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Contextualizing HIV/AIDS Prevention and Treatment Programs in Zanzibar, Tanzania

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Contextualizing HIV/AIDS Prevention and Treatment Programs in Zanzibar, Tanzania

by

Naheed Ahmed

A thesis submitted in partial fulfillment
of the requirements for the degree of
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and

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Abstract

International aid organizations and wealthy nations have contributed billions to combat the spread and treatment of HIV/AIDS in sub-Saharan Africa; however, these programs have been critiqued for not addressing the socioeconomic and cultural context of the epidemic, instead relying upon generalized approaches. The prevalence rate in Zanzibar, Tanzania is low in the general population, but high among vulnerable segments of Zanzibari society, resulting in interventions focusing on particular groups (e.g. sex workers, drug users, and men who have sex with men). Through interviews with government agencies, non-profit organizations, medical professionals, vulnerable populations, and HIV/AIDS patients, this paper examines how local realities inform and challenge HIV/AIDS programming in Zanzibar.

Chapter One:

Introduction

Since the 1980s, when HIV/AIDS first came to the attention of health officials, there have been many successes in lengthening the lives of patients and raising awareness about the virus and the disease. According to the Joint United Nations Programme on HIV/AIDS, five million patients are receiving treatment, which has contributed to a decrease in the number of AIDS related deaths (2010). Recent data also show that the epidemic has either stabilized or decreased in some countries. These statistics are promising and indicate HIV/AIDS interventions have been successful in some areas. However, the epidemic continues to disproportionately affect sub-Saharan Africa, where there are 22.5 million adults and children living with HIV/AIDS, which accounts for 68% of all global cases (2010). The region also has the highest incidence rate in the world and approximately 1.8 million new cases were diagnosed in 2010 (UNAIDS 2010). There have been successes in increasing access to anti-retroviral (ARV) medication in certain countries, with Botswana achieving universal access (80% or higher) and the countries of Benin, Ethiopia, Mali, Namibia, Senegal, Swaziland, Tunisia, and Zambia reaching 50%-80% coverage rates (WHO 2010). However, universal access to ARVs is a distant goal for other sub-Saharan African nations with limited resources. Explanations for these statistics are varied and complex, but researchers identify some of the primary causes as poor health care infrastructure, social stigmatization, gender relations, food insecurity,

and poverty (Singer et al. 2005; Wilson and Halperin 2008; Lockhart 2008; Himmelgreen et al. 2009).

Billions in international aid have been devoted to halt the spread of and provide treatment for HIV/AIDS in the region. Increasing access to rapid HIV tests and ARV medication, preventing mother-to-child transmission of the virus, male circumcision campaigns, and public awareness programs are some examples of internationally funded initiatives in sub-Saharan Africa (UNAIDS 2010; Pfeiffer 2004; Wilson and Halperin 2008). Awareness campaigns in particular have been used to educate communities about HIV; for example, how it is transmitted, preventative measures, and the importance of knowing one's HIV status (Epstein 2008). While this aid has been helpful in some respects, it has been criticized for not addressing the socioeconomic and cultural context of the epidemic and instead relying upon generalized approaches (McElroy and Townsend 2009; Singer 1998; Pfeiffer 2004; Wilson and Halperin 2008). Specifically, critics of these initiatives argue prevention campaigns rely too heavily on behavior change and risk reduction models that exaggerate the agency of individuals and neglect the social realities in which people live (Singer 1998; Farmer 2003; Schoepf 2001; Singer and Clair 2003). Additionally, prevention messages imported from Western countries are culturally inappropriate and in some cases offensive to African communities (Schoepf 1992; Pfeiffer 2004). Anthropologists have advocated for more contextually grounded HIV/AIDS programming, based on ethnographic data to gain a more nuanced perspective of social realities and structural barriers (Schoepf 2010; Pfeiffer 2004; Singer and Clair 2003). Furthermore, there is a need for multidimensional prevention approaches, involving a focus on food insecurity, nutrition education, increasing access to health

services, and income generating activities, which will contribute to reducing prevalence rates (Himmelgreen et al. 2009; Romero-Daza and Himmelgreen 1998; Singer 2011).

Factors shaping the HIV/AIDS epidemic are varied and complex, necessitating the use of multidimensional prevention initiatives in order to effectively address issues contributing to the transmission of the virus.

Another concern in designing relevant prevention messages is the inclusion of strategies addressing the various modes of transmission pertinent to a specific geographic location. Although heterosexual intercourse has been identified as the primary mode of transmission in sub-Saharan Africa, sex work, drug use, and sex between men are additional areas of concern (UNAIDS 2009, 2010). These high-risk groups can act as a bridge to the general population through overlapping sexual networks. Additionally, HIV/AIDS studies in the Middle East and Eastern Europe have shown how concentrated epidemics among injection drug users (IDUs) have the potential to affect the general population through the sexual partners of IDUs (Rosenberg 2010). An additional concern is the elevated rate of infection among women in comparison to men, which affects children in terms of the loss of caregivers and mother-to-child transmission of the virus (Lugalla et al. 1999; Robberstad and Evjen-Olsen 2010). The marginal status of these groups in most societies restricts their ability to take precautions in preventing infection or seeking help for health related concerns. Seale (2009) argues that drawing attention to these vulnerable groups implicitly challenges legal, political, and religious institutions in sub-Saharan Africa, which are contributing factors to the challenge of adequately addressing health concerns among these populations in HIV/AIDS programming.

These issues are pertinent to the HIV/AIDS situation in Zanzibar, Tanzania, where I conducted research in 2010 as a Boren Fellow. The archipelago of Zanzibar, located along the eastern coast of Tanzania, has a low prevalence rate of 0.6% among the general population and 0.9% among pregnant women (UNAIDS 2009). However, the islands are experiencing a concentrated epidemic among high-risk groups, specifically men who have sex with men (MSM) (12.3%), sex workers (10.8%), and IDUs (15.1%) (UNAIDS 2009; ZACP 2007). Recent epidemiological studies indicate that the prevalence rate in Zanzibar may be higher than reported, which has led to concern about the lack of resources and coordinated efforts on the islands (UNGASS 2005). Increases in prevalence rates have been attributed to wide spread heroin use, the growth of the sex trade, and the underground nature of sexual practices among MSM (Dahoma et al. 2009; UNGASS 2008). Strict adherence to religious teachings in Zanzibar pose a challenge in combating HIV/AIDS in terms of broaching sexual practices, which are not openly discussed. According to Islamic teachings, sex within marriage is acceptable and meant to be an enjoyable experience for both partners, but outside of marriage it is a sin, and as a result, pre-marital and extra-marital sexual relations are kept hidden in Zanzibar (Beckmann 2010).

Although the epidemic has primarily affected high-risk groups, there are concerns that these individuals will act as a “bridge” to the general population due to the interconnectedness of sexual relationships on the islands (Dewing et al. 2006; UNGASS 2005). National HIV/AIDS policy and international donors have focused on prevention programs geared towards high-risk groups, but reaching them has been challenging because of their marginal status in Zanzibari society. Factors contributing to the marginal

status of these groups are a law banning homosexuality, police harassment, and societal disapproval of behaviors (e.g. sex outside of marriage, sex between men, drug use) these groups engage in, resulting in widespread stigmatization of these populations, which ultimately impacts their health status (Dahoma et al. 2009; Johnston et al. 2010). The objectives of the research project presented here were to: 1) Identify non-profit and government sponsored activities targeting marginalized populations; 2) Identify cultural, religious, and structural factors that contribute to or are a barrier to the success of HIV/AIDS programming in Zanzibar; and 3) Understand primary modes of HIV transmission in Zanzibar and how contextual factors contribute to increasing prevalence rates on the islands.

LITERATURE REVIEW

HIV/AIDS first came to the attention of the health community in the 1980s and initially was believed to only infect gay men, hemophiliacs, and ethnic minorities (McElroy & Townsend 2009). These early misconceptions have contributed to a “blame the victim” and “lifestyle choices” attitude toward HIV/AIDS patients. Individuals who contract HIV are viewed as sexually irresponsible and morally loose, as some religious organizations have called HIV a punishment for sinful behavior (Schoepf 2010; Wringe et al. 2009; Zou et al. 2009). Social stigmatization resulting from these beliefs has made it difficult for individuals to seek testing and treatment services (Castro and Farmer 2005). Fear of judgment and ostracism from family and community members, prevents many patients from disclosing their HIV status, which limits their ability to harness social and medical support services (Watt et al. 2009; Wringe et al. 2009). Furthermore, the difficulty of broaching the topic of sex and sexually transmitted infections (STIs) has

hindered public discussions about HIV/AIDS in communities, where sex outside of marriage or between men is considered a sin (Beckmann 2010; Zou et al. 2009). These factors have led to inadequate HIV/AIDS programming in terms of an emphasis on behavior change interventions, resulting in prevention strategies that fail to address the structural factors, which increase susceptibility to HIV/AIDS (Wilson and Halperin 2008; Singer 2005; Himmelgreen et al. 2009).

Anthropological Research on HIV/AIDS

Anthropological research on HIV/AIDS has attempted to shift the direction of programs toward strategies that are context specific (Farmer 2003; Pfeiffer 2004; Singer 1998). Rather than focusing on behavioral factors, anthropologists have examined the socioeconomic conditions, which lead to actions increasing one's risk of acquiring HIV (Farmer 2004; Singer 2011; Lockhart 2008; Schoepf 2010). Some examples of socioeconomic issues explored in anthropological research are gender inequality, poverty, food insecurity, political rights, and social relations (Schoepf 2001; Himmelgreen et al. 2009, Singer 2011). One of the theoretical frameworks incorporated into this project, is the theory of the political economy of health, which Singer states deals with "the health consequences of social inequality as well as the immediate effects of a highly stratified health care system" (Singer 1997:10). This theory can be traced back to Engel's study of factory conditions in the 1800s and Virchow's analysis of the underlying social causes of epidemics. Engel's and Virchow's research highlighted the disconnect between the treatment of diseases and the socioeconomic situation of patients. The biomedical model is "characterized by an effort to treat diseases as if they were distinct entities in nature, separate from other diseases, and independent of the social

contexts in which they are found” (Singer et al. 2006: 2011). Virchow argued that factors such as unemployment, lack of government assistance, inadequate housing, and overcrowding contributed to the outbreak of typhus in East Prussia (Singer 1998). Ignoring these determinants provides incomplete care for patients as the illness is treated, but not its causes. Using this theoretical framework, Singer argues analysis of macro and micro-level factors can be used to gain a deeper understanding of the underlying causes for the HIV/AIDS epidemic. An example of a macro-level factor salient to many sub-Saharan African nations is structural adjustment policies imposed through International Monetary Fund loans, the impact of which, include lowered national spending on social services, the privatization of public industries, and reduced trade protections to make the country more attractive to foreign donors (Singer 2011; Lockhart 2008). The fallout from these policies, include weakened education and health systems and the disruption of subsistence agricultural practices for cash crops, among many other issues.

Furthermore, proponents of the political economy approach are highly critical of traditional prevention initiatives, most of which are based on behavior change and self-efficacy models (Singer et al. 2006; Lockhart 2008; Romero-Daza and Himmelgreen 1998). These models are grounded in individual risk reduction approaches, which exaggerate the agency of individuals to make healthy decisions and fail to address how extreme poverty can lead to survival sex work, subsequently increasing an individual’s susceptibility to HIV (Schoepf 2001). Singer writes that “These approaches have tended to focus attention at the individual level, treating the targets of intervention as if they were independent beings and not members of families, peer groups, communities, and the broader society” (1998:14). Additionally, individualistic models, such as the Health

Belief Model and the Theory of Reasoned Action, are harmful in that they contribute to victim blaming, as people who become infected are perceived as making poor choices, rather than examining how larger structural forces impact health status (Schoepf 2010; Singer et al. 2006; Coreil 2009).

Using a political economy of health perspective of HIV/AIDS in Lesotho, Romero-Daza and Himmelgreen (1998) provide a comprehensive examination of how factors such as labor migration, poverty, survival sex work, and infertile land have contributed to high rates of HIV/AIDS in the country. While Romero-Daza and Himmelgreen agree that condom promotion is a necessary component of prevention strategies, they argue that structural issues, such as high levels of unemployment, unequal gender relations (e.g., the legal status of women as minors which constrains their ability to become economically self-sufficient), limited economic opportunities for men and women, and high levels of food insecurity must also be addressed, as they all impact “high risk” practices, such as survival sex. Similarly, Brooke Schoepf (2010, 2001, 1992) examines issues of gender inequality, poor health care infrastructure, poverty, and traditional healers in her research on HIV/AIDS in Zaire. Schoepf advocates for a shift from individual risk reduction approaches to a social analysis of the local environment, which ultimately increases our understanding of the epidemic and improves the effectiveness of prevention initiatives (2010, 2001). For example, based upon her research in Zaire, Schoepf recommends the use of traditional healers in HIV/AIDS programming, since many community members often seek out health advice from these individuals and traditional healers are in a position to educate patients on issues related to HIV/AIDS (e.g. condom use, testing) (1992).

Another theoretical approach related to political economy is structural violence, which asserts social structures prevent individuals from meeting basic needs and exercising their agency (Farmer 2004). Through his work with HIV/AIDS patients in the USA, Haiti, Rwanda, and other countries, Paul Farmer (1999) has observed how the disease spreads along “fault lines,” specifically among the poor and marginalized. He is a vocal critic of lifestyle and behavioral explanations for HIV/AIDS cases and argues agency among patients is grossly exaggerated. Racism, sexism, homophobia, and poverty are some of the factors that constitute structural violence, which physically manifest in poor health outcomes. Farmer writes that “fundamentally social forces and processes come to be embodied as biological events” (1999:14). This statement refers to how vulnerable groups, such as the poor and women, are disproportionately affected by HIV/AIDS.

Some researchers have cited AIDS-related stigma as an explanation for poor health outcomes among patients, however, Castro and Farmer (2005:58) criticize this approach as “shallow” and for ignoring how stigma is “both cause and consequence of inequality.” They write that economic and political processes have a larger impact on HIV/AIDS prevention and treatment, in terms of access to medication and other health services. Castro and Farmer (2009: 54) propose a structural violence framework in studying AIDS-related stigma, in terms of examining how structural violence increases individual risk of infection, disease progression, access to testing and drug therapies, and in determining which patients deal with stigma and discrimination.

An additional theoretical approach that ties the theories previously discussed together is syndemic theory. Singer and Clair (2003: 429) define a syndemic as “a set of

intertwined and mutually enhancing epidemics involving disease interactions at the biological level that develop and are sustained in a community/population because of harmful social conditions and injurious social connections.” A well-documented example of a syndemic is the interaction between HIV/AIDS and tuberculosis (TB). Individuals infected with HIV/AIDS have a compromised immune system, which increases their susceptibility to TB and additionally there is a synergistic relationship between these two infections, resulting in enhanced co-infection in the patient (Singer and Clair 2003; www.cdc.gov). Among latent cases of TB, HIV co-infection has been associated with progression to active TB, which can shorten the life of a patient (www.cdc.gov). Additionally, TB is more common among the homeless and prisoners, due in part to crowded living conditions, which facilitate the transmission of TB. Inadequate nutrition and compromised immune systems contribute to the progression of the disease, ultimately increasing the patient’s risk of becoming infectious to those around them (www.cdc.gov). The lengthy treatment required for successfully curing TB poses another challenge in terms of poor patients having limited access to health care facilities and receiving inadequate follow-up throughout the treatment process (Singer and Clair 2003). Singer and Clair write “As the case of TB suggests, diseases do not exist in a social vacuum nor solely within the bodies of those they inflict, thus their transmission and impact is never merely a biological process. Ultimately, social factors, like poverty, stigmatization, racism, sexism, ostracism, and structural violence may be of far greater importance than the nature of pathogens or the bodily systems they infect” (2003: 428). Syndemic theory considers these various factors through an analysis of how biological and social forces interact with each other to increase disease burden among

certain populations (Singer et al. 2006; Himmelgreen et al. 2009). This theoretical approach has also been used to examine the importance of addressing food insecurity alongside HIV/AIDS, since malnutrition increases susceptibility to infection and HIV/AIDS patients have heightened nutritional needs (Singer 2011; Himmelgreen et al. 2009). However, community beliefs and perceptions are also important, since they shape behaviors and responses to disease. Singer and colleagues (2005: 2020) argue, “knowing through research what people actually believe and do, and hearing their voices about such matters, presents a firmer foundation on which to construct prevention messages and effective prevention.”

These theoretical approaches have been used by anthropologists to analyze the HIV/AIDS epidemic in sub-Saharan Africa, particularly the underlying structural determinants that increase an individual’s vulnerability of contracting HIV. Studies using these frameworks have identified several factors contributing to high prevalence rates in the region. Armed conflicts, transportation networks, the increasing mobility of populations, and urbanization are some of the causes identified by researchers as the driving force behind the epidemic (Msisha et al 2008; Greif et al. 2011; Morris and Ferguson 2007; Romero-Daza and Himmelgreen 1998). Healthcare infrastructure is lacking in many countries, in particular rural areas, restricting access to quality medical services for many patients (Waako et al., 2009; Wringe et al., 2009; Himmelgreen et al, 2009). Inadequate training of doctors and nurses, in addition to poor medical supply chains are some of the challenges that must be addressed. Additionally, there is competition and lack of coordination among agencies that provide HIV/AIDS services, compounding efforts to support and treat patients (Himmelgreen et al. 2009). Cultural

and religious beliefs further complicate interventions due to the difficulty in broaching the topic of sex and STIs (Wringe et al., 2009; Zou et al., 2009). These beliefs along with low educational levels and AIDS-related stigma affect ARV adherence among patients (Wringe et al., 2009; Watt et al., 2009; Habib et al., 2008; Zou et al., 2009).

Additionally, poverty has led to an increase in survival sex work, primarily among women, which increases their risk of contracting HIV (Msamanga 2006; Romero-Daza and Himmelgreen 1998). Unequal gender relations prevent many women from negotiating condom use with partners, increasing their risk of being infected with HIV or other STIs. HIV infections among women in turn affect mother-to-child transmission of the virus and the subsequent loss of primary caregivers due to AIDS related deaths.

Himmelgreen and colleagues (2009) argue for a multidimensional approach in HIV/AIDS programs, in which the multiple issues contributing to the epidemic are addressed simultaneously, rather than in isolation. This strategy will increase coordination among agencies and the overall effectiveness of prevention and treatment programs, since both health and socioeconomic concerns will be incorporated into HIV/AIDS initiatives.

Zanzibar



Figure 1: Map of Zanzibar (www.worldatlas.com)

Zanzibar consists of two islands, Unguja and Pemba, located along the eastern coast of Tanzania. Zanzibar's location on the Indian Ocean led to its use as a trading post for Europeans and Arabs, which has contributed to a unique mix of cultures on the islands. Various colonial authorities have governed the islands, including the Portuguese, Omani Arabs, Germans, and British (Ndembwike 2006). Zanzibar was an important trading port in the 19th Century, in particular for the transportation of slaves, ivory, spices, and gold. The influence of Arab traders and rulers has resulted in a sizeable Muslim population along the East African Coast and approximately 95% of Zanzibaris are Sunni Muslims (Beckmann 2009, 2010).

In 1964, Zanzibar became an independent nation and signed an agreement with the mainland, forming the United Republic of Tanzania. Although the two regions are united, Zanzibar retains its own government and is relatively semi-autonomous from the mainland. Zanzibar has its own government separate from the mainland, including a President and an elected House of Representatives. Following the lead of the mainland

government shortly after independence, the Zanzibari government adopted a socialist policy. However, severe socioeconomic disparities persist and it is estimated that 51% of the population (1 million) lives below the poverty line (UNMDG 2008). Zanzibar was the primary global supplier of cloves, but their status has diminished as a result of government involvement in the spice trade in the 1960s and competition from other countries on the global market. Tourism makes up 23% of the gross national product, which is evident in the number of hotels, bars, and touring companies catering to tourists on the islands (Beckmann 2009). The primary city in Zanzibar, Stone Town or Zanzibar Town, was declared a UNESCO heritage site in 2000, in part due to the various cultural traditions that have infused architectural structures in the town. This designation and beautiful white sand beaches have helped make Zanzibar a popular tourist destination. Studies of tourism in Zanzibar and other coastal islands in East Africa have noted an increase in the migration of people to these islands for economic reasons, which have coincided with an increase in sex work and drug use (Beckerleg 2004; Beckerleg et al. 2005; Beckmann 2009; Demovic 2007). Positions in the tourism sector are divided along gender lines, men usually work directly with tourists as guides and taxi drivers, and women are often found in traditional female roles, as cooks and maids (Demovic 2007).

HIV/AIDS in Zanzibar

In terms of the HIV/AIDS epidemic, the prevalence rate is relatively low among the general population at 0.6%, 0.9% among pregnant women, and 0.2% among men (UNAIDS 2009; UNGASS 2008). Additionally, recent epidemiological data indicate that 86% of HIV transmission occurs among adults between 20 to 49 years and that female house workers have higher HIV rates (3.8%) than housewives (0.8%) (UNGASS 2008).

Overall, the general prevalence rate is much lower than mainland Tanzania (5.6%), which some researchers attribute to the predominantly Muslim population on the islands (e.g. protective benefits of male circumcision) and societal disapproval in Zanzibar of alcohol consumption and sexual relations between unmarried individuals, which restrict when and where illicit activities occur (Croce et al. 2007; Wilson and Halperin 2008; WHO 2007). However, the islands are experiencing a concentrated epidemic among high-risk groups, specifically men who have sex with men (MSM) (12.3%), sex workers (10.8%), and IDUs (15.1%) (UNAIDS 2009; ZACP 2007). These statistics have led to the Zanzibar government and NGOs focusing on these marginalized populations in HIV/AIDS programming, since there is concern these groups can act as a “bridge” to the general population through interconnected sexual relationships on the islands (UNGASS 2008; Dewing et al. 2006). The susceptibility of these groups to HIV infection is compounded by their marginal status in Zanzibar, due in part to laws against homosexuality and police and community harassment of individuals belonging to these groups (Dahoma et al. 2009; Johnston et al. 2010).

Drugs

Zanzibar’s location on the Indian Ocean and numerous, unmonitored sea ports have made it an ideal entry point for drug traffickers (Johnston et al. 2010; Dahoma et al. 2006; McCurdy et al. 2007; Aguilar-Millan 2008). According to the United Nations’ Office on Drugs and Crime, there has been an increase in the trafficking of cannabis, heroin, cocaine, and amphetamines to East Africa from Asia and the Middle East due to local demand, ineffective border controls, and international travel to the region (2011). These drugs are widely available in Zanzibar and relatively inexpensive depending on the

amount purchased (ZACP 2007). Studies of drug use in Zanzibar suggest that experimentation with drugs begins at a young age, starting with alcohol and marijuana, and eventually progressing to heroin use in some instances (Dahoma et al. 2006).

Researchers have also found that some male and female drug users reported exchanging sex for drugs and that condoms are inconsistently used with paying and non-paying sexual partners (Dahoma et al. 2006; Dahoma et al. 2009; Johnston et al. 2010). Furthermore, female users were more likely to report engaging in sex work than men. An additional concern are reports of drug users engaging in group sex and witnessing sexual assaults on users who have over dosed (UNGASS 2005). The criminalization of drug use and the discrimination of users have restricted their access to health services and increased their susceptibility to health problems and police harassment (Dewing et al. 2006; McCurdy et al. 2007; Johnson et al. 2010). Pharmacists sometimes refuse to sell needles to suspected or known users, which is a contributing factor in needle sharing and high HIV prevalence rates among IDUs. The government is currently discussing the start of a needle exchange program, but significant barriers remain to its implementation (Johnson et al. 2010).

Men Who Have Sex with Men

While quantitative studies have indicated high numbers of HIV/AIDS cases among MSM, there is limited information on MSM in Zanzibar and other African countries (Johnston et al., 2010; Knox et al., 2010; Rispel and Metcalf, 2009; Onyango-Ouma et al., 2009; Seale, 2009, Tadele, 2010). Barriers to fully understanding the sexual health of MSM include discrimination, denial, stigma, and the criminalization of homosexuality. Sexual relations with same sex partners are outlawed in several African

countries, including Zanzibar (Johnston et al. 2010; Ross et al. 2009). Researchers who have studied MSM in Africa, faced significant opposition from institutional review boards and if approval was granted, investigators had difficulty in locating participants, since many MSM are reluctant to disclose their sexual orientation (Onyango-Ouma et al. 2009; Tadele 2010).

Studies in Zanzibar have shown that it is not uncommon for many MSM to have sexual relations with women as well and that condoms are inconsistently used with male and female partners (Dahoma et al. 2009; Johnston et al. 2010). There are also reports of MSM engaging in sex work, using drugs, such as heroin, and dealing with harassment from police officers. Johnston and colleagues (2010) found MSM participant's knowledge of HIV transmission was high; however, this did not prevent risky behaviors, such as needle sharing or inconsistent condom use. Restricted access to clean needles, drug use, poverty, and higher payment for sex without a condom may explain the discrepancy between awareness of risk and engaging in certain high-risk behaviors. While there are several HIV testing and counseling centers on the islands, these services are primarily geared towards the general population. MSM face considerable barriers to accessing health services in Zanzibar, which affect their ability to seek testing and treatment for illnesses (Johnston et al. 2010; Dahoma et al. 2009).

These studies highlight the vulnerable position of MSM in Africa, gaps in the literature regarding their health status, and the importance of addressing their health needs. Another concern is the absence of in-depth qualitative research on MSM, which Onyango-Ouma and colleagues write can "give voice to those minorities, as opposed to survey techniques, which tend to combine together sexual minorities in the category of

the ‘other’” (2009:827). Similarly, Douglas Feldman is an advocate for ethnographic studies of gay men and MSM, since this approach allows for a nuanced and contextually grounded understanding of sexual identities and behaviors (2010). An additional benefit of qualitative research is in deepening knowledge of how social vulnerability and structural factors negatively impact the health and general well-being of MSM in Africa.

HIV/AIDS in Tanzania



Figure 2: Map of Tanzania (www.geology.com)

Although the field site for this study is in Zanzibar, I will briefly delve into the literature on HIV/AIDS and background information on the mainland to compare and contrast the two regions. Tanzania is located in East Africa and borders the countries of Kenya, Uganda, Burundi, Rwanda, the Congo, Zambia, Malawi, and Mozambique. Along its eastern border is the Indian Ocean, contributing to its use as a major port in the region. The Germans and the British served as colonial authorities of the country beginning in the 19th Century, but ultimately Tanzania gained its independence in 1961

(Ndembwike 2006). The Tanzanian government structure includes a President, Vice President, Prime Minister, cabinet ministers, and an elected National Assembly. Agriculture is a significant portion of the Tanzanian economy, but other smaller revenue sources are natural minerals, natural gas, and tourism (IMF 2011). The Tanzanian government experimented with socialism following independence, but the nationalization of banks and other industries failed to deliver economic prosperity. There are approximately 43,739,051 million people in Tanzania and it is estimated that 34% of them live at the poverty level (e.g. income and food insecurity), with higher rates of poverty in rural areas (IMF 2011, WB 2009). The HIV/AIDS prevalence rates among 15 to 49 year olds is 5.6% and it is estimated that 52% of eligible HIV/AIDS patients are receiving ARV drugs due to international funding (UNAIDS 2009, 2011). Epidemiological data indicate that approximately 89,000 patients died due to AIDS related complications in 2009 and 1.3 million children have been orphaned as a result of the epidemic (UNAIDS 2009).

While there are similar concerns (e.g. drug use, sex work) regarding the HIV/AIDS epidemics in Zanzibar and Tanzania, there are other issues unique to the mainland, which are shaping the transmission of the virus in Tanzania. There are a number of major transportation routes throughout the country that are traveled by long distance truck drivers, who have been identified as a high-risk group in terms of the spread of HIV/AIDS (Msisha et al. 2008; Gysels et al. 2000). Studies of transportation networks in sub-Saharan Africa have shown that truck drivers often engage in sexual relations with sex workers during trips and that highways are contributing to the spread of HIV/AIDS across country borders (Gysels et al. 2000; Ramjee and Gouws 2001; Morris

and Ferguson 2011; Maternowska 2009). Along these highways are multiple rest stops, where alcohol and sex workers are available to truck drivers. Research on this highly mobile population indicate that many drivers have a history of STIs, report inconsistent condom use with sexual partners, and that some sex workers are offered more money if a condom is not used (Ramjee and Gouws 2001; Morris and Ferguson 2011; Maternowska 2009). HIV/AIDS prevalence rates among this population are difficult to estimate, due to the transient nature of their work, but researchers believe it is high in comparison to the general population (Morris and Ferguson 2011; Gysels et al. 2000).

Religion is another issue that requires attention when designing interventions, since many faith-based organizations provide important services to HIV/AIDS patients and religious teachings can contribute to social stigmatization in some situations (Wringe et al. 2009; Watt et al. 2009; Zou et al. 2009; Roura et al 2010). Tanzania has large Christian and Muslim populations, with the majority of Muslims concentrated along the coastline. Studies have shown that religious groups can be both a positive and negative influence on HIV/AIDS programming. One benefit is that some religious leaders require that couples show proof of taking an HIV test before granting marriage licenses, which is a useful method in encouraging individuals to seek testing (Zou et al. 2009). However, a drawback to this approach is the difficulty in maintaining confidentiality of test results. In other cases, societal stigma is exacerbated by religious teachings, some of which assert that HIV/AIDS is a punishment for sinful behavior (Schoepf 2010; Beckmann 2010). Obtaining the participation of religious organizations in HIV/AIDS programming will assist in decreasing social stigma and provide an important social and support system for HIV/AIDS patients (Roura et al. 2010). Little research has been done on Muslim

communities and their receptiveness to HIV/AIDS interventions, and is one of the reasons for the selection of Zanzibar as a research site (Habib et al. 2008). Studies that have been conducted among Muslims indicate that they are at lower risk for contracting HIV because of the protective benefits of male circumcision, which is religiously mandated for males (Wilson and Halperin 2008; WHO 2007). Furthermore, religious prohibitions against alcohol consumption reduce high-risk sexual activities (Wamai et al., 2008; Zou et al., 2009).

Additionally, adherence to ARV treatment among patients is another issue of concern on the mainland. Prior research has shown there are several factors that contribute to and protect against poor adherence (Watt et al., 2009; Wringe et al., 2009). Non-disclosure of one's HIV status prevents patients from harnessing the emotional support their family and friends can provide. In addition, non-disclosure restricts a patient's ability to take their medication openly and explain their absences for medical visits. Educational level has also been identified as a risk factor; some studies showing that patients with at least a secondary level education have higher adherence rates (Zou et al., 2009). Beliefs regarding the cause of illnesses are another factor, in that sickness attributed to supernatural causes may result in patients seeking treatment from traditional healers, rather than medical professionals. Additionally, traditional healers are an important source of medical advice for many sub-Saharan African, some of whom see a local healer first before a doctor or nurse (Shuster et al. 2009; Nyika 2007; Simmons 2009). Medical professionals have expressed concern regarding these consultations, since it can contribute to delayed diagnoses and treatment of the infection (Simmons 2009). Furthermore, patients unaware of their HIV serostatus may unknowingly spread

the virus to others. In response to these concerns, efforts have been initiated to merge biomedical treatment models with traditional healing systems (Bodeker et al. 2006; Shuster et al. 2009). Educational programs targeting indigenous medical systems encourage local healers to refer severely ill patients to health clinics. Additionally, traditional healing is seen as complementary to ARV medication in some countries, since it treats the spiritual well-being of patients, whereas medication only treats the physiological aspects of the disease (Boderker et al. 2006).

For those patients who have access to ARVs, they face the challenges of economic insecurity, in regards to their ability to purchase food and pay for transportation to health facilities (Lugalla et al. 1999; Greif 2011). The healthcare system in Tanzania is lacking in many parts of the country, especially in rural areas and medical equipment and medications are in short supply (Johansson et al. 2011). Although first line ARV drugs are available, second line drugs are in short supply, which raises concern regarding patients who become resistant to first line drugs. Patients who have not disclosed their serostatus to family and friends are in a difficult predicament in terms of taking their medication privately and explaining absences for medical appointments (Wringe et al. 2009). Additionally, transportation costs are a significant barrier for poor patients, who do not have the income to make each medical appointment (Zou et al. 2009). Medication expenses for treatment of opportunistic infections is another challenge for patients, many of whom are unable to pay for these drugs (Johansson et al. 2011)

HIV/AIDS rates among drug users have dramatically increased in recent years as injection drug use among heroin users has become more common in urban areas of Tanzania (McCurdy et al. 2005). Prior to the 1990s, heroin was smoked, sniffed, or

inhaled, and now with the introduction of needles, injection drug use has become another mode of transmission in urban areas. Of special concern are reports of a new drug practice called “flash blood” in Dar es Salaam and Zanzibar (Dickinson 2009; UNGASS 2005). In response to money shortages and severe withdrawal symptoms, addicts who are unable to purchase drugs pair up with a user who has money. The individual with money injects the heroin and then draws blood from their body, which is then injected into the body of the second individual. This recent development in drug taking practices has the potential to accelerate the transmission of HIV among IDUs and their sexual partners.

Summary

The literature discussed regarding HIV/AIDS in Zanzibar and Tanzania highlights the differences and similarities between the epidemics in these two regions, demonstrating the importance of contextually grounded prevention efforts, in order to address issues relevant to a particular geographic location. Both regions are struggling with the influx of illegal drugs, high rates of heroin addiction, and the accelerated transmission of HIV among IDUs (McCurdy et al. 2006; Dahoma et al. 2006). Religious teachings regarding sexual behaviors is another challenge in both regions, as some religious establishments perceive HIV as a punishment for sinful behavior and condemn infected individuals for being immoral (Zou et al. 2009; Beckmann 2010). These beliefs contribute to widespread stigma in communities, leading to the reticence of many patients to disclose their serostatus or accessing medical and support services available to them (Wringe et al. 2009; Watt et al. 2009). Although both regions have transient populations due to road and shipping networks, the general prevalence rate on the mainland (5.6%) is

much higher than Zanzibar (0.6%) (UNAIDS 2009). The predominantly Muslim population in Zanzibar has been cited by researchers as a contributing factor to the difference in prevalence rates, in terms of the protective benefits of male circumcision and societal disapproval of alcohol consumption and sex outside of marriage, factors which may reduce the transmission of the virus (Croce et al. 2007; WHO 2007).

Chapter Two:

Research Design and Sample

Data for this project were collected from January through July 2010 in Zanzibar, Tanzania, involving semi-structured interviews and participant observation of outreach activities. Data collection primarily took place in Unguja, but some interviews and participant observation activities took place in Pemba during a brief five day visit to the island. Prior to my departure for Zanzibar, I contacted a local HIV/AIDS non-governmental organization (NGO) on the island to request assistance with my project. This NGO was recommended by a personal contact who works in the non-profit international health sector. Through e-mail and telephone exchanges, I explained my research goals and the executive board agreed to participate in the project. Establishing a relationship with this organization proved to be extremely helpful, since the agency has partnerships with other local NGOs and with government agencies working on HIV/AIDS programming. The agency also assisted me with the research clearance process through the Ministry of Health. Through its network and other contacts I made in Zanzibar, I was able to interview staff at one international organization, three government agencies, and four local NGOs. These organizations were selected using a snow-ball sampling method, in which NGO contacts referred me to agencies involved in prevention and treatment programs targeting youth, sex workers, drug users, MSM, and HIV/AIDS patients.

METHODS

Semi-structured Interviews

Semi-structured interviews took place at the offices of these organizations and in public settings and lasted 30 to 60 minutes. Questions asked during interviews dealt with staff responsibilities, organizational activities, target populations, funding sources, and challenges in implementing HIV/AIDS programming. The total number of semi-structured interviews, include NGO staff (n=20), government employees (n=4), peer educators (n=5), nurses (n=2), and HIV/AIDS patients (n=7). Educational levels among participants varied greatly, some holding university degrees, nursing degrees, some only had secondary school diplomas, and others had not completed secondary school. However, all had received specialized training on how HIV/AIDS is transmitted and treated through government and international donor sponsored education initiatives.

Some interviews were recorded with the permission of participants and transcribed by hand. Locally hired research assistants helped with interviews conducted in Swahili and the translation of transcripts. A total of three male research assistants were hired during the course of the project, but none were employed simultaneously. These assistants were hired based on their fluency in English and prior experience translating Swahili to English. Assistants were trained before hand on the objectives of the project, informed consent process, interview questionnaire, and the importance of maintaining the confidentiality of participant identities and responses. An assistant would only accompany me to interviews, where participants did not speak English and act as the primary interviewer, since I was not fluent enough in Swahili to carry out interviews on my own. In some instances, when an assistant was unavailable to

accompany me, staff at NGOs and government agencies helped me with interviews conducted in Swahili. Interviews conducted entirely in Swahili were then transcribed and translated into English by an assistant. Interviews in English were conducted and transcribed only by me.

Participant Observation

Participant observation of outreach activities and counseling meetings was an additional component of this research project. For this phase of the project, I attended outreach events focusing on raising community awareness (n=1) and targeting certain groups, specifically drug users (n=5), sex workers (n=2), and MSM (n=1). The community awareness event was held on the grounds of a school in a rural area and was facilitated by several NGOs. During the event, local school children performed songs and dances about HIV/AIDS, contests were held to test participants' knowledge of HIV/AIDS, a skit was performed about relationships, and HIV rapid testing was available in a classroom. A large crowd gathered at the site, somewhere between 200 and 300 people and the atmosphere was lively, filled with excited children and adults. A DJ loudly played popular Tanzanian songs during breaks between performances, which energized the crowd. I did not ask questions of the attendees, but I was asked by the organizers to help with estimating the crowd size and awarding prizes at the end. Approximately 100 individuals took an HIV test at the event.

The government agency responsible for implementing HIV/AIDS prevention initiatives funds outreach programs geared towards MSM and sex workers. Peer educators, some of whom are sex workers and MSM, assist in organizing and facilitating these activities. Government officials and NGO staff told me that these outreach

activities would not be possible without peer educators because of the difficulty in reaching these particular groups. Through personal contacts and knowledge of where these groups are usually found, peer educators set up meetings at local bars, guesthouses, and in some cases private homes. Organizers try to hold four outreach events each month, but this number varies depending on funding and staff availability. Because HIV rapid tests are offered during these activities, state lab technicians accompany peer educators during visits. I was not permitted to ask clients questions during MSM and sex worker outreach activities, but I did speak with peer educators regarding their experiences and insights into current programming.

The first outreach activity I attended focused on MSM and was held at a private home in an area outside of town. The meeting took place in the evening and four male peers and one lab technician facilitated the event. Approximately 18 men attended the event and the peers provided information on STIs and condom use. Male and female condoms were distributed to clients and all participants agreed to be tested for HIV. After the event ended, I asked the peer educators questions about their work and the status of MSM in Zanzibari society.

My interaction with sex workers involved participant observation of a weekly meeting for them at a local NGO, accompanying peer educators on an outreach visit to a bar outside of town, and observation of sex workers at nightclubs in Zanzibar Town. One local NGO is known for working with sex workers, MSM, and drug users, due in part to funding from international donors focusing on these vulnerable populations. The NGO reached out to sex workers in the area and asked them to come to the office for weekly meetings to discuss their concerns. Topics discussed are raised by the participants

themselves and NGO staff members are present to answer questions and distribute condoms. The women who attend these meetings sometimes bring their male partners with them, but only a few men were present at the meeting I attended.

The sex worker outreach activity was organized by the same government agency that runs MSM outreach events. Five female peer educators and two lab technicians facilitated the event. It was held at an outdoor bar and guesthouse outside of town catering to locals. Women who work at the bar also sometimes engage in sex work, but I was unable to determine if this was a condition of their employment at the bar or way to supplement their salary. The peers gathered the female employees into a group in an open area of the bar, where they provided information on STIs and condom use. Male and female condoms were distributed to bar employees and clients. A storage room with a door was used for HIV rapid testing. Most of the bar patrons were either watching a football (soccer) game or playing pool, but some found the information session entertaining and frequently interrupted it. Some of the men were clearly intoxicated and some were aggressive towards the peer educators, in one case asking a peer educator for sex. The atmosphere was tense because of these men and the peers and lab technicians did their best to get through the activity without any conflict.

Drug user outreach activities involved visiting neighborhoods where addicts are known to congregate and observing peers as they counseled clients. During these activities, several neighborhoods were visited in one session, during which peer educators distributed condoms, spoke about the dangers of using drugs and sharing needles, and referred clients for testing at local voluntary counseling and testing sites. Clients requiring medical attention were assisted with scheduling appointments at the local

hospital and in some cases, peers would accompany them to appointments. These outreach activities were one of the few occasions where I was allowed to ask questions of clients, in addition to the peer educators. I also established contact with a locally run recovery program for addicts, where I was permitted to attend counseling sessions and other related events.

Data Analysis

I kept detailed field and interview notes, in addition to a personal diary to record my personal thoughts and reflections throughout my research project. These notes and transcribed interviews were coded by hand using a code book developed prior to my project and refined as I took note of new themes in my data. Next, I input these coded notes and interviews into Atlas.ti to assist with the organization and analysis of these data. Using Atlas.ti, I generated the output for each code, which I examined for recurring themes and relevant quotes. These common themes and quotes were then divided according to the pertinent sections within the results chapter (prevention messages, drug users, MSM, sex workers, and HIV/AIDS patients). I carried out all data analysis without anyone else.

ETHICAL CONDUCT

The University of South Florida's Institutional Review Board granted approval of this project, along with a waiver for documentation of informed consent on December 9, 2009 (IRB# 108626). On November 16, 2010, approval was given for an increase in sample size and the project end date extended. Additionally, approval was obtained from the Zanzibar Ministry of Health on March 29, 2010.

Informed Consent

Due to concerns regarding participant reluctance to disclose their serostatus or involvement in certain activities, consent was obtained verbally. An IRB approved script was read to participants about the project, its goals, the minimal risks associated with participation, measures taken to ensure the confidentiality of the information they provide, and the benefits of their participation in the project. Following the reading of this script, potential participants were given a chance to ask questions about the project and concerns they may have. Some participants asked if the information collected would be used for commercial purposes, such as pamphlets or advertisements and I assured them it would not and no monetary gains would result from this project. Next, they were asked if they wanted to participate or not, and told that their refusal would not result in any adverse consequences. If they agreed to participate, I informed them of their right to withdraw their consent at any time during the study.

Names and other identifiers, such as organization names, were removed from notes and transcripts. Participants were informed that data would be aggregated and pseudonyms used to protect their anonymity. As an additional precaution, since Zanzibar is small and it is relatively easy to determine which organizations I worked with, the results chapter was sent to key informants for them to look over and comment on quotes used and if they are identifiable in the study. Only the researcher and research assistants had access to data. Prior to their involvement in the project, research assistants were instructed on the importance of maintaining the confidentiality of what they hear and read.

Compensation was not offered or given to any participants. Interviews were conducted at their place of work or other meeting spaces of their choice, so as to not incur any costs to participants. Furthermore, participants were asked if there were any issues they thought I should explore in order to increase the relevance and usefulness of this project to them.

CHALLENGES

Access to Marginal Populations

Gaining access to marginal groups, specifically drug users, sex workers, MSM, and HIV/AIDS patients, was a significant challenge throughout this project. Distrust of outsiders, reluctance to reveal their identities, and fear of police harassment are some of the explanations for the reticence on the part of these groups to participating in research studies, which NGOs and government agencies also struggle with in outreach efforts. Additionally, NGOs and government agencies that serve these populations are protective of clients and require outside researchers to go through a vetting process before allowing them access to meetings and other events. These restrictions are understandable, since these organizations want to protect the interests of their clients and meet with researchers beforehand to ensure the project's objectives are not harmful and will benefit participants in some way. Eventually, I gained access to meetings and outreach activities focusing on marginal groups, but I was not allowed to ask questions of clients in certain situations and as a result I have few first-hand accounts from individuals belonging to these populations. I relied upon interviews with NGO staff and government employees to understand common issues among these groups, which affects the representativeness of data collected.

Because of the sensitive nature of the issues that were explored in this study, I started my project with the concern that potential participants may be reluctant to talk to me or disclose personal information. I was also aware of the drawbacks of using research assistants, since Zanzibar is small and the majority of people are connected to each other in some way. Considering these circumstances, I knew participants may be reticent to open up in front of me and a research assistant. What I discovered in the interviews was there were some situations where the presence of a research assistant did not affect participants, but in others it did. In some situations, it was apparent that potential participants were uncomfortable in the presence of the research assistant and when he was not present, these participants were more relaxed and open with me. Additionally, when I visited organizations on my own, staff were actually more helpful and in some instances assisted with translating during interviews with non-English speaking clients and staff.

Translations

Although I was enrolled in Swahili classes throughout my stay in Zanzibar, I still relied upon research assistants for interviews conducted in Swahili and with translations. During the translation process, assistants were instructed to translate transcripts verbatim, so the original meaning of the speaker remained intact. All assistants were hired based on their fluency in English and experience with translating, however the possibility remains that the information was lost or misinterpreted during the translation process.

Subjective Experience

My background and previous experiences working on HIV/AIDS programs influenced how I carried out this research project. I was a volunteer in South Africa from

2005 to 2007, where I worked on HIV/AIDS programs focusing on orphans and vulnerable children, women living with HIV/AIDS, and at-risk youth. This experience broadened my understanding of the HIV/AIDS epidemic, in terms of examining how underlying factors, such as poverty, racism, and gender affect health outcomes. Although the context of South Africa is different from the situation in Zanzibar, it helped me appreciate how a broad perspective can deepen my knowledge and understanding of HIV/AIDS.

Additionally, my Muslim background influenced this research in terms of my understanding and perspective of how Islam is practiced and how Muslims negotiate sexual relations in an Islamic context. Although I am aware that pre- and extra-marital relations occur among Muslims, I expected Zanzibaris to be more conservative because of the Islamic dresses worn by men and women and restrictions on unmarried individuals of the opposite sex mingling with each other. Women in particular are dressed conservatively, covered from head to toe and in some instances wearing a mask that only reveals their eyes. My assumptions were quickly dispelled once I arrived in Zanzibar and spent time getting to know people. Although Zanzibari society may appear conservative on the surface, underneath public images a different picture emerges, in which individuals do not rigidly follow Islamic doctrines. Alcohol is available in certain establishments, sex workers congregate at local nightclubs, drugs are openly used in some neighborhoods, and pre-marital sexual relations occur, although they are rarely openly discussed.

SUMMARY

Data for this project were collected from January through July 2011, involving semi-structured interviews with government and NGO agencies, and participant observation of outreach activities. A total of 38 interviews were carried out with government and NGO staff, and I attended 9 outreach activities by the end of the project. Research assistants helped with interviews conducted in Kiswahili and the transcription and translation of these interviews. These data, along with field notes, were analyzed using Atlas.ti after the data collection phase in order to identify recurring themes and relevant quotes for use in this paper

Chapter Three:

Results

Current research on HIV/AIDS in Zanzibar is primarily from a public health perspective, which although important in gauging the extent of the concentrated epidemic on the islands, fails to delve into the lived experiences of Zanzibaris and how structural violence has diminished the agency of individuals. Applied medical anthropology is well situated to uncover these issues through ethnographic field methods, resulting in a more comprehensive understanding of how HIV/AIDS is spread and disease's impact on Zanzibaris. Additionally, these vulnerable populations are often reduced to the risky behavior they engage in, which contributes to narrow and discriminatory perceptions of individuals belonging to these groups. Through in-depth interviews and participant observation of HIV/AIDS interventions, a comprehensive and nuanced picture of vulnerable populations emerges. Additionally, this methodology is beneficial in terms of not taking a reductionist approach to individuals associated with high-risk behaviors and instead exploring the obstacles that threaten their general well-being.

In this chapter, findings are divided according to specific themes. The prevention strategies section is on NGO and government HIV prevention initiatives primarily targeting the general population, specifically examining what strategies are currently in place and issues concerning comprehensive approaches to prevention. Next, initiatives targeting drug users, sex workers, and MSM are examined. The focus of these sections

are on interventions in place that target vulnerable populations and the challenges these groups face due to their marginal status in Zanzibari society. Lastly, the medical and social support services available to HIV/AIDS patients are examined in the final section.

PREVENTION STRATEGIES

Most government officials and NGO workers identified the ABC method (Abstinence, Being faithful, and using Condoms) as their primary prevention strategy. While the majority of participants interviewed knew what the ABC method entails, many emphasized an abstinence only message until marriage. Islamic prohibitions against pre- and extra-martial sexual relations were cited as the main obstacle to discussing being faithful and using condom messages. A few NGOs use a comprehensive approach, broaching all prevention strategies in their programs. However, when asked to explain the ABC method, some staff presented a linear understanding that provides an incomplete approach to protecting against STIs and unwanted pregnancies. A male staff member said:

“[We] Tell people to wait until marriage...don’t have sex outside of marriage. Those who can’t wait we use B method. For those who don’t follow A and B, we go to C.”

This approach to the ABC method involves the use of one strategy at a time, which has less protective benefits than using more than one. Most NGOs receive HIV/AIDS training from a variety of sources, including the Zanzibar government and foreign donors, such as international aid organizations and development agencies from other countries. The consistency and accuracy of the information provided at these various trainings is difficult to assess, which may have contributed to a linear understanding of the ABC method among some staff.

Condoms are available in some grocery stores and stand alone pharmacies. However, purchasing condoms is a challenge in Zanzibar (Beckmann 2010). The thought of entering a crowded store, where there is the risk of encountering neighbors, friends, relatives, and acquaintances, dissuades many Zanzibaris from buying condoms. Additionally, condoms are only available at certain stores, since some owners refuse to sell them. The government and NGO staff with whom I spoke said they could only name a few pharmacies and grocery stores that sell condoms and only knew of three that sell lubricants. According to these staff members, some shop owners refuse to sell condoms based on the belief that condoms encourage pre- and extra-martial sexual relations.

Many NGO staff spoke of the difficulty in openly discussing condoms and dealing with opposition from religious leaders, some of whom believe condoms encourage promiscuity and prostitution. During some outreach events, staff members were physically attacked for talking about condoms, resulting in many organizations restricting where and to whom they provide and discuss condoms. An NGO staff member described some community members throwing rocks at him during an outreach event, when he brought up condoms. Most NGOs find it easier to distribute condoms to vulnerable populations in semi-private settings. The logic behind this approach is that these individuals are known for engaging in high-risk behaviors and face significant barriers to changing their actions, so interventions should focus on these particular groups. A male NGO staff worker said:

“We don’t actually distribute condoms. For instance, we give to CSW [commercial sex workers] because we know they’re having sex. Condoms we give to special populations. For example, CSW because we know they’re having sex and they cannot [stop], but we want them to do safe sex....We also give to IDUs and MSM. Not to general population.”

Furthermore, it is unlikely that protests would erupt over condom distribution to these populations, since these groups are perceived as immoral because of their involvement in high-risk behaviors.

Opposition to condoms is also an issue among NGO staff members, some of whom support a comprehensive prevention approach, while others advocate an abstinence only strategy. One NGO settled staff differences through indirect distribution of condoms at their centers according to a male staff member who said:

“Don’t do it [distribute condoms] directly. If we tried directly, parents would be upset. So we don’t provide directly, especially to the youth.”

During youth programs, condoms were kept in the restroom for clients to take, if they chose. This compromise allowed for youth to have access to condoms, while at the same time working around parental and staff concerns about the explicit promotion of condoms. While this compromise allowed staff to reach consensus on how to provide access to condoms, a male staff member mentioned concern regarding knowledge among youth on correct condom usage:

“Practically, people are using condoms mainly in Zanzibar. But when you come theoretically talking in front of people...[the]majority of people deny [it], but when [you] go practically a lot of youth are using condoms. They’re very much interested. If you go to the school to teach the students about prevention of HIV and whatever, if you didn’t touch the issue of condoms they’re not interested. But if you talk about condoms they’re very happy. So condom[s] they’re using and [want] distribution. In fact they’re searching themselves, buying in shops. The problem is [that] they don’t have enough knowledge of using condoms. This is the problem, but the majority of them are using and it’s hidden.”

Another barrier to reaching youth is a Ministry of Education ban on talks about and distribution of condoms in schools, which means adolescents must look for information elsewhere. Several NGO staff members spoke of the challenge with providing a comprehensive prevention strategy, while simultaneously negotiating societal disapproval

of sex outside of marriage and their own personal beliefs regarding sexual relations. A male staff member expressed his conflicting personal opinions and professional obligations, saying that:

“Personally, I’m in a dilemma. Can’t say I’m supporting directly, but on the other hand [we] can say we have no option whether we like or not because this issue is known and practiced. Theoretically, we are not allowed to let people use condoms, but when you go on the other [side]... they’re familiar with it and they’re using. It is an issue, but our aim is to prevent them from getting infected. How to prevent is up to them. We’re giving them options of using any means, but the aim is to prevent them from getting any infection.”

Through their work, most NGOs are aware of the realities of sexual relationships and transmission of STIs on the islands. Some staff members interviewed said that protecting individuals from HIV and other STIs overruled personal reservations, which has contributed to some NGOs adopting a comprehensive prevention strategy. A female staff member said:

“There are some who say, but I am not sure...they say our prophets and companions used condoms [that] our fellows used because of family planning. But things change, now the situation is completely different, we have to use it to protect ourselves from diseases. There are several sexually transmitted diseases, such as gonorrhoea, syphilis. When we distribute condoms, they protest and say we emphasize sex, but we say we protect our people from HIV/AIDS as some practice sex with people who are HIV+. By doing so we believe we are saving their lives.”

Protecting individuals and educating them on all prevention methods has become the primary concern for some NGOs. Regardless of their personal beliefs or religious teachings, some staff believe it is their responsibility to help their clients make well-informed choices. Some organizations have reached out to religious leaders for the purpose of educating them about HIV/AIDS and obtaining their support:

“We try to conduct seminars and workshops with Muslim leaders.. Shehas. We give them education and they try to put matter in religious way. Because previously these Mashehas or leaders were shouting this is a sin. Even you the

provider will be looked [at] differently...you're distributing these things. You are against God. But when we use Muslim leaders they know how to put it. In certain circumstances, it's not bad to avoid. They give hadith [sayings of the Prophet Mohammed] and other things like that. But still it is a problem. It's reduced but it's still a problem."

NGO staff said it is promising to hear that some leaders are changing their opinion of prevention strategies and some are using their position to educate communities about HIV/AIDS.

Voluntary counseling and testing (VCT) is another prevention strategy used by some NGOs, which is less controversial than the condom-distribution approach. Many NGO offices offer on-site rapid HIV testing and some conduct mobile VCT visits to rural areas and hidden populations. These mobile VCT visits usually coincide with outreach activities, where participants are given information on HIV, for example how it is transmitted and protective measures against infection. I attended several outreach events, where I observed many people taking HIV tests and participating in various educational activities. These outreach activities target a broad spectrum of groups in Zanzibar; however condoms are only distributed to vulnerable populations (e.g. sex workers), not the general public. NGO staff credit awareness campaigns with the widespread adoption and acceptability of HIV testing. This growing awareness has also carried over into marriage practices, where it is now common for couples to get tested before the wedding ceremony. A male NGO staff member said:

"For instance, in our culture before marriage you're supposed to test [for] HIV. That's education...before marriage get test HIV. So people are coming to test for today and married tomorrow. We tell them to check health all the time. Now people are asking have you tested. So you have people coming. Give them information to get tested every 3 months."

In situations, where clients receive a positive result, the staff at one NGO has a comprehensive protocol in place on how to respond:

“There are some people who come for testing and they understand that there is a problem and some who don’t understand, which require having skills to do so. The person is in the condition of panic and anxiety. Some [of] them think they are not in the world [dead], so by we counseling him and explaining what happened to him to make him understand his situation. Our objective is to then accompany the client for referral to Mnazi mmoja, Bububu or Kivunge [local hospitals]. We make sure he starts getting treatment and support for that day, then we can go back to other matters.”

Receiving a positive test result is a scary experience for most patients, which underscores the importance of lab technicians also receiving counseling training. Furthermore, a positive test result requires confirmation with another blood test and physically accompanying clients ensures follow-up and entry into the healthcare system.

DRUG USERS

Drugs are widely available and relatively inexpensive in Zanzibar, specifically marijuana, heroin, and cocaine. The numerous, unmonitored sea ports are conducive to the trafficking of illegal drugs to Zanzibar from the Middle East and Asia. Heroin use is increasing on the islands, as is the use of needles, contributing to higher rates of HIV among IDUs. Drug use has soared among Zanzibari youth and according to study participants, many families have at least one relative struggling with addiction.

A majority of the current and former users with whom I spoke said they began using drugs in their teens, starting with alcohol and marijuana, and eventually progressing to heroin. Reasons for experimenting with drugs vary, but some of the more common explanations are peer pressure, perception of drugs as cool, and for others an escape from difficult home lives. One former user recounted his early initiation into drugs:

“I started using marijuana when I was in school. I was a football player and most of my friends were smoking marijuana. We thought if we smoked marijuana and went to the game we would play well. At first it was well, but then ... most of all [my] brothers were using heroin. I didn’t know whether it was a problem. I liked they way they were doing, talking...it was foolish. But such I like the way they get money. People who are using, they go to the street and come back with money. They had lots of money. I didn’t want to know how they got that money. I wanted to get money quickly. I started using and I got money quickly. I was cheating and stealing.”

As their addiction grew and took over their lives, many users found themselves estranged from family and friends. One user who was contemplating entering a treatment center, said that although he still lives with his family, there is no communication between them and he only sleeps and eats at the house.

While drug use is more common among men it is also a growing problem among women, which is further complicated by higher numbers of female users reporting transactional sex for drugs than men (UNGASS 2005). A female NGO staff member who works with drug users, explained a common situation for female users without money to purchase drugs and how NGOs address this issue:

“You are female addict and you might be in a situation where you are sick and you want drugs badly and you meet male addict who has drugs and he wants you to have sex with you. Some of them they end up doing, but by giving them condoms, they use those condoms and it help to stop spreading AIDS among them.”

Other staff members said that sex workers sometimes turn to drugs to cope with their work and although underreported, some male drug users also engage in sex work for drugs.

Although smoking and sniffing are the most common methods for ingesting heroin, injection drug use is on the rise and in conjunction with this practice, needle sharing. Needles are available at pharmacies for around 100 Tsh, which is approximately

\$0.07 in US currency. However, pharmacy owners often refuse to sell needles to suspected drug users. The Zanzibar government is debating the implementation of a needle exchange program, but until it is approved and initiated NGOs working with IDUs have used other strategies for preventing new HIV infections. One NGO actively recruits ex-drug users to work as peer educators, since their experiences provide them with the knowledge to locate and talk to addicts. During these outreach programs, peers inform addicts on the dangers of drug use, sharing needles, and having unprotected sex. Condoms and bleach cleaning kits are distributed to users, along with special instructions on how to clean needles:

“We teach them 3 by 3 by 3. It’s a three step and the first step you clean your syringe with clean water three times then you clean with bleach three times and then you clean with new clean water three times. That’s what we call 3 by 3 by 3, it’s a process that kills bacteria with water.”

The staff at this particular NGO believes their efforts have made an impact, in that more users have stopped sharing needles and some regularly check their HIV status:

“Sometimes they share one syringe among four people. We talk to them and they stop sharing and they are coming for testing to know their status. The ones who are not sharing they just use one syringe all day or they will clean their syringe.”

Another issue regarding injection drug use is a practice called “flash blood,” where a user without money or drugs pairs up with someone who has drugs. The user with drugs injects himself and then immediately draws blood from his arm back into the needle. This blood-filled syringe is then passed onto the second user, who injects it into his body, in the hope that he will feel the effects of the drugs in the blood. This drug taking practice was noted in a 2005 government study, indicating that 9.1% of IDUs reported using this method (ZACP). NGO staff that frequently work with IDUs say they have no direct field observations of this practice and few of their clients admit to doing it.

A majority of the current and former users with whom I spoke said they smoke heroin. Considering the circumstances under which flash blood occurs, it is not surprising that there are no field observations of it, since a user desperate for a fix is unlikely to speak with peer educators.

A problem that continues to frustrate NGO staff and clinicians is low ARV adherence among HIV positive drug users. Staff members said that users often miss doctor appointments and fail to take their drugs as prescribed. Tracking down participants is problematic, as some move frequently and others are homeless. A female NGO worker said:

“I am so grateful they cooperate with us; they set dates and time to come back, but you will see some of our patients using drugs and they disqualify themselves, so we have to find and attach them back to the treatment.”

When a user is found, a peer educator is assigned to accompany him to the hospital to ensure their attendance. Additionally, some clients are assigned a home based care worker to check their health status in between hospital appointments.

Several former users spoke of encounters with police, in which they were threatened with arrest, unless they were able to pay a bribe. They also said that although drug dealers are well known in Zanzibar, most are able to pay the police off and avoid prosecution. As a result of police harassment and a general distrust of law enforcement capacity to uphold the law, most users are wary of outsiders. Peer educators spoke of the difficulty in doing their work before they were given identification badges, as many users suspected them of being undercover police officers. A female peer educator said:

“We now have IDs because we complained a lot that it was a big issue. When we’re working in the field, IDUs want to see our IDs. Sometimes the police come to talk to IDUs, so the IDUs want to see ID to make sure we’re not the police.”

In terms of addiction treatment programs in Zanzibar there is only one locally managed, non-profit program run by ex-drug users, which provides in-patient and out-patient counseling services. The fees are too high for most users and the majority of clients are sponsored by their families. Deciding to enter treatment is not easy for most addicts and often requires multiple attempts before becoming clean. Clients currently in the treatment program said heroin took over their lives, damaging their relationships with family and friends, disrupting their education, and hindering their ability to hold down a job. A former user who recently celebrated his one-year anniversary of being clean said:

“I want to study. Because I learned until secondary school Form Four, but at Form Four I started using. [I] Don’t have [a] certificate. I was clever in school, but drugs drove me crazy. I didn’t do well on my exams. I didn’t do well in mathematics or Swahili.....I failed all my exams. I want to get certificate and then study [for] kind of job.”

Many recounted attempts to quit on their own, which usually ended in failure and it was not until they entered the treatment center that they were able to quit. Treatment center staff recommend users stay a minimum of three months and continue attending meetings afterwards for continued support. The foundation of the treatment center is the Narcotics Anonymous (NA) 12 Step Program and complete abstinence from controlled substances is required of all clients, including from alcohol and certain prescription medication. The first 72 hours of entering the program are described as the hardest, since withdrawal symptoms are particularly painful and there are no drugs available to help with this stage in recovery, such as methadone or buprenorphine. Here is a former user’s account of his first days in the treatment center:

“It was a really hard time. Then the fourth day, fifth day, when I got awake I felt ok, just a little bit. But I couldn’t get sleep. I asked for some medication to sleep, but they said we quit without any medication and you need too as well. They say come clean.”

While many clients have successfully completed the program, the greatest challenge to their continued recovery is re-integrating back into society and avoiding the temptations of drugs. Because of their past drug use, criminal records, and incomplete education, finding employment is difficult for the majority of former users. Furthermore, employers are reluctant to hire former drug users, despite their successful completion of a recovery program. For some, the situation is dire since they are unable to seek support from family or friends who have cut ties with them due to their past drug use. A former user spoke of the difficulty his father has with trusting him:

“My father [does] not [trust me] yet. He starts to believe me, but he is still afraid. Because he said most of the people who are using can’t stop may be they can stop for a time but then they’re using again. He’s still thinking I’ve done a lot of destruction at home. I’ve stolen many things. So he’s still afraid.”

Two former users said tourism is one of the few sectors where positions are available to them, especially if they speak multiple languages. However, the risk of relapse is great, since many tour operators use drugs and drugs are widely available in tourist areas. Additionally, once they have completed the program, some clients believe they are strong enough to drink alcohol and use marijuana without succumbing to the temptation of heroin. This often proves to be a fatal miscalculation, as many clients find themselves hooked on heroin again and seeking re-admittance to the treatment center. A former male user, who volunteers at the center said:

“[I] See a lot of people who complete the program and leave. But when they’re outside they start using marijuana and alcohol because they think it’s okay, but most relapse.”

The hurdles to maintaining sobriety are significant and not easily overcome, which is why center staff emphasize the importance of life long practice of the 12 Steps and

regular attendance of NA meetings. A male staff member said the following regarding long-term recovery:

“No one wants to relapse, but relapse happens. Some of them for angry, resentment [reasons or they’re] missing contact with other recovering addicts. I was so busy to get my stuff [drugs] and now I have to be so busy to stay clean. They forgot about program and forget they’re addicts. If you’re addict always to be with your addiction.”

SEX WORKERS

Sex work on the islands has increased, in response to tourism and local demand. NGOs that focus their programs on sex workers said that both men and women engage in the sex trade on the islands, although men are less likely to admit to it. Sex work is not illegal in Zanzibar, but according to government and NGO staff it is highly unlikely that sex workers would be allowed to organize themselves into a registered group. In response to this challenge, some NGOs and government agencies have made an effort to reach out to sex workers. Employees at both civil and government organizations spoke of the difficulty in locating and engaging with sex workers on health issues, since many are reluctant to reveal their identities. I heard from NGO staff and sex workers themselves about the lengths to which some women will go to conceal their identity in public. An Islamic dress for women, called a *buibui*, is a long black dress with wrist-length sleeves is commonly worn in Zanzibar, however, some sex workers will also wear a mask that covers their entire face, except for their eyes, to maintain anonymity. This practice is more common among Zanzibari sex workers than women from the mainland, since they must still contend with family and friends finding out about their work in the sex trade. NGO staff said sex workers from the mainland are able to avoid this problem

and it is easier for them to convince family members that they are working in the formal employment sector.

Common locations where sex workers are found and where NGOs conduct outreach visits are bars and guesthouses that cater to locals. Women work at these locations as cooks, waitresses, and some of them also engage in sex work with patrons. Sex workers reported that some clients will pay more money if a condom is not used, which some women find difficult to turn down due to their insecure finances. A female NGO staff member said:

“Others have sex without condoms because they are offered high amount of money from their clients some of them up to 40,000/- TSH [approximately 26 US Dollars].”

Additionally, some sex workers say clients can become aggressive if asked to use a condom, which is a significant barrier to raising the issue of and negotiating condom use. A peer educator said that there is a common saying among men that “you can’t enjoy the sweet with the wrapper on it” which has proven to be a significant barrier to normalizing condom use. Female condoms are available through certain NGOs and government agencies; however, a sex worker stated that it took time and practice before she was able to learn how to use it correctly. Another concern voiced by sex workers is condom breakage, which occurs often. Sex workers stated that lubricants would help in preventing this problem, but only a few shops carry lubricants and at a high price, and NGOs and government agencies do not distribute lubricants.

One of the few NGOs that work directly with sex workers holds weekly meetings for them at its office. These meetings are led by the participants themselves. A female staff member at the NGO said:

“Also, we are working with FCSW [female commercial sex workers]. [We] provide classes every Thursday on behavior change, emphasis on the importance of using condoms and we provide a safe place for them to talk on their issues. The group grew from six to twenty to thirty members.”

NGO staff is present at these meetings, but the women direct the discussion and the staff are on hand to answer questions. Condoms are distributed during these meetings and rapid HIV testing is available at the office. This same NGO also distributes condoms to drug users and MSM through their outreach program. Since condoms are not easily obtainable in shops, clients of this NGO sometimes sell condoms to other people. A peer educator said sex workers sometimes sell condoms to their clients and that this is a continuing issue NGOs struggle with in their interventions targeting vulnerable populations. Peer educators are currently working on convincing bar and guesthouse owners to provide free condoms to clients.

When asked why they started engaging in sex work, some women said the financial draw of it lured them in, based on their observations of other sex workers:

“I decided to engage in sex work because some people had built houses and they are living a good life. Life was also very difficult for me with my children, getting the supplies for the household was so difficult. That’s another reason to engage in sex work.”

Poverty, low education levels, and peer pressure were some of the more common reasons given for entering the sex trade. Once women start engaging in sex work, many deal with the health and safety issues associated with this type of work:

“Engaging in sex work has many risks. The police are harassing us, raping us and sometimes we are sent to prison. It’s a very difficult life. The good thing is there is no law that forbids sex work. Whenever a sex worker is sent to the court, we are charged with jobless and laziness offense.”

Since there is no law against sex work, women are arrested for being “unemployed.”

This statement illustrates how clients are not the only ones who harass sex workers, as the

police have been abusive towards them as well and in some cases used sex workers to make money:

“Police harass us and sometimes use us to get money from our customers. The police pretend that we were caught with our clients in a restricted area.”

Women also talked about the discrimination and harassment they face from community members, which has jeopardized their safety and well-being. A female NGO staff member said:

“People wanted to burn down the houses where sex workers were living. Children started to shout and despise them. The community was against them and they were harassing them so much. In some situations, the ferries didn’t allow a sick worker to board the ferry. The response from the people from the boat was: “This is a prostitute, if we take her she will die on our hands.””

Despite these hardships, some of the women took a realistic perspective of their work and said it has allowed them to provide for themselves and their families, as long as they treat it like any other job:

“Sex work business is like any other business. Having a good life depends on the way you save what you earn. Sex work pays, but it is difficult to plan.”

Some women also said they supplement their sex work with other jobs, which has made them “successful” in terms of income in comparison to other women who solely engage in sex work.

The weekly meetings at this NGO are one of the few places where sex workers can go for support, but there continues to be an absence of health services for these women. Outreach programs at the bars and guesthouse, where sex workers can be found, are conducted on a weekly basis through a government agency focusing on prevention efforts among vulnerable populations. However, these visits are subject to funding shortages. Furthermore, limited health services are provided through these visits,

specifically STI education, condom instruction and distribution, and rapid HIV testing. Additionally, NGOs and government agencies encourage women to find alternative sources of income, but there are currently no programs in place to help women make this transition, such as educational and business training initiatives.

MEN WHO HAVE SEX WITH MEN

Out of all the vulnerable groups upon which NGOs and government agencies focus on, MSM are the most difficult to locate and reach because of the hidden and secretive nature of this population. NGO staff said that without the recruitment of MSM peer educators they would not be able to reach this group. MSM peers help in identifying other MSM and setting up outreach activities at private homes, bars, and guesthouses. Unlike American conceptions of homosexuality, in Zanzibar there is a differentiation between MSM based on their role in sexual acts. Men who are receivers and perform oral sex are viewed as homosexuals, whereas men who penetrate and receive oral sex are not. Neither sexual role is acceptable, since homosexuality is forbidden under Islamic doctrine, but there are different classifications of homosexuality in comparison to American notions of sexuality. Although there are different terms for men who engage in sexual relations with men, depending on their position in sexual encounters, government and NGO agencies use the term MSM to refer to both groups.

The MSM peers with whom I spoke said they deal with regular harassment from the public and their own families, who verbally abuse them for their sexual orientation and in some cases banish them from home. A male NGO staff member said:

“MSM who are open [about their sexual orientation]...[are] rejected by family and community members. Everyone talks about them.”

NGO staff and MSM peers spoke of some MSM engaging in sex work, which exacerbates the already precarious position of MSM:

“The biggest challenge MSM face is shame and discrimination from others... Sometimes people arrange sexual meetings with MSM, but then they don’t pay them afterward. Also, some clients threaten them verbally and the MSM run away. There are dishonest clients out there.”

While it is likely that female sex workers deal with non-payment and assault issues as well, there are more reports of it among MSM sex workers. Additionally, MSM peers reported that some clients tell other men about sexual meet ups, resulting in some MSM being gang raped. Unfortunately, there are few avenues for legal redress, since MSM say the police are indifferent to their problems.

Furthermore, there is evidence of overlapping sexual networks among drug users and MSM, which raises concerns about the transmission of HIV and other STIs among vulnerable groups. Another issue is the “bridging” effect between these groups and the general population, since many MSM also have relationships with women. A male peer educator said:

“With MSM there is a “give and take”...they have girlfriends and wives. [The] majority do this....have a wife or girlfriend, but see men on the side.”

An NGO staff member said it is unlikely that these women are aware that their boyfriends or husbands also have relations with men, and coupled with prior research indicating inconsistent condom use among MSM, there is a heightened risk of HIV infection among women (Dahoma et al. 2009; Johnston et al. 2010).

HIV/AIDS PATIENTS

ARVs are available for free in Zanzibar, however, there are significant barriers to patients accessing services and resources in order to maintain their health status. The

patients I interviewed said they took an HIV test in response to symptoms associated with HIV (e.g., skin lesions) or because their partner tested positive. While NGOs and government agencies have increased mobile VCT sites, testing continues to be an issue for some. One particularly sad case involved a mother getting tested because her child was extremely sick and not responding to treatment:

“[I] Had a child, but the child was very sick. [I] took the child to the hospital. [She] didn’t respond to treatment. [I] knew if I have HIV, she has HIV, so [I] got tested first. All of them [children] tested positive.”

Although HIV testing is a routine part of prenatal care, not all mothers have the finances for regular doctor visits or hospital births.

After an individual tests positive, they are referred to special HIV/AIDS wards within specific hospitals for further testing and evaluation. After a confirmed HIV diagnosis, patients receive short-term nutritional assistance from the government; however, this type of support has the unintended consequence of disclosing a patient’s serostatus to the community. A patient recounted how neighbors discovered her and her husband’s HIV status:

“ [We] used to go to weekly support meeting and get nutritional support from ZACP [government HIV/AIDS agency]. People living near us, saw us with food and this is new. See us going to town and coming [back] with food parcel...[people] started shouting at us.”

Because Zanzibar is so small, it is common for neighbors and acquaintances to notice behaviors that are out of the ordinary. Additionally, HIV/AIDS support organizations are well known in the community and if individuals are seen entering these centers, it is assumed that they are HIV positive. Once a patient’s HIV status is disclosed, whether deliberately or inadvertently, there is a very real risk of patients dealing with AIDS

related stigma from the community. A female NGO staff member recounted a disturbing example of how one patient was treated:

“The HIV+ patients was treated badly in our neighborhood, they isolated him, he slept alone in an abandoned room like a chicken. They threw him food by legs [food was thrown into his room]... that’s a kind of stigma. Then HIV/AIDS took him down, they used to isolate him from other people because he has HIV/AIDS. When you are HIV + and others stigmatize you, your health will deteriorate quickly because you might have strong body defense, but due to the things you face it weakens your defense due to stigmatization.”

Some patients are able to continue receiving support from family and friends, while others are left to fend for themselves. In some cases, an adult’s HIV status also affects their children’s interactions in that other families may tell their children to stay away from that particular child. Even more troubling are situations where HIV positive children are discriminated against in school. A male NGO staff worker recounted the following case they had recently intervened in at the time of our interview:

“There was an experience of stigma at [a school in] Mangwapani. There was a child with HIV/AIDS. The teachers said we don’t want this child because he is suffering from HIV/AIDS and he will infect other children in the school. They [teachers and school administrators] chased out the child [from the school]. Our organization went there [to the school] to share with them and educate them [about HIV/AIDS] and now the child is going to school.”

One of the primary complaints among patients and clinicians is the absence of free drugs for opportunistic infections. ARVs are freely available, but not other drugs, which many patients are unable to afford on their own. A female patient said:

“It is a challenge because there is no medicine to help us, except ARVs and Seprin. One of our fellows [patient] who was told to buy some medicine and he could not afford to buy them. The medicine cost Tsh 27,000 [approximately 18 US Dollars] per dosage.”

Adherence to ARV medication is another concern among clinicians, who treat HIV/AIDS patients, as some stop taking their drugs and miss appointments, once they start feeling

better. Patients who struggle with substance abuse problems have non-compliance issues throughout their treatment, since adherence cannot be achieved without them overcoming their addiction first. Pediatric patients are the most vulnerable to disruptions in their medical care according to a female nurse who treats HIV/AIDS patients:

“Most pediatric patients are orphans. They’re not staying with parents. [They are] passed from family member to family member. They have difficulty adapting to new home environments and adhering to medicine.”

This nurse said that several pediatric patients are on second-line ARV medication, since they have stopped responding to first-line drugs, which is a troubling development considering the lack of medical supplies on the islands and the life long treatment of AIDS.

Furthermore, a side effect of ARVs is an increase in appetite, which is a significant challenge for patients struggling to meet their daily nutritional needs. A male patient said:

“The medicine I am taking is helpful. But the medicine I take adds more problems because when I take the medicine I feel very hungry. The medicine is very powerful and I need to take in enough food every time I feel hungry, but I can’t afford to have enough food every time I need to and I have no help, no support now.”

The hunger pangs are severe enough that some patients have stopped or refused to take their medication because they do not have the means to purchase extra food. Some NGOs stated that in the past international donors provided nutritional support for patients, but this has ended now that donors are asking for community participation in HIV/AIDS programming. NGO staff said that it is difficult to encourage community involvement, since many Zanzibari families struggle to take care of themselves and do not have the means to assist others.

A troubling issue that emerged in this project is the discrimination some patients face from doctors and nurses. While I expected to hear examples of AIDS related stigma and discrimination in the community, I was surprised to hear about its occurrence in clinical settings. Patients recounted situations where they were denied care or treated in a hostile manner. A female NGO staff member, who is HIV positive and participates in stigma assessments of clinical settings, said:

“I work in the stigma assessment program for our NGO. I interviewed a pregnant client who was stigmatized at the hospital. She needed an injection, but the doctor didn’t want to touch her, so he threw the needle at her arm.”

This is an issue outside of HIV/AIDS care centers and although hospital administrators are aware of the problem and have stepped in to ensure patients are given appropriate care, the issue continues to persist. Through this stigma assessment program, NGO staff members have interviewed doctors and nurses about their opinion of HIV/AIDS patients, through which they have heard disturbing and judgmental comments:

“[I] Asked them, “How they feel about people with HIV? Do you feel bad that they’re suffering?” [The doctor said,] “They’re okay because they found it themselves. Let them suffer. Let them die. No need to remove pain from them.” [The] Doctor didn’t know I have HIV.”

Current medical supplies in Zanzibar are another concern in that there is only one CD4 count machine in Unguja and it breaks down frequently. As a result, patients’ CD4 counts are irregularly tested, even though this is one of the primary indicators for determining if a patient needs to start ARV therapy. Additionally, there is no equipment available to test a patient’s viral load, which is important in evaluating their health status and response to medication.

SUMMARY OF MAIN FINDINGS

In conclusion, an analysis of data collected indicates that structural violence restricts the agency of individuals belonging to marginalized populations and negatively affects their health status. Police harassment, limited health services, societal discrimination, poverty, food insecurity, and gender relations are some of the factors, which influence poor health outcomes among these groups. Furthermore, there are severe restrictions on which prevention measures can be openly discussed and to whom. Programs focusing on marginalized populations are attempting to address issues unique to each group, but gaps remain in access to resources. Although injection drug use is becoming more common, as of now there is no needle exchange program and only one recovery program. Weekly group sessions for sex workers provide women with a safe forum to discuss their concerns, but do not address the socioeconomic status of women which led them to engage in sex work. MSM remain an extremely difficult group to reach, which is troubling because of the interconnectedness of sexual relationships in Zanzibar. Additionally, HIV/AIDS patients face discrimination from the community, medical professionals, and have unmet nutritional and medication needs, which affect their general well-being and ability to manage their disease.

Chapter Four:

Discussion

The high prevalence rates among sex workers, MSM and drug users in comparison to the general population, have led to the Zanzibar government focusing HIV/AIDS programming on these vulnerable groups (UNGASS 2008, 2005; ZAC 2010). The National HIV and AIDS Strategic Plan specifically outlines interventions geared towards these “most at-risk populations,” since they are perceived as a “bridge” to the general population through interconnected sexual relations (ZAC 2010). This programmatic focus has contributed to government sponsored activities that center on educational and behavioral change efforts among these groups. High-risk behaviors, low condom use, needle sharing, sex between men, and multiple sexual partners are identified as the driving force behind prevalence rates among vulnerable populations. As a result, interventions tend to focus on educating individuals belonging to these groups about the dangers of having unprotected sex, the importance of regularly testing for HIV and other STIs, how to properly use condoms, and the risks associated with sharing needles. Because of the difficulty in locating these populations and reluctance of sex workers and MSM to reveal their identities, peer educators are used to organize outreach visits to locations where vulnerable groups are known to congregate, such as bars, guesthouses, and certain neighborhoods. These initiatives are beneficial in terms of providing

information, referring clients to local health centers, and distributing condoms to neglected groups, who have restricted access to health resources on the islands.

However, the emphasis on high-risk behaviors associated with vulnerable groups, fails to address how structural violence restricts an individual's agency and negatively impacts their overall health status. Additionally, these behavior change interventions contribute to perspectives blaming marginalized populations as the propagators of the HIV/AIDS epidemic. The involvement of these groups in socially unacceptable roles places vulnerable populations in a precarious position in terms of accessing social support and health services, which is exacerbated further with their association with a highly stigmatized infectious disease. Addressing the underlying reasons for why certain groups engage in risky behaviors is complicated, but simply telling people to use condoms and to test regularly is only part of the solution to preventing new HIV infections. A multidimensional prevention strategy is needed to address the various factors shaping the HIV/AIDS epidemic, for example focusing on food insecurity, nutrition education, increasing access to health services, and income generating activities (Singer 2011; Himmelgreen et al. 2009). Implementing a comprehensive approach to preventing and treating HIV/AIDS requires a deeper understanding of the lived experiences among vulnerable groups and HIV/AIDS patients. Unfortunately, there is limited qualitative research among these marginalized populations in Zanzibar, resulting in little knowledge of the social realities of people struggling with addiction, poverty, and their sexual identity.

Parker writes that “Without overcoming the consistent denial of their basic rights and dignity, gay and bisexual men, sex workers, and injecting drug users will continue to

suffer the effects of the epidemic, independent of the degree of behavior change on the part of individuals within these groups” (2000: 41). Through interviews with individuals belonging to marginal groups, NGO staff, and government employees, I heard about the significant challenges these groups face, specifically how discrimination, poverty, sexual and physical assaults, and police harassment are some of the factors, which severely restrict their agency, and negatively affects their health status. Ethnographic field methods contribute to a more nuanced and comprehensive understanding of vulnerable populations, which can be used to improve the overall effectiveness and relevance of current HIV/AIDS programs.

Prevention Strategies

Government and NGO staff reported dissension among colleagues and opposition from some community members regarding comprehensive prevention messages, specifically the promotion of condoms. Some NGOs found ways to work around this issue through the indirect distribution of condoms, while other organizations are more open. The literature on the ABC approach supports this finding, in that some communities, especially ones with strong prohibitions against pre- and extra-martial relations are often opposed to condom promotion and distribution (Pfeiffer 2004; Lugalla et al. 1999). HIV/AIDS agencies in Zanzibar are aware of the sensitive nature of openly discussing condoms, which is why many have taken a discreet and targeted approach in their interventions. While this solution has increased the amount of condoms available to vulnerable populations, the general public is neglected in regards to this HIV prevention strategy. Some government and NGO staff expressed the hope that in the future,

condoms will be more openly discussed among Zanzibaris, but they were realistic in realizing this would take time.

A troubling issue that came up during some interviews is a linear understanding of the ABC approach. The problem with educating individuals to use one method at a time is the unstated message that individuals who use condoms are unfaithful. Additionally, it fails to acknowledge how condoms can protect against unwanted pregnancies, which is an issue in Tanzania where abortions are illegal and many women seek care for complications from illegal abortions at the maternity wards of hospitals (Rasch and Kipingili 2009; Grady 2009). Advocating the use of condoms only in situations where a partner is unfaithful poses a risk for individuals who believe they are in a monogamous relationship, when in actuality their partner is unfaithful and for individuals reluctant to negotiate condom use for fear of being labeled a cheater or accused of not trusting their partner. These issues underscore the importance of normalizing condom use for STI and pregnancy prevention.

HIV testing is a more acceptable prevention strategy, which many NGOs use in campaigns targeting the general population, especially individuals engaged to be married. Confidentiality remains an issue considering that community testing events are held at schools, where there is minimal privacy due to open windows and doors. It was easy to see who received an HIV test and their reaction to their results at the awareness events I attended. Additionally, while it is important couples are getting tested before marriage, these results are reported to not only their future spouse, but also to family and community members. A positive result could result in an individual's serostatus immediately being revealed and subsequent ostracism from the community. Other

researchers have described how pre-marital testing serves as a litmus test of an individual's morality and the anxiety it causes, since the results quickly become public knowledge (Beckmann 2009; Zou et al. 2009). Ensuring the confidentiality of results is a missing component of this testing strategy.

Drug Users

Easy access to drugs has contributed to Zanzibari youth experimenting with drugs, leading to addiction for some individuals. Societal disapproval of drug users and limited access to health services impedes an addict's agency in seeking treatment or finding employment. Multiple failed rehabilitation attempts have left many users depressed and alienated from family and friends, who believe users cannot overcome their addiction. Some users reported engaging in sex work to support their addiction, which corresponds with other research on drug users and sex work (Dahoma et al. 2006; Dahoma et al. 2009; Johnston et al. 2010). Additionally, many participants reported police harassment, corroborating other findings regarding the experiences of drug users (Dewing et al. 2006; McCurdy et al. 2007). These issues, along with the criminalization of drug use, increase the personal and structural violence inflicted upon drug users. The fortunate individuals who successfully enter and complete the one recovery program on the islands, continue to struggle with making amends for past wrongs and finding employment. Family members are reluctant to forgive past misdeeds or believe their relative has successfully overcome their addiction. The loss of their family's assistance leaves many ex-drug users without a support system, which is necessary for their continued recovery. Although regular meetings are held at the recovery program, the location of centers are primarily in urban areas of Unguja and Pemba, which are far from

outlying rural and beach areas. Finding employment is a significant challenge for ex-users, since many have incomplete educational degrees, minimal work experiences, and criminal records. Additionally, many employers are reluctant to hire someone with a history of drug use.

Sex Workers

Women are more likely to report engaging in sex work because of the limited employment opportunities available to them and although men are also involved in the sex trade, they are less likely to admit to it. Prior research on the formal employment sector in Zanzibar has shown lower levels of education among women place them at a disadvantage when seeking employment and the positions that are available to them are usually traditional female roles, for example as cooks and cleaners (Demovic 2007). This situation leads to some women engaging in sex work and due to their precarious finances, many are unable to negotiate condom use with clients, increasing their risk of contracting HIV, other STIs, and dealing with unwanted pregnancies. Other studies of sex workers in East Africa have shown similar findings regarding the inability of sex workers to negotiate condom use with clients (Ramjee and Gouws 2001; Morris and Ferguson 2011; Maternowska 2009). Sex workers spoke of the harassment they suffer from family, community members, clients, and in some instances the police. Although sex work is not illegal in Zanzibar, the police find other excuses to place sex workers under arrest and in some situations used sex workers to entrap clients. Physical and sexual violence, insecure housing, and limited financial resources are some of the daily struggles of sex workers in Zanzibar, many of whom have few avenues of social support. Government and NGO staff encourage sex workers to find alternate income sources, but there are

currently no programs in place to assist with this transition from sex work to the formal employment sector.

Men Who Have Sex with Men

Legal and religious prohibitions against MSM, place these men in an especially precarious position in comparison to the other marginal groups studied in this project. MSM are the most secretive and difficult population to reach due to these issues, which make the work of government and NGO staff targeting this group extremely challenging. It can take months to build a network of contacts in order to conduct outreach activities; however, the services offered at these events are minimal and do nothing to address the socioeconomic conditions in which MSM live. These findings corroborate other research on MSM in sub-Saharan Africa, specifically how legal, religious, and cultural sanctions contribute to the hidden nature of this population, which impede HIV/AIDS interventions targeting this group (Johnston et al. 2010; Knox et al. 2010; Rispel and Metcalf 2009; Onyango-Ouma et al. 2009; Seale 2009; Tadele 2010). Men who are open about their sexual orientation often face harassment from family and community members. Some MSM lose the support of their family leading to some engaging in sex work to support themselves. Simultaneous sexual relations with men and women were reported by participants, which other researchers have found among MSM in Zanzibar (Dahoma et al. 2009; Johnston et al. 2010). Additionally, some reported partner violence, in which some of their sexual partners will tell other men about meetings, resulting in disturbing accounts of gang rape. Similar to sex workers, the marginal status of MSM in society subjects them to physical and sexual violence with no legal means of reporting these incidents.

HIV/AIDS Patients

HIV/AIDS patients in Zanzibar have made great strides in establishing centers of social support and health services on the islands, but they too face discrimination because of their serostatus and gaps remain in the level of care available to them. Although HIV testing is more widely available and acceptable in Zanzibar, many of the patients who participated in this study said they tested in response to symptoms or if a partner tested positive, which raises concerns regarding the speed at which testing is becoming a part of regular health check-ups. Patients also spoke of disturbing accounts of medical personnel treating them in a discriminatory manner. These accounts are troubling and speak to the need for an assessment of clinician views regarding HIV/AIDS and implementation of stigma reduction programs targeting doctors and nurses. This issue, along with inadequate medical equipment and limited access to drugs and food, paint a dismal picture of the medical care available to patients on the islands. Studies of healthcare systems in Tanzania have shown it to be insufficient, particularly in regards to medical services available to HIV/AIDS patients (Lugalla et al. 1999; Johansson et al. 2011). An additional concern is food insecurity among HIV/AIDS patients, which Himmelgreen and colleagues (2009) have said increases the cycle of poverty and disease in that the health of patients with compromised immune systems is exacerbated due to limited access to food and simultaneous infections. Many of the patients who participated in this study said that food is a pressing concern for them, especially since the medicine they take increases their appetite, and adequate nutrition is necessary for their immune systems to fight the virus.

STUDY LIMITATIONS

There are several limitations in this study, the first being access to marginal populations. Many government and NGO agencies have restrictions in place regarding outsiders having access to their clients to ensure the confidentiality and safety of the individuals they assist. Additionally, these agencies deal with their own access issues to these populations and their client base fluctuates frequently. Given these access issues, the majority of interviews were with staff at government and NGO agencies and I have few accounts from individuals belonging to marginal populations. This issue affects the overall representativeness of the study, since second hand accounts were relied upon for information regarding the groups examined. Another limitation is the work of research assistants in conducting interviews in Swahili and translating transcriptions of interviews. Although all assistants were trained on the interview guide and hired based on their fluency in English, there is a possibility that information was lost during the translation process.

RECOMMENDATIONS

There are no easy solutions to addressing the HIV/AIDS epidemic, but applied anthropology can assist in deepening our understanding of underlying causative factors and implementing contextually relevant programming. I am by no means an expert on the HIV/AIDS situation in Zanzibar and I present these recommendations as suggestions for NGOs and government agencies currently involved in HIV/AIDS programming. Most of the Zanzibaris with whom I spoke are aware of the challenges and gaps in current initiatives and my hope is to present these findings in a manner that is useful and

beneficial. With these issues in mind, I present the following recommendations that I believe are feasible in the short-term:

- Increase access to condoms through shops and NGOs and set-up private locations where condom instruction can be provided. The reality is that pre- and extra-marital sexual relations are occurring regardless of societal disapproval and it is important that people learn how to use condoms correctly and have access to them. Both men and women should be targeted in order to increase knowledge among the public of how HIV is transmitted and protective measures that can prevent infection.
- Increase access to clean needles through educational initiatives targeting pharmacists on how needles prevent the transmission of blood borne diseases, such as HIV and Hepatitis C. Needles are available at pharmacies, but some owners refuse to sell them to suspected drug users. Although the government is discussing the establishment of a needle exchange program, this initiative will take time to launch and in the interim access to clean needles can be increased through pharmacies.

The following are recommendation that will require more resources, coordination, and time to implement:

- Provide vocational education workshops for sex workers looking to find an alternative source of income. While current outreach activities focus on educating sex workers and bar owners on safe sex practices, efforts should also be directed towards addressing the socioeconomic status of women. An additional benefit to increasing the socioeconomic status of women is

enhancing their independence from men and their ability to negotiate condom use with partners. The poverty and unemployment rates in Zanzibar are high and it will be difficult to launch viable income-generating projects.

- MSM have the most difficult time accessing services because of their reluctance to reveal their identities and many are estranged from family and friends. The establishment of a safe and anonymous center for MSM to meet and access health services would be beneficial in reaching out to this hidden group and providing them with a place to visit for support and assistance. Although news travels quickly in Zanzibar and HIV/AIDS office locations are well known, there is an anonymous HIV/AIDS support group through a local NGO that is able to maintain the confidentiality of its meetings and members. The presence of this anonymous support group is a promising sign in terms of establishing a similar meeting place for MSM.
- Implement HIV/AIDS stigma reduction programs targeting doctors and nurses. HIV/AIDS patients and their medical caregivers reported disturbing accounts of some medical professionals providing care in a discriminatory manner or in some instances no care at all. This issue needs to be remedied through training initiatives educating medical personnel on how HIV is transmitted and the appropriate manner in which to provide treatment to all patients regardless of their serostatus.
- Decrease the food insecurity of HIV/AIDS patients through community and individual-level gardening initiatives. Many patients spoke of the difficulty in obtaining enough food to maintain their health and a side effect of ARV

medication, which increases their appetite. Although the government provides nutritional assistance to patients, it is only for a limited amount of time. Some patients have actually refused to take their ARV medication because of the side effects and hunger pangs, which speaks to the dire situation of HIV/AIDS patients in Zanzibar.

FURTHER AREAS OF RESEARCH

This study contributes to other research projects conducted on HIV/AIDS in Zanzibar, however, there continues to be an absence of ethnographic research on this issue, which can help in uncovering the lived experiences of marginal populations and giving them a voice. Surveys and other general measurement tools only provide a cursory examination of health problems and reduce groups to high-risk behaviors. Anthropological research on the other hand can provide a more comprehensive understanding of why marginal populations are susceptible to HIV, teasing out the legal, political, social, religious, and cultural factors that contribute to the vulnerability of these populations. Additional qualitative research is needed into the lives of sex workers, MSM, drug users, and HIV/AIDS patients in Zanzibar in order to expand upon understandings of these groups and improve current HIV/AIDS programming.

CONCLUSION

This study examined prevention programs currently in place to assist vulnerable populations and services available to patients infected with HIV/AIDS in Zanzibar. Although government and NGO agencies have made a concerted effort to reach out to marginalized groups, gaps remain in the services provided, specifically addressing the socioeconomic conditions in which these populations live. Additionally, societal stigma

and institutionalized discrimination have left many of these populations without legal, political, or social rights. Former drug users and HIV/AIDS patients are fortunate to have established registered non-profit organizations that serve their needs; however, this option is not available to sex workers or MSM. Poverty, unemployment, addiction, food insecurity, homelessness, police harassment, and physical and sexual violence are some of the issues affecting these groups, which are currently being overlooked in current programs. Singer writes “The objective of most political-economic research has not merely been to understand the spread of AIDS and people’s responses to it, rather, the full agenda of this approach includes a driving concern with the development of useful knowledge and a commitment to collaboration with people living with AIDS and at high vulnerability to AIDS in the development of effective and sensitive programs of prevention, support, and advocacy” (1997:22). Gaining the input and opinions of groups targeted in HIV/AIDS programming assists in developing a more nuanced perspective of their lives, rather than simply focusing on high-risk behaviors associated with these populations, and contributes to more supportive and effective interventions.

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Appendices

APPENDIX A: INTERVIEW GUIDE

NGO Staff Member

1. How long have you worked at NGO NAME?
 - a. How did you become interested in working at NGO NAME?
2. What position(s) have you held with the organization?
 - a. What were your responsibilities in these position(s)?
3. What programs at your NGO have you been involved in designing and implementing?
 - a. Please provide details on the programs you were involved in implementing:
 - i. Target population (Injection drug users, commercial sex workers, youth, people living with HIV/AIDS, men who have sex with men)
 - ii. Duration of program
 - iii. Activities implemented
 - iv. Challenges/successes of program
4. Where do you obtain funding for your programs?
 - a. Which donors have funded your programs?
 - b. What guidelines/regulations did you have to follow when you accepted the grant?
5. How do cultural/religious beliefs and practices inhibit/assist your work?
 - a. Some issues to bring up in the interview:
 - i. Abstinence, Be Faithful, and use Condoms (ABC) message
 - ii. Instruction and distribution of condoms
 - iii. Pre-marital sexual relations
 - iv. Men who have sex with men
6. What challenges do HIV/AIDS patients face in accessing testing and treatment services in Zanzibar?
 - a. How big a problem is social stigma (from community, family members, religious leaders)?
 - b. Where are HIV testing locations? Where do patients who test positive go for their AIDS medication?
7. What tools/resources does NGO NAME need to improve its services?

HIV/AIDS Patient

1. How long have you known your HIV/AIDS status?
2. What were some of the challenges you faced in deciding to take the test?
 - a. Where did you get tested?
 - b. How did you feel after you received your result?
 - c. Did someone counsel you after you received your result?
3. Are you currently taking antiretroviral medication?
 - a. If you are taking antiretroviral medication:
 - i. Where did you obtain your drugs and what side effects have you experienced from taking them?
 - ii. Do you have enough food to take your medication?
 - iii. Are you taking any other medications?
 - b. If you are not taking antiretroviral medication, are you taking any other medications?
4. Have you disclosed your status to your family and friends?
 - a. If you have disclosed your status to family/friends:
 - i. How did you come to the decision to disclose your status?
 - ii. How did your family/friends react when you disclosed your status?
 - b. If you have not disclosed your status:
 - i. Why have you decided not to disclose your status?
5. How long have you been receiving services from NGO NAME?
 - a. Do you feel the services you are currently receiving are enough or do you need more support?
 - b. Are you receiving support/services from any other NGOs or government organizations?
 - c. Do you find the services you are currently receiving beneficial?
6. What challenges/successes have you dealt with in coping with and treating your illness?
7. What tools/resources do you think need to be made available to HIV/AIDS patients in Zanzibar?

Substance Abusers

1. How old were you when you started using drugs?
 - a. What factors led you to start using drugs (i.e. peer pressure, stress, etc..)?
 - b. What drugs have you used?
 - i. Have you ever used needles to inject drugs into your body? What factors led to you using needles?
 - c. How did you feel when you were taking drugs?
2. How did using drugs affect your life?
 - a. Ask about:
 - i. Employment
 - ii. Relations with family and friends
 - iii. Trouble with the police
3. What made you decide to seek treatment for your addiction?
 - a. Have you gone to other treatment centers before?
 - b. Have you ever relapsed? What factors led to your relapse?
 - c. How do you feel now that you stopped using drugs?

Ask follow-up questions if these topics are brought up during the interview:
Flash Blood

Sex Workers

1. How old were you when you started engaging in sex work?
 - a. What factors led you to you engaging in sex work (i.e. unemployment)?
 - b. Do you support anyone else (i.e. family, spouse)?
2. How has engaging in sex work affected your life?
 - a. Ask about:
 - i. Relations with family and friends
 - ii. Violence from work environment (i.e. physical attacks)
 - iii. Trouble with the police
 - iv. Health (i.e. pregnancy, sexually transmitted diseases)
3. What types of clients do you see?
 - a. Tourists
 - b. Locals (Zanzibaris, people from the mainland)
4. Do you use condoms?
 - a. Where do you obtain condoms from?
 - b. How easy/difficult is it to obtain condoms?
 - c. Do you use condoms with all of your clients?

- d. Do some clients refuse to use condoms? What do you do when a client refuses to use a condom?
- 5. Do you use contraceptives?
 - a. What contraceptive method do you use?
 - b. Where did you obtain your contraceptive?
 - c. How easy/difficult is it to obtain contraceptives?
- 6. What services are you currently receiving from NGO NAME?
 - a. Do you feel these services have benefited you?
 - b. What other services do you believe you need?

Men Who Have Sex with Men

- 1. Are you open about your relationships with men?
 - a. Do your family and friends know?
 - b. If you are not open about your relationships with men:
 - i. What would happen if your family and friends found out you have relationships with men?
 - c. Do you have relationships with women as well?
 - i. If yes, do these women know you also have relationships with men? How do they feel about your relationships with men?
 - ii. If no, why have you chosen not to tell these women about your relationships with men?
 - d. Do you use condoms with all of your partners (both men and women)?
 - i. Why or why not?
- 2. How do Zanzibaris' view relationships between men?
 - a. Ask about:
 - i. Religious leaders
 - ii. Teachers
 - iii. Government officials
 - b. How do Zanzibaris react to men who have relationships with other men (physical and verbal reactions)?

Counselor (Voluntary Counseling and Testing)

- 1. How long have you worked as a counselor?
 - a. What training have you received in order to be a counselor?
 - b. Where did you receive your training?
- 2. What information do you provide to clients before you test them for HIV?
 - a. What information do you provide to clients if they test negative?
 - i. Prevention methods (which ones?)
 - b. What information do you provide to clients if they test positive?

- c. What reactions have you seen from clients who test positive?
- 3. What types of clients do you see?
 - a. Couples, drug users, students, etc...
- 4. What health services are available to HIV/AIDS patients in Zanzibar?
 - a. What challenges do patients face in accessing these services?
 - i. Social stigma
 - ii. Transportation
 - iii. Ability to pay for food to take medicine
- 5. How do cultural/religious beliefs and practices inhibit/assist your work?
 - d. Some issues to bring up in the interview:
 - i. Abstinence, Be Faithful, and use Condoms (ABC) message
 - ii. Instruction and distribution of condoms
 - iii. Pre-marital sexual relations
 - iv. Men who have sex with men
- 6. What challenges do you face in work?

Peer Educator

- 1. How long have you worked as a peer educator?
 - a. What training have you received in order to be a peer educator?
 - b. Where did you receive your training?
- 2. What is your target population (injection drug users, sex workers, students, youth, men who have sex with men)?
 - c. What information do you provide to them about HIV/AIDS?
 - d. What materials do you provide to them (condoms, pamphlets)?
 - e. Where do you work (schools, neighborhoods)?
- 3. How big a problem is social stigmatization of HIV/AIDS patients in Zanzibar?
 - f. Can you provide examples of discrimination against HIV/AIDS patients?
- 4. How do cultural/religious beliefs and practices inhibit/assist your work?
 - e. Some issues to bring up in the interview:
 - i. Abstinence, Be Faithful, and use Condoms (ABC) message
 - ii. Instruction and distribution of condoms
 - iii. Pre-marital sexual relations
 - iv. Men who have sex with men
- 5. What challenges do you face in your work?