Zimbabwe National HIV and AIDS Strategic Plan 2011 – 2015

Abridged Version

“Delivering on our commitment to
Zero new HIV infections, zero discrimination and zero AIDS related deaths”

10 November 2011
"...As we embark on another journey of five years, it is necessary to focus on specific measurable and achievable set of results, that will make us turn our commitments into action and ensure that we achieve zero new HIV infections; zero discrimination; and zero AIDS-related deaths among our people........"

H.E. Robert Mugabe
President – Republic of Zimbabwe
Foreword

Global rates of new HIV infections have steadily declined over the past years, with the annual rate falling by nearly 25% between 2001 and 2009. Southern Africa remains the epicentre of the global HIV epidemic. I am heartened by the fact that Zimbabwe is among the first countries in the region to have recorded such a decline. HIV prevalence declined from 20.1% (2005) to 14.26% in 2009. The annual HIV incidence has also declined from a peak of 1.14% in 2006 to 0.85 in 2009. My government, through the National AIDS Council (NAC) in collaboration with local and international partners is providing effective leadership for the national multi-sectoral HIV and AIDS response despite significant funding, human resource, and material challenges. Through the decentralized NAC structures, we are able to ensure that services reach all people. Our vigorous national behaviour change campaign and the employment of several prevention strategies must be hailed. However, let me hasten to say that if we have to achieve an AIDS free generation, we should aim to reduce the annual HIV incidence by more than fifty per cent by 2015.

The implementation of our response between 2006 and 2010 was informed and guided by the Zimbabwe National HIV and AIDS Strategic Framework. A review of this framework shows new emerging issues that we must address now. We are further committed to fulfil our international and regional obligations including Millennium Development Goals, the United Nations Declaration of Commitment commonly known as the UNGASS Declaration and the 2011 Political Declaration on HIV and AIDS, the Global Plan towards elimination of new HIV infections in children and keeping mothers alive, Maseru and Brazzaville Declarations, and the Maputo Plan of Action. As we endeavour to achieve Universal Access to HIV prevention, treatment, care and support, we must ensure availability, accessibility and affordability of HIV and AIDS services to all our people. In this regard we must strengthen our health and community systems to ensure sustained and equitable services delivery.

As we embark on another five-year journey, guided by the new Zimbabwe National HIV and AIDS Strategic Plan II 2011-2015, it is necessary to focus on specific measurable and achievable set of results. This demands concerted efforts and strong commitment at policy and operational levels to ensure that everyone plays a complementary role in the fight against HIV and AIDS.

Over the years, we adopted a multi-sectoral approach in our fight against HIV and AIDS. We will continue with this approach in order to ensure that all sectors play their role based on their mandate and comparative advantage. In this regard, we remain guided by the National AIDS Council in the implementation of the Zimbabwe National HIV and AIDS Plan II 2011-2015, within the context of the ‘Three Ones’ principle. This principle implies that we shall have one National multi-sectoral HIV and AIDS strategic plan, one coordinating authority, and one national monitoring and evaluation system. I call upon all our stakeholders and partners to align their plans with the national strategic plan.

Zimbabwe is grateful to the support and contribution of international partners, non-governmental organisations, faith based organisations, community based organisations, community leaders and the communities themselves in the fight against HIV and AIDS. It is my sincere hope that the spirit of cooperation and partnerships, the spirit of oneness that exists, will see us through as we implement this plan to achieve ‘zero new HIV infections; zero discrimination; and zero AIDS-related deaths’ by 2015.

R. G. Mugabe
H.E. The President of the Republic of Zimbabwe
1. Introduction – background information / country context

1.1 Background information

This document is an abridged version of the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) II 2011-2015. The strategic plan is a multi-sectoral and decentralised plan developed to guide and inform national response implementation. The ZNASP II implementation will facilitate Zimbabwe realise its aspiration of achieving zero new HIV infections, zero discrimination and zero AIDS related deaths by 2015. The strategic plan builds on the achievements made and lessons learnt during the implementation of the outgoing ZNASP (I) 2006–2010. The development of the strategic plan has used a human rights-based planning, evidence and results-based management approaches. Gender dimensions have been mainstreamed in the strategic plan’s strategies and anticipated results.

Through the implementation of ZNASP II, Zimbabwe will deliver on its commitment to zero new HIV infections, zero discrimination, and zero AIDS related deaths.

The strategic plan provides an opportunity for many and diverse stakeholders to find their strategic niche based on their mandate and comparative advantage. This will not only improve the efficiency and effectiveness of the response but will also optimise the use of resources and strategic information. The strategic plan anchors the HIV and AIDS response in the overall national socioeconomic development framework, with the objective of sustaining HIV and AIDS agenda on the social and political agenda, in addition to creating meaningful opportunities for non-health sectors participation and involvement in the national response.

2. Strategic orientation of the national response

2.1 National Priorities

Through an extensive consultative process that has been complemented by empirical data, Zimbabwe has identified the following, as the priorities for the national HIV and AIDS response -

i. **Prevention of new adult and children HIV infections**: Zimbabwe aims to reduce the annual infections by 50% by 2015. Zimbabwe has consistently recorded a decline in HIV incidence from 1.14% in 2006 to 0.85% in 2009.

ii. **Reduction of Mortality amongst PLHIV**: Available evidence indicates that Zimbabwe reduced annual deaths from 123,000 in 2006 to 71,299 in 2010. This was due to the provision of ART, management of TB/HIV co-infection and improved nutrition among others. Sustained provision of ART will not only help reduce death rates but also contribute to HIV prevention efforts.

The strategies to operationalize these priority areas are discussed in section 5 below (Strategic interventions).

2.2 National priority results

The following are the strategic impact level results that are anticipated to be achieved through an efficient and effective implementation of the ZNASP II.

**Impact Result 1**: HIV incidence reduce by 50% from 0.85% (48,168) for adults (2009) to 0.435% (24,084) for adults by 2015.
By 2009, approximately 48,168 people were infected annually with 132 new infections occurring every day. Projections indicate that new adult infections will increase to 54,000 by 2015, unless further risk reduction is achieved. Majority of new adult infections comes from low risk heterosexual sex accounting for 55.9% and followed by casual heterosexual sex (24.0%), and sex workers and their clients (14.05%)

Zimbabwe is also committed to virtue elimination of mother to child transmission of HIV by 2015. The Global target for virtue elimination is less than 5% of mother to child transmission. By 2010, it was estimated that approximately 14,152 new infections occurred among children annually. The Target for the ZNASP is to reduce new infections among children to less than 5% by 2015.

The priority interventions that will contribute to the 50% reduction of new infections by 2015 include reduction in sexual transmission of HIV, reduction of mother to child transmission, and elimination of new infections through blood transfusion or accidental infection through contacts with infected blood in the workplace or sexual abuse. Specific interventions range from social and behaviour change communication, voluntary male circumcision, consistent and correct use of male and female condoms, PMTCT, control and management of sexuall transmitted infections, ensuring blood safety and provision of post exposure prophylaxis.

**Impact Result 2:** HIV and AIDS related mortality reduced by 38% from 71299 (2010) for adults and 13,393 for children (2009) to 44,205 for adults and 8,304 for children by 2015

Provision of comprehensive and quality antiretroviral therapy (ART) will aimed at reducing mortality amongst PLHIV. By 2009 annual AIDS related deaths stood at 70,543 for adults and 13,393 for children. By December 2010, ART coverage for adults and children was at 31.5% (28,149) and 59% (298,092) respectively. **Effective ART will also contribute to reduction of new infections**

The strategic plan will accelerate the provision of ART. It is projected that ART coverage will be increased from 31.5% in children and 59% in adults in 2010 to 85% for both adults and children by 2015. While the focus for Zimbabwe zero AIDS related deaths, the target for ZNASP is reducing annual death rates from 71,299 in 2010 to 51,808 by 2015.

**Impact Result 3:** The efficiency and effectiveness of the national multi-sectoral response improved: The NCPI rating is improved from 6.2 in 2010 to 9.0 in 2015

The respect and fulfilment of basic human rights is the basis for an efficient and effective national response. Improving the efficiency and effectiveness of the national multi-sectoral HIV and AIDS response will also take into account the existence of a social, policy and legal enabling environment, the effectiveness of coordination and management systems, an efficient and effective functional M&E system, sustainable financing of the response, and the mainstreaming of human rights and gender in all aspects of the response. **This is in addition to mainstreaming HIV in non-health sectors.** Meaningful participation and involvement by all people is a pre-requisite for effective and efficient services delivery and sustainability of the response. For Zimbabwe the desired enabling environment will be characterised by respect and fulfilment of basic human rights, adequate and relevant policies, legislation, gender equality and gender sensitivity of the response, reduction of stigma and discrimination in all settings, meaningful participation by all PLHIV, a strong political leadership and commitment.
The key ZNASP II approach is to ensure services integration in appropriate service delivery systems and sector operations. Efficient coordination and management of the multi-sectoral response remains an important strategy to ensure efficiency and effectiveness of the national multi-sectoral response, equitable distribution of services, access by all people including key populations, reduction of duplication of efforts, increased synergy, strong strategic partnerships and alliances.

2.3 Guiding principles

The implementation of the national response will be guided by the following principles -

- **Respect and fulfilment of human rights**: Respect and fulfilment of human rights is a pre-requisite for an efficient and effective HIV and AIDS response. Efforts will be made to ensure that duty bearers (service providers) respect and fulfil their obligations to provide quality and comprehensive services to all people. Rights holders (beneficiaries) will be empowered to access and utilise such services.
- **Equity**: Access to services is a human right. During the ZNASP II efforts will be made to ensure equitable distribution, availability and access to services by all people.
- **Evidence and results-based management**: The planning and management of the national response will be informed by empirical qualitative and quantitative evidence, and implementation will focus on measurable impact, outcome and output results.
- **Integrated service delivery**: The ZNASP II will support services integration as a strategy to improve synergy between intervention, complementarity and optimise the use of resources. The strategic plan will support implementation of strategies that improve services coverage.
- **Meaningful involvement of people living with HIV (MIPA)**: PLHIV involvement will improve services uptake and address the challenges of stigma and discrimination, among other barriers to services uptake. The involvement of PLHIV will enhance their participation in prevention of new infections.
- **Good practices**: Stakeholders will be encouraged to use good practices that are supported by empirical evidence on their efficacy to inform their planning and improve service delivery.
- **The “Three Ones” Principle**: Zimbabwe will consolidate the application of the three ones principle of having one national coordinating authority, one national strategic plan and one national monitoring and evaluation system.
- **Gender sensitivity and responsiveness**: Given the gender bias of the HIV and AIDS, efforts will be made to ensure that strategies address gender inequality and biases of the epidemic.
- **Creating an enabling environment**: An enabling environment is premised on the existence of appropriate and effective policies, laws, operational guidelines and standards, and more importantly respect and fulfilment of human rights. During the ZNASP II period policies and legislations will be reviewed and strengthened, advocacy work will be undertaken to ensure enforcement and compliance with such policies and legislation and fulfilment of human rights. Political commitment and leadership will be galvanised.

3. Situation analysis – epidemiology and national response
Adult HIV prevalence has declined from 27.2% (1998) to 14.26% in 2010 (HIV estimates, 2009). By 2010 the total number of adults and children living with HIV in Zimbabwe was estimated at 1,168,263. Of this 414,338 were men and 608,700 women. The total number of PLHIV is projected to increase to 1,187,087 by 2015.

It is estimated that 47,309 new adult infections occurred in 2010 with a projected increase to 54,053 in 2015. Similarly 14,152 new infections in children were estimated to have occurred in in 2010. However the number of children infected by HIV annually is expected to decrease to 11,162 by 2015. Approximately 17,000 new infections were estimated to have come from children in 2009, as a result of vertical transmission from mother-to-child (MTCT). MTCT is the second major HIV transmission route in Zimbabwe. Available data from the 2010 Estimates using EPP/Spectrum suggest that there has been a decline in annual HIV incidence from 1.14 in 2006 to 0.85 in 2009.

Overall Zimbabwe is among several countries in Southern Africa with a HIV epidemic showing a consistent decline in prevalence over the last decade. The decline is attributed partially to successful implementation of prevention strategies (i.e. significant changes in sexual behaviour) and high mortality due to low coverage of ART provision. Between 1999 and 2006 less than 5% of PLHIV had access to ART.

HIV transmission remains predominantly sexually driven, accounting for over 80% of infections. Majority of new infections occur in the age group 20 - 29 years. New infections are expected to come from low risk heterosexual sex (55.88%), casual heterosexual sex (23.92%) and sex workers and their clients (14.05%)

In 2010, the estimated number of AIDS related deaths was 71,299. It is anticipated that the number will decline to about 51,808 deaths by 2015. Despite this projection Zimbabwe is committed to working towards “zero AIDS related deaths”.

HIV transmission remains predominantly sexually driven. Sexual transmission accounts for over 80% of infections. Majority of new infections occur in the age group 20 - 29 years. New infections are expected to come from a variety of sources as shown in the table below.

<table>
<thead>
<tr>
<th>Source</th>
<th>% - Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Low risk heterosexual</td>
<td>57.6%</td>
</tr>
<tr>
<td>2. Casual heterosexual</td>
<td>7.5%</td>
</tr>
<tr>
<td>3. Partners of casual heterosexual</td>
<td>18.8%</td>
</tr>
<tr>
<td>4. Clients of heterosexual</td>
<td>6.4%</td>
</tr>
<tr>
<td>5. Men who have sex with men (MSM)</td>
<td>4.0%</td>
</tr>
<tr>
<td>6. Male partners of MSM</td>
<td>2.7%</td>
</tr>
<tr>
<td>7. Female partners of MSM</td>
<td>0.4%</td>
</tr>
<tr>
<td>8. Sex workers</td>
<td>1.4%</td>
</tr>
<tr>
<td>9. Injecting Drug Users (IDU)</td>
<td>1.1%</td>
</tr>
<tr>
<td>10. Partners of IDU</td>
<td>0.1%</td>
</tr>
<tr>
<td>11. Medical Injections</td>
<td>0.1%</td>
</tr>
</tbody>
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(Source: Power point presentation by NAC, 2011)

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4. The National Response Analysis

Over the years Zimbabwe has implemented diverse strategies to prevent the spread of HIV, reduce mortality and morbidity, mitigate the socioeconomic impacts of the epidemic, and improve the efficiency and effectiveness of services delivery. The following is a synopsis of the national response

**Prevention of New HIV infections:**

- Zimbabwe developed and has been implementing the “Zimbabwe National Behaviour Change Programme”, that seem to have started to yield desired results. The decline in HIV incidence is attributed to behaviour change and high mortality rate. Currently Zimbabwe is in the process of developing a robust HIV prevention strategy that is aligned to ZNASP II.
- Annual HIV incidence has declined from 1.14% in 2006 to 0.85% in 2009. HIV prevalence equally declined by almost 50% from 27.2% in 2008 to 14.26% in 2009.
- In 2009, 85% of pregnant women attending ANC were tested for HIV. 59% of HIV positive women were enrolled on ART by 2009. In 2008, 80% of infants born to HIV positive mothers were provided with ARV prophylaxis for PMTCT at birth.
- **Voluntary male circumcision** was adopted as a key prevention strategy. By the end of September 2010, 11,102 men had been circumcised. The programme is being scaled up.
- 150 million male condoms were distributed in 2010 and 15,426,325 female condoms were distributed between 2006 and 2009.
- The annual total number of STIs treated declined by 55% from just over 480,000 in 2006 to 268,000 in 2009.
- Zimbabwe has attained 100% blood safety as all donated blood is screened in accordance with national guidelines that are aligned to international guidelines for blood screening.
- By 2010, about 85% of people had tested and received their results. HIV testing and counselling through “Provider Initiated Testing and Counselling” (PITC), increased from 35% in 2006 to 64% in 2010. Couple counselling also increased from 12% in 2007 to 25% in 2009.

**Treatment, Care and Support**

- By December 2010, 326,241 of the 593,168 were receiving ART treatment representing a coverage of 54% based on CD350 criteria. Of these, 60% were females and 32,000 children. ART sites have increased from 32 in 2006 to 387 by June 2010.
- Annual AIDS related deaths reduced from 123,000 in 2006 to 71,299 in 2010.
- Significant progress was made in strengthening the technological capacity of laboratories. By 2007 Zimbabwe procured and distributed 71 CD4 count, 69 haematology and 45 biochemistry machines to public health facilities.
- In order to expand human resources (HR) capacity for diagnostic service provision, the MoHCW reintroduced the State Certified Medical Laboratory Technician (SCMLT) training programme in 2007. To date 186 SCMLTs have been trained and posted to districts. Training of microscopists has also been expanded with 320 people out of the 520 target for 2010. As mentioned earlier, 13% of districts were offering early infant diagnosis (EID). Viral load testing has recently been launched.

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2 MOHCW data base
3 MOHCW data base
Impact Mitigation and Support

- The number of people receiving community home based care (CHBC) services increased from 489,000 in 2008 to 697,000 at the end of 2009.
- The Government has supported provision of therapeutic and supplementary feeding of children and adults living with HIV who suffer from severe and moderate acute malnutrition respectively.
- Of the 1.6 million orphans and vulnerable children (OVC) in Zimbabwe, 62% were due to HIV and AIDS. Of all the OVC, only 410,000 (25%) had received support through the programme of support (PoS).

Management, Coordination and M&E of the National HIV Response

- NAC has decentralized coordinating structures (AIDS Action Committees) at provincial, district, ward and village levels – PAACS, DAACS, and WAACs. Additional structures such as Ward Health Teams, development structures such as VIDCO, WADCO and DDCOs and Child Protection Committees have been established to support coordination of the implementation of the national response, and advocate for an enabling environment.
- Outside of the government structures multi-sectoral coordination has been consolidated through umbrella coordinating structures such as ZBCA, ZAN, ZNNP+, UNJT, CCM, and GFATM.
- Community and health systems continue to be strengthened to improve the efficiency and effectiveness of service delivery.

Monitoring and Evaluation

- A national database for the HIV and AIDS response has been established.
- Training has been conducted for M&E officers from both public and civil society organisations.
- A national M&E plan was developed to monitor and report the implementation of ZNASP I. The plan is being reviewed to align it with ZNASP II, monitoring and evaluation requirements.
- Zimbabwe has consistently reported on its regional and international obligations on HIV and AIDS including the MDGs.

Financing of the National Response to HIV and AIDS

- Funds collection through the National AIDS Levy has increased from US$ 5 million in 2006 to US$ 19 million in 2010. 50% of the funds are used to procure ART.
- Funding from bilateral and multilateral partners as well as international foundations has increased US$25 million in 2008 and US$38 million in 2009 towards HIV and AIDS programs.
- Zimbabwe also received funding from the GFATM through Round 5 Grant- US$60 million; and Round 8 - US$46 million by December 2010.
- Funding through the Expanded Support Program (ESP) received US$ 42 million between 2007 and 2009 from Canadian International Development Agency (CIDA), Department for International Development (DFID), Norwegian Aid, Irish Aid and Swedish International Development Agency (SIDA).

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7 ZDHS 2006-2010 and EPP/Spectrum estimates (June 2010)
8 Reporting on 2009 funding matrix by Bilateral, Multilaterals and International Foundations for Zimbabwe UNGASS 2010 Report
The OVC strategic plan was supported through the Programme of Support (PoS) with US$84 million for 3-years by several donors to support OVC education, healthcare, birth registration and access to HIV and AIDS prevention, treatment, and care and support services.

5. Strategic Plan Interventions

The ZNASPII implementation will revolve around prevention of new infections, treatment, care and support and HIV mainstreaming in non-health public and private sectors in addition to accelerating the design and implementation of strategies aimed at improving the efficiency and effectiveness of the national response. The following section presents a synopsis of the ZNASPII under four sub-headings of prevention of new HIV infections, Accelerating provision of comprehensive and quality treatment, care and support, National response systems strengthening, and HIV mainstreaming.

5.1 Prevention of new HIV infections

Prevention of new HIV infections among adults and children is a national priority for Zimbabwe. The ZNASPII has anchored strategies that will reduce or prevent infection if exposure occurs, reduce the probability of infection if transmission occurs and those that will influence social and cultural behaviour change in areas where cultural and social norms, values and practices remains barriers to adopting effective prevention behaviours. The strategies demand a revolutionary rather than an evolutionary approach for Zimbabwe to attain the goal of reducing new HIV infections by 50% by 2015.

The implementation of these strategies is premised on the "combination prevention strategy". The strategy will promote and support dynamic, rights-based and evidence-informed mix of behavioural, biomedical and structural interventions that are tailored to meet local needs, are gender sensitive and responsive, and are community driven.

Priority interventions intended to reduce or prevent HIV infections if exposure has occurred include male circumcisions, prevention of mother to child transmission (PMTCT), consistent and correct use of condoms, prevention of infection among discordant couples, blood safety, treatment and control of sexually transmitted infections (STIs) and addressing the broader issues of gender based violence, sexual and reproductive health and family planning (SRH/FP), stigma and discrimination.

In an effort to prevent infection if transmission is assumed to have occurred Zimbabwe will provide a comprehensive antiretroviral and post exposure prophylaxis respectively.

The benefits of reducing new infections are enormous including the possibility of an AIDS free generation (virtual elimination of mother to child transmission), improved quality of life as more PLHIV live longer and delayed orphanhood (contribution by an effective ART programme). Prevention will contribute significantly to reducing the burden and cost of care. As more people remain negative the burden on health and social welfare systems will be lessened and provision of health care in general will improve including maternal health care, reduction in child mortality and malnutrition. As the human capital improves Zimbabwe will be able to meet its Millennium Development Goals (MDG) commitments. Resources currently committed for treatment, care and support will be freed for use in national socioeconomic development including enhancing the quality of education, health care, improving food security and alleviating poverty.

Prevention interventions will be scaled up, targeted, intensified, geographical and beneficiary coverage expanded. Efforts will be made to reduce fragmentation and improve coordination at all levels through strategic partnerships and alliances. The involvement of political and community leadership, and PLHIV will be critical in achieving human rights based and gender responsive prevention outcomes. The linkages and synergy between prevention and treatment will be strengthened as demonstrated by the impacts of ART, HTC and control and management of STIs.

5.2 Accelerating comprehensive and quality treatment, care and support

The goal of ART programme in Zimbabwe is in the first instance to improve the quality of life of PLHIV by reducing mortality and morbidity due to AIDS. Current data indicate that survival of PLHIV on ART has improved significantly. In 2009, 69% of adults and children known to be on ART after 24 months after initiation were still alive. Annual death rates decreased from 123,000 to 71,299 by 2010. This data serves to illustrate the effectiveness of the ART programme and the need to sustain it.

Secondly, available global evidence indicates that an effective ART programme will also contribute to prevention of new HIV infections. The ZNASP II, also recognise that the relationship between the impact of HIV and vulnerability is reciprocal. On one hand, social and economic circumstances such as poverty, abuse, violence, prejudice and ignorance (i.e., pre-existing vulnerability before HIV infection) increases an individual's susceptibility to HIV infection and therefore fuels HIV infection. In some other cases, being HIV positive generates and re-enforces vulnerability that enable the epidemic to thrive and further worsens the quality of life of the person affected. However, the effectiveness of the treatment, care and support programme has made it possible for many PLHIV to live a normal life, thereby reducing their vulnerability to these factors.

This progress has been achieved through a combination of interventions including a shift from CD4 200 to CD4 350 criteria for initiating ART, improvements in laboratory technology, increased training of health service providers in adult and paediatric ART, and a comprehensive home base care programme. Although adherence has had some challenges, overall analysis shows that many PLHIV adhere to treatment. These services will not only be scaled up but will also be intensified. The aim is to reduce AIDS related mortality by 38% from 71,299 (2010) for adults and 13,393 for children (2009) to 44,205 for adults and 8,304 for children by 2015.

5.3 Mainstreaming HIV and AIDS in sector operations and programmes

The challenges of HIV and AIDS are complex, dynamic and transcend institutional boundaries. This calls for an effective national multi-sectoral and decentralised response with active participation of all sectors. Mainstreaming HIV in sector operations and programmes has been identified as an effective strategy to engage all sectors in the national response based on their mandates and comparative advantage.

During the period of the ZNASP II, efforts will be made to strengthen the capacity of sectors to undertake internal and external HIV mainstreaming. In the context of internal mainstreaming the focus will be supporting the development of comprehensive HIV and AIDS workplace programmes using a human rights, evidence and results-based management approaches. Advocacy work will be conducted among sectors to encourage them mainstream HIV in the workplace through HIV and AIDS workplace programmes, and in their development programmes taking cognisance of human rights and gender
sensitivities. The public sector is key in HIV mainstreaming given that it is the largest employer in the country. Zimbabwe has prioritised 13 Government ministries for HIV mainstreaming.

5.4 Coordination and management of the national response

The core focus in coordination and management is to improve the efficiency and effectiveness of the national response through systems strengthening.

Systems strengthening has been defined as efforts to improve the functioning of a system for better outcomes, including increased access, coverage, quality, effectiveness and efficiency in services delivery. The process recognises that individual systems components within a broader systems framework work together towards shared outcomes. In the context of ZNASP II, health and community systems have been prioritised for strengthening. Within these systems are sub systems that address effectiveness and efficiency in coordination and management, social protection, M&E, social, policy and legal systems. A Human rights and results based approach has been adopted to inform and guide the systems strengthening processes. Given the complexity of the HIV and AIDS response, it will be necessary to ensure that these systems function simultaneously and complement each other.

The national level coordination has increasingly become complex and dynamic given the many and diverse stakeholders providing a wide range of services. At this level coordination will focus on policy formulation, facilitating joint planning and programme reviews, resource mobilisation and tracking, advocacy for technical assistance, monitoring and evaluation of the response based on agreed results and targets, harmonisation and alignment of interventions, facilitating strategic partnerships and alliances.

During the period of ZNASP II, the capacity of coordinating structures will be strengthened in line with their mandates, roles and responsibilities with the aim of improving their efficiency and effectiveness in coordination and management, accountability and leadership among others. The enabling policy, and legal environment will be strengthened through policy reviews, advocacy and monitoring of compliance by stakeholders. Sufficient resources will be mobilised to support the implementation of the national response. Community and health systems will be strengthened too, to ensure efficient and equitable service delivery, monitoring and evaluation and resource tracking.

6. The process of developing the ZNASP

The process of developing the ZNASP has been participatory involving a wide range of stakeholders from public sector institutions, private sector, and civil society organisations (NGOs, FBOs, and CBOs) to organisations of PLHIV, and communities themselves. It started by conducting know your epidemic and know your national response situation analysis. This was complemented by a number of other technical studies that have generated the evidence that was necessary to inform the planning and development of ZNASP II.

Stakeholders’ participation varied from stakeholder to another and involved consultative workshops, representation in technical working groups, reviewing and validating draft plans and situation analysis report. Stakeholders also provided documents that were used for desk review for the epidemiological and national response analysis. The strategy development took place between September 2010 and May 2011.