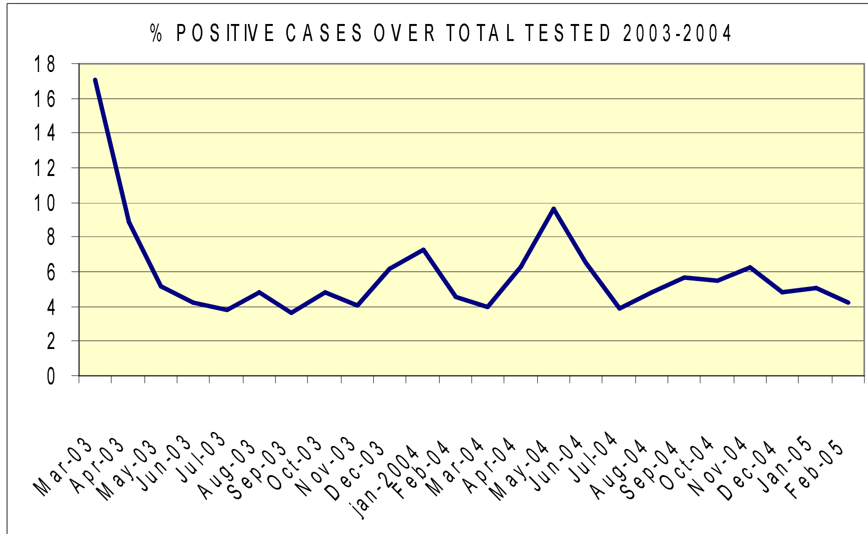
Name	Type	Counseling	Testing	PMTCT	ART	HBC	STI	TB
Shidi	PHCU					1		
Chambani	PHCU					1		
Muambe	PHCU					1		
Kiwani	PHCU					1	Yes	
Kengeja	PHCU					-	Yes	
Kangani	PHCU					1		
Shamiani	PHCU					1		
Wete District								
Wete	Hospital	Yes	Yes			4	Yes	
Wete MCH Clinic	Hospital	Yes				1		
Jadida	PHCU					2		
Tungamaa	PHCU					-		
Pandani	PHCU					1	Yes	
Mzambarauni	PHCU					1		
Chwale PHCU	PHCU	Yes				1		
Vumba	PHCU					1		
Kambini	PHCU					-		
Fundo	PHCU					1		
Ole	PHCU					1		
Kisiwani	PHCU					1		
Uondwe	PHCU					1		
Ukunjwi	PHCU	Yes				1		
Msheli Sheli Kibutu	NGO	Yes	Yes			-		
Junguni	PHCU	Yes				1	Yes	
Kojani	PHCU					1	Yes	
Kiungoni	PHCU					1		
Minungwini	PHCU					-		
Kangagani	PHCU					1		
Micheweni District								
Micheweni	Cottage Hospital	Yes	Yes			1	Yes	

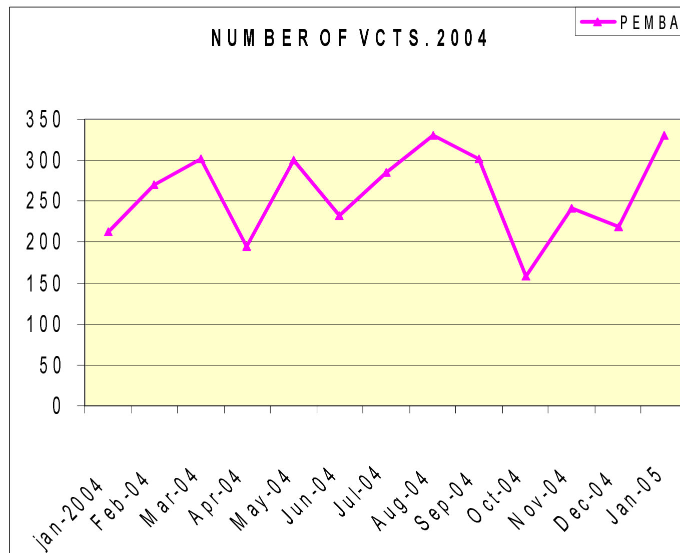
Name	Type	Counseling	Testing	PMTCT	ART	HBC	STI	TB
Msuka	PHCU					1		
Konde	PHCU					-	Yes	
Tumbe	PHCU					-		
Makangale	PHCU					-	Yes	
Kiuyu	PHCU					-		
Maziwangombe	PHCU					-		
Shuma Viyamboni	PHCU					-		
Kinyasini	PHCU					-		
Finya	PHCU					-		
Wengwi	PHCU					-		

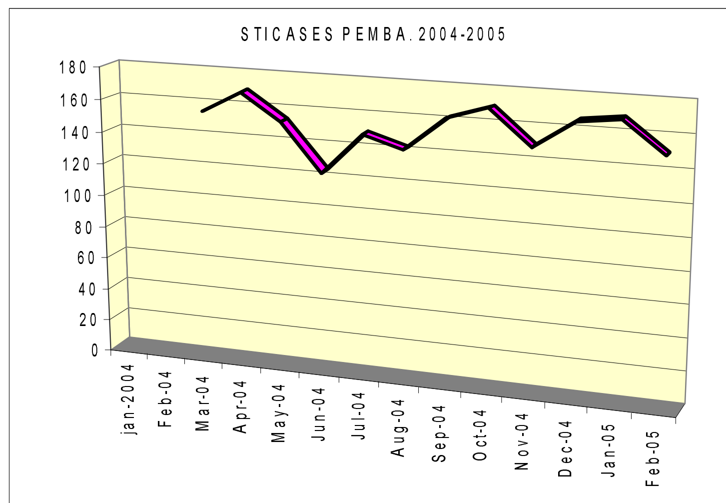
ATTACHMENT F: ZANZIBAR HIV/AIDS AND STI DATA






% POSITIVE CASES OVER TOTAL TESTED 2003-2004
18
16
14
12
10
8
6
4
2
0
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
Sep-03
Oct-03
Nov-03
Dec-03
jan-2004
Feb-04
Mar-04
Apr-04
May-04
Jun-04
Jul-04
Aug-04
Sep-04
Oct-04
Nov-04
Dec-04
Jan-05
Feb-05


NUMBER OF VCTS.2004
PEMBA
350
300
250
200
150
100
50
0
jan-2004
Feb-04
Mar-04
Apr-04
May-04
Jun-04
Jul-04
Aug-04
Sep-04
Oct-04
Nov-04
Dec-04
Jan-05


STICASES PEMBA. 2004-2005
180
160
140
120
100
80
60
40
20
0
jan-2004
Feb-04
Mar-04
Apr-04
May-04
Jun-04
Jul-04
Aug-04
Sep-04
Oct-04
Nov-04
Dec-04
Jan-05
Feb-05

ATTACHMENT G: UNGUJA COMMERCIAL SEX WORKER ASSESSMENT (Medicos del Mundo)

An approach to riskiest sex in Zanzibar

CSW STUDY UNGUJA

This survey was conducted among 156 female commercial sex workers (CSW) in Unguja (Zanzibar). Its objective was to establish the baseline knowledge, attitudes, and practices in order to plan future activities to be implemented among this group. **The survey does not intend to be scientifically rigorous, but to provide a behavioural snapshot** for the implementation of the Médicos del Mundo Zanzibar HIV Prevention Programme.

Data was collected in March 2003 through a standard questionnaire from Family Health International adapted and translated into Kiswahili**.** The fieldwork was conducted by a team of 7 commercial sex-workers previously trained by MDM.

Questionnaire results

1. **Socio–demographic background**

A total of 141 (90.38%) commercial sex workers (CSW) had an age between 16 to 45 years; only 6 (3.85%) were under 16 years.

AGE DISTRIBUTION

Age group		
Less than 16	6	3.85%
16 to 35	105	67.31%
36 to 45	36	23.08%
More than 46	5	3.21%
Refuse	4	2.56%
TOTAL	156	100%

Table 1

77 (49.36%) of 156 CSW are from Zanzibar, 73 (46.8%) are from mainland and only 5 (3.21%) aren't from Tanzania.

2. Drug use

76 (51.70%) of 147 respondents had alcoholic drinks or used other drugs every day, while 18 (12.24%) less than once a week or never. 13 (8.96%) of 145 respondents used injected drugs during the last year.

3. Characteristics of sex work

The places of client contact were: bars/night clubs in 89 (57.05%) of CSW, hotels/guest houses in 23 (14.74%), homes 25 (16.03%), street 7 (4.49%), and others 9 (4.49%).

Most of the clients: 84 (53.85%) were from Zanzibar, and 43 (27.56%) were from areas of high HIV prevalence (Tanzania mainland and Kenya). 51 (33.55%) of the respondents had experienced violence by the client during the past year; 101 (64.74%) had not.

4. Sexual practices

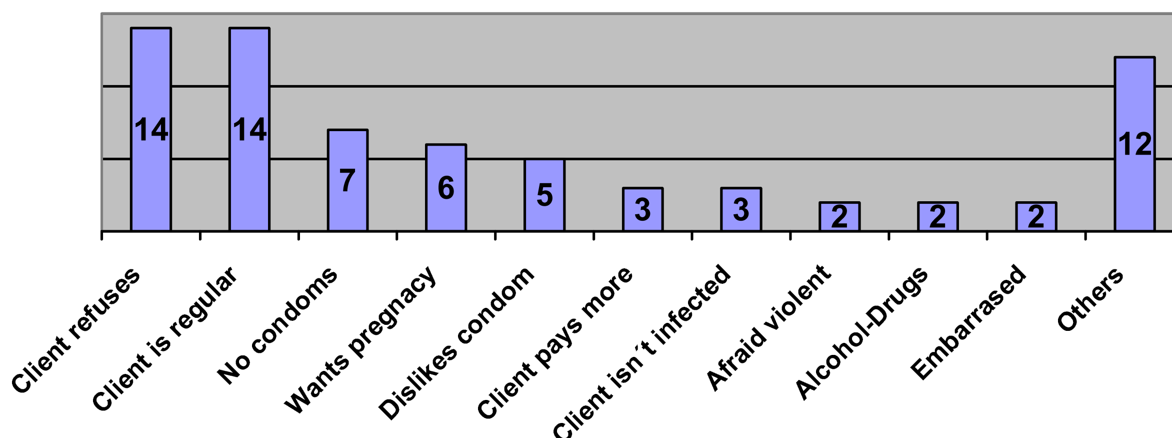
40 (25.46%) sex workers confirmed using substances to tighten the vagina and cause dry sex, while 109 (60.87%) had never used them. Anal sex was practiced by 51 (32.69) of the respondents.

5. Condom use

Condom use with clients

Of the 151 respondents, 76 (50.33%) used a condom every time they had sex with a client in the last three months; 36 (23.84%) sometimes; and 39 (25.82%) never. The reasons for not using condoms consistently between the 75 CSW who don’t use condoms always are given in **Figure 1**.

FIGURE 1: REASON FOR NOT USING CONDOMS WITH CLIENTS



As shown in **Table 2**, sex workers under 16 years are the ones that used condoms less with their clients.

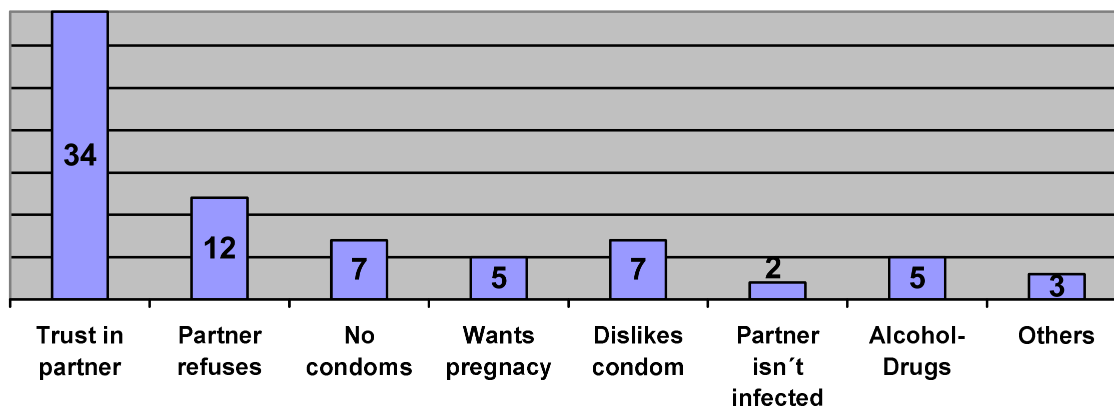
TABLE 2: FREQUENCY OF CONDOM USE WITH CLIENT BY AGE GROUP

Age group	Never	Sometimes	Always	Total
Less than 16	5 (100%)	0 (0%)	0 (0%)	5
16 to 35	22 (21.5%)	23 (22.5%)	57 (55.8%)	102
36 to 45	8 (22.8%)	12 (34.2%)	15 (42.8%)	35
More than 46	2 (40%)	1 (20%)	2 (40%)	5
TOTAL	**37 (25.1%)**	**36 (24.5%)**	**74 (50.3%)**	**147**

- **Condom use with partners**

Of the 152 respondents, 75 (49.34%) used a condom every time they had sex with a non-paying partner, 36 (23.68%) sometimes and 41 (26.97%) never. The reasons for non-condom use given by 75 respondents are shown in **Figure 2**.

FIGURE 2: REASON FOR NOT USING CONDOMS WITH PARTNER



The frequencies of condom use with partner by age group were similar to the frequency of condom use with client.

- **Sources of condoms**

The pharmacy was reported by 48 (39.34%) of 122 respondents as their condom supplier, while the shop provided condoms for 36 (29.50%) of the CSW. Other condom sources were clinics 16.39%(n = 20), bar/hotel/guest house 9.01% (n=11) , and clients 4.09% (n=5).

108 (69.23) of CSWs thought that it's easy for them to get a condom.

- **Female condom**

Most of them (94.87%, n=148) had never used a female condom. 52 (33.33%) of the respondents thought that female condoms would be useful for them; 74 (47.44%) didn't know and 28 (17.95%) thought that it would not be useful for them.

- **Re-use of condoms**

Of the 134 respondents, 84 (62.68%) never used a condom more than once, 16 (11.94%) sometimes and 34 (25.37%) always used a condoms more than once.

- **Condom use with different sexual practices**

Condom use with the clients among the women who had higher risk practices like dry sex and anal sex was higher than in oral sex. (**Table 3**)

TABLE 3: CONDOM USE WITH DIFFERENT SEXUAL PRACTICES

	Never	Sometimes	Always	Total
Oral sex	138 (89.61)	11 (7.15%)	5 (3.25%)	154
Dry sex	3 (7.5%)	12 (30%)	25 (62.5%)	40
Anal sex	5 (9.81%)	20 (39.22%)	21 (41.18%)	51

6. STD

25 (17.48%) of 143 respondents self-reported episodes of genital sores, abnormal vaginal discharge or genital pain during the past six months.
Most of the CSW 137 (87.82%) considered abnormal discharge, pain, and genital sores a sign of illness, only 13 (8.33%) did not consider sign, and 4 (2.56%) didn't know. The behaviours, if they had some of the symptoms, given by 155 respondents are shown in **Figure 3**.

Figure 3

STD BEHAVIOURS

7. **Attitudes towards HIV testing**

When the survey participants were asked if they would like to have an HIV test, 71.71% (109 of 152) said they would like to be tested; 28.28% (n = 43) didn't want to be tested. In **Table 4** we can see the distribution by age groups.

TABLE 4: ATTITUDES TOWARD HIV TESTING

Age group	Would like to have HIV test	Wouldn't like to have HIV test	Total
Less than 16	3 (50%)	3 (50%)	6
16 to 35	82 (79.6%)	21 (20.3%)	103
36 to 45	18 (52.9%)	16 (47.1%)	34
More than 46	4 (80%)	1 (20%)	5
TOTAL	**107 (72.3%)**	**41 (27.71%)**	**148**

A total of 77.77% CSW respondents knew an HIV testing location, while 22.22% (n = 34) did not. Of all the respondents, 30 (19.48%) had been previously tested. Most of the CSW 119 (76.28%) thought that they had an easy access to a VCT centre; only 18 (11.54%) thought that it was not easy, and 18 (11.54%) didn't know.

8. **HIV risk perception**

A total of 140 (90.32%) of 155 sex workers agreed that a healthy looking person could be HIV infected, while 12 (7.74%) disagreed and 3 (1.93%) did not know. When they were further asked to estimate their own risk of contracting HIV/AIDS, 75.16% (n = 115) of the 153 respondents believed they were at risk, 13.72% (n = 21) at no risk, while 11.11% (n= 17) did not estimate their risk.

9. **HIV prevention request**

When they were asked how could we help you to prevent HIV/STDs, 82 (50.31%) of respondents said with free condom distribution; 32 (19.64%) with CSW education on HIV/STDs; 22 (13.50 %) VCT; 11 (6.75%) condom promotion; 7 (4.30%) IGA; 4 (2.46%) faithfulness promotion; 3 (1.84%) school education and 2 (1.23%) general population education.

MDM Zanzibar team