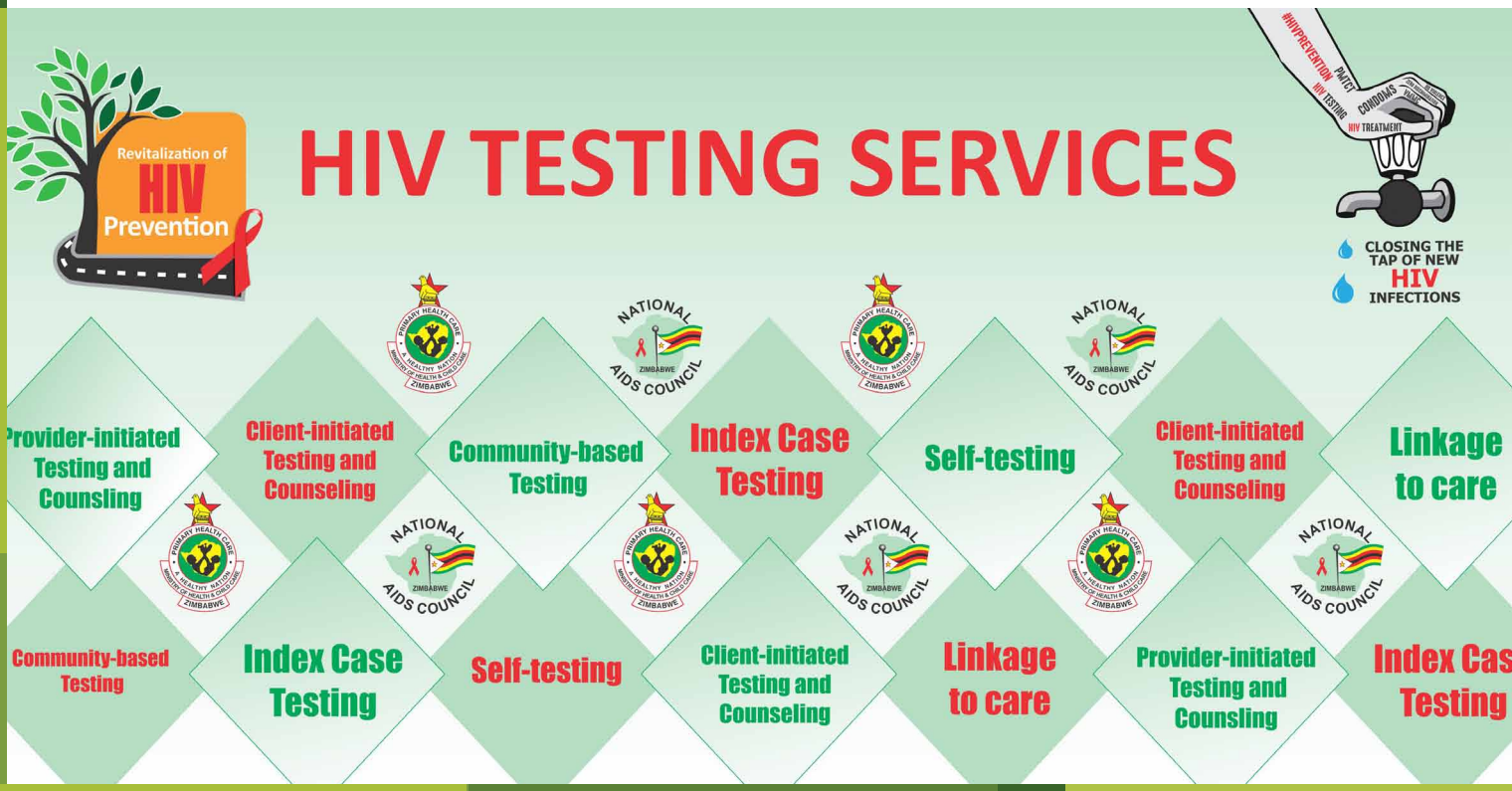
MINISTRY OF HEALTH
AND CHILD CARE



HIV TESTING SERVICES STRATEGY

2017-2020

Contents

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
CDC	Center for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CITC	Client Initiated Testing and Counselling
DBS	Dried Blood Spots
DHIO	District Health Information Officer
DHIS	District Health Information System
DLS	Dedicated Logistics System
DMO	District Medical Officer
PCR	Polymerase Chain Reaction
DNO	District Nursing Officer
DTS	Dried Tube Specimens
DTTU	Delivery Team Topping Up
EID	Early Infant Diagnosis
EPI	Expanded Program on Immunizations
ePMS	Electronic Patient Management System
EQA	External Quality Assurance
HCW	Healthcare Worker
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HMIS	Health Management Information System
HPO	Health Professionals Organization
HTS	HIV Testing Services
IEC	Information, Education and Communication
IQC	Indefinite Quantity Contract
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn and Child Health
MOHCC	Ministry of Health and Child Welfare
MSM	Men Who Have Sex With Men
NAC	National AIDS Council
NMRL	National Microbiology Reference Library
OI	Opportunistic Infection
OPD	Out Patient Department
PC	Primary Counsellor
PEDCO	Provincial Epidemiology and Disease Control Officer
PITC	Patient Initiated Testing and Counselling
PLHIV	Person Living with HIV
PMTCT	Prevention of Mother To Child Transmission
PNC	Postnatal Care
POC	Point-of-Care
QA	Quality Assurance
SCM	Supply Chain Management
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
ZINA	Zimbabwe Nurses Association
ZINQAP	Zimbabwe National Quality Assurance Program
ZONA	Zimbabwe Occupational Nurses Association

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Definition of Terms

Age of Consent: The legal age at which people are informed of the process for HIV testing and counselling, as well as their right to decline services. In Zimbabwe the age of consent for HIV testing and counselling is 16 years old, with the exception of mature and emancipated minors.

Informed Consent: Whereby a participant must have an adequate understanding of the HIV testing process. Health workers should ensure that no one is coerced into testing, and participants must understand that they have the right to opt out at any point.

Community Based Testing: A number of approaches to testing outside of health facilities, such as door-to-door/home-based testing and mobile outreach campaigns and testing in workplaces, parks, bars, places of worship and educational establishments.

Emancipated Minor: Refers to a child or adolescent under the age of 16 who is married, pregnant or a parent.

Entry Point: Point at which specific services can be accessed at a health care facility.

Facility Based Testing: Facility-based HIV testing services refers to those services provided in a health facility or laboratory setting.

Key Population: Defined groups that, due to specific higher-risk behaviours, are at increased risk for HIV irrespective of the epidemic type or local context. Guidelines refer to the following groups as key populations: men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people.

Mature Minor: A child or adolescent under the age of 16 who can demonstrate that he/she is mature enough to make a decision on their own and has taken responsibility for their own health, through for example, heading a household or living independently from a parent/caregiver.

Priority Population: Defined groups that are impacted by HIV and critical to efforts to respond to the epidemic. These groups include infants, children, adolescents, pregnant women, men, couples and partners.

Screening Tools: Refer to mechanisms used for case finding of associated HIV illnesses in order to facilitate early detection and treatment.

Yield: A positive HIV test result after conducting a test.

Youth Friendly Services: Services with policies and attributes that attract young people to them, create a comfortable and appropriate setting, and meet young people's needs.

Acknowledgements

The revision and development of this strategic plan is a result of determined collective effort from various organisations, people and health implementers. The MOHCC therefore would like to acknowledge these organisations and stakeholders for their commitment and valuable comments that were extremely vital to the development of this 2017-2020 HTS Strategy. Special acknowledgement and appreciation goes to all provincial staff and communities who participated and provided insights during the review of the National HIV Testing and Counselling Strategic Plan 2013-2015. The MOHCC HIV Prevention Team and the Technical Working Group (TWG) members who tirelessly participated in the review meetings and provided valuable contributions are also acknowledged as welll as Dr Mugurungi and Ms Gertrude Ncube from MOHCC for their support. The development of this strategy was made possible with the financial and technical support from the Clinton Health Access Initiative (CHAI) for which we are very grateful as it enabled the provincial and national stakeholder consultative meetings and interviews. Last but not least the MOHCC extends a very special thank you to the WHO for their technical review and support as well as Wadzanai Motsi-Khatai for her dedication in putting the document together and Daniela Cristofori for the design and layout.

Foreword

Zimbabwe has over the years recorded significant progress and achievement in reducing HIV prevalence and incidence, with a decline in prevalence from a once staggering 29% in 1999 to an encouraging 15% in 2017. The decline in the infection rates is attributed to a number of interventions, with knowledge of one`s HIV status through the structured HIV Testing Services (HTS) being at the core of this achievement. The resultant actions that an individual takes after undergoing HIV testing has contributed significantly to the overall success of the HIV programmes through improved linkages to other HIV services, risk reduction and personal behaviour medication, among others.

HTS remains a critical entry point to HIV prevention, treatment, care and support. Under the 2013-2015 HIV Testing and Counselling Strategy, the Ministry of Health and Child Care (MOHCC) set the objective of increasing coverage and access to testing services for the general population, as well as ensuring that 85% of men and women know their status and receive a standard package of HIV testing and counselling services[i]. According to the 2015 Zimbabwe Demographic and Health Survey, significant progress was made towards this objective, with 80% of adults receiving testing at least once by 2015. This was made possible through increasing the number of health institutions conducting provider initiated testing and counselling from 80% to 95% by 2015 and also the innovative strategies of conducting HTS campaigns to increase access to testing services with linkages to prevention treatment care and support. However, a review of this framework also showed new emerging issues that must be addressed as we work towards ending AIDS by 2030.The HTS programme is committed to this ambitious goal, and therefore the 2017-2020 HTS strategy detailed in this report is closely aligned to the 90-90-90 UNAIDS Global Fast Track targets aimed at ensuring that by 2020:

90% of all people living with HIV will know their HIV status;

90% of all people diagnosed HIV positive will receive sustained antiretroviral therapy;

90% of all people receiving antiretroviral therapy will have viral suppression.

The MOHCC recognises and has embraced the need to achieve these ambitious targets and therefore calls on all our stakeholders, local and international partners working in the fight against HIV and AIDS to join the government of Zimbabwe in mobilising the requisite financial and technical resources for the sustainable implementation of the priority interventions identified in this HTS strategic plan.

Brigadier General, Dr. Gerald Gwinji

Permanent Secretary, Ministry Of Health
and Child Care, Zimbabwe

Executive Summary

15%

Is the prevalence of HIV of the adult population in Zimbabwe 2015

Zimbabwe had an estimated 1.4 million people living with HIV in 2015[ii]. Over the 2010-2015 period, the country saw a gradual decline in HIV prevalence, with prevalence in the adult population decreasing from 18% to an estimated 15%[iii]. Availability of anti-retroviral treatment has also improved over the same five year period, with coverage increasing from 32% in 2010 to 65% in 2015[iv] for adults and from 33% in 2010 to 80% in 2015[v] for children.

HIV testing serves as an entry point to HIV prevention, care and treatment programs. Under the 2013-2015 HIV Testing and Counselling Strategy, the MOHCC set the objective of increasing coverage and access to testing services for the general population, as well as ensuring that 85% of men and women know their status and receive a standard package of HIV testing and counselling services[vii]. Progress was made towards this objective, with 80% of adults receiving testing at least once according to the 2015 Zimbabwe Demographic and Health Survey . In late 2015, the country adopted the UNAIDS 90-90-90 Global Fast Track targets aimed at ensuring that by 2020:

90% of all people living with HIV will know their HIV status;

90% of all people diagnosed HIV positive will receive sustained antiretroviral therapy; and

90% of all people receiving antiretroviral therapy will have viral suppression.

As part of this framework, the MOHCC has committed to not only increasing testing coverage for the general population, but prioritizing strategies and testing initiatives that are more likely to identify those living with undiagnosed HIV. These priorities and strategies will be in line with the global objective to end AIDS by 2030. In order to achieve these revised commitments, in January 2016 the MOHCC embarked on the process of revising the national HTS Strategy to align with the new strategic objectives, as well as increasing the uptake of HIV Testing Services.

The revised strategy will be implemented using a framework that is based on six thematic areas, namely:

- **Management and Coordination,** which will focus on creating an enabling environment to facilitate implementation of HTS policies and strategies, a system of accountability for HTS performance as well as the provision of operational guidelines and frameworks for all health facility levels.
- **Service Delivery,** which aims to implement strategies that focus on the consistent provision of integrated HTS at the facility level, as well as strengthening linkage to prevention and care and treatment services.
- **Demand Generation,** which has an overall objective of ensuring the effective implementation of targeted, evidence-based demand generation strategies for HTS.
- **Strategic Information,** which seeks to develop improved mechanisms to monitor and evaluate HTS performance in order to identify gaps, make improvements to the program and report progress made towards achieving the program's strategic goals.
- **Supply Chain Management,** which aims to reinforce procurement and supply chain management systems in order to guarantee regular and consistent supplies for HTS.
- **Quality Assurance,** which looks toward ensuring high quality and control in the provision of HTS at all levels.

The framework is supported by a target setting model, which quantifies the yields and testing volumes at the various entry points needed in order to ensure 90% of all HIV positive people know their HIV status by 2020. The purpose of this document is to guide the country towards attainment of the first 90 in Zimbabwe and to increase coverage of HTS, with the mission to end AIDS by 2030.

Strategic Objectives and Implementation Priorities

1 Strategic Objective 1: Strengthen management and coordination of the HTS programme to improve efficiency and effectiveness

1.1: Strengthen the human resources structure and capacity to effectively manage and coordinate the HTS program at all levels of the health systems

1.2: Strengthen the management of financial resources for the HTS program to deliver an efficient service that meets the needs of the population

1.3: Strengthen the engagement of the private sector to leverage on its strengths for delivery of HTS services

2 Strategic Objective 2: Strengthen service delivery capacity to increase access to high quality HTS for all population groups

2.1: Ensure HTS guideline availability to all levels to enhance provision of good quality service

2.2: Strengthen the implementation of provider-initiated testing and counselling (PITC) at all entry points to reduce missed opportunities for identifying undiagnosed people living with HIV (PLHIV)

2.3: Strengthen HTS integration as part of standard of care to reduce missed opportunities for HIV testing and ensure efficient utilization of resources including human resources

2.4: Strengthen linkages to post-test services to enable follow up and support of referred clients to complete the referral pathway

2.5: Strengthen service provision for key populations to increase access to quality HTS

2.6: Strengthen service provision for priority populations to increase access and utilisation of HTS

2.7: Strengthen the quality of counselling in HIV testing services provision to effectively respond to clients' concerns

2.8: Enhance the capacity of the private sector to provide standardised quality HTS

2.9 Enhance the implementation of current community approaches to HTS that are targeted, whilst allowing for the introduction of new innovative models

3 Strategic Objective 3: Strengthen the national human resource capacity for HIV Testing Services in line with the broader Human Resource for Health Plan

3.1: Establish universal awareness of the program, its key components and considerations through standardized integration of HTS into pre-service training

3.2: Sustain on-going site based training and capacity building as part of in-service training for HCWs

3.3: Support scale-up of additional PCs for providing testing services in the facility

3.4: Increase human resources for providing services at the community level

Strategic Objective 4: Strengthen the demand generation for HTS based on local evidence to effectively reach out to all population groups **4**

4.1: Ensure effective coordination of demand generation activities for HTS

4.2 Strengthen appropriate and targeted messaging to effectively reach out to priority populations

Strategic Objective 5: Strengthen the strategic information of HTS to provide evidence for effective decision making **5**

5.1: Promote data demand, dissemination and utilization at all levels

5.2: Strengthen facility (public and private) and community based HTS information management systems for robust evidence generation

5.3: Strengthen the human resources capacity for M&E to enable effective data analysis to inform decision making

5.4: Reinforce effective M&E of programme linkages and client tracking mechanisms to provide evidence for improving the linkages

5.5: Strengthen utilisation of data to make programme decisions at all levels of the health system to enable appropriate targeting of interventions

5.6: Strengthen M&E for HTS demand generation to produce local evidence to inform activity planning and implementation

Strategic Objective 6: Strengthen the Supply Chain Management systems for HTS commodities to ensure their adequate availability to meet programme needs **6**

6.1: Strengthen the HIV testing kits stock management systems to ensure adequate stocks are kept at all levels of the health system including the private sector as well as at every HIV testing entry point

6.2: Ensure timely access to early infant diagnosis (EID) testing services

6.3: Evaluate and effectively deploy EID point-of-care (POC) devices

Strategic Objective 7: Strengthen the quality assurance for HIV testing to minimise the risk of HIV misdiagnosis **7**

7.1: Ensure quality of HIV test kits and reagents

7.2: Ensure that HTS is being conducted efficiently, with adherence to quality control at all testing sites

1. Background

In 2015, Zimbabwe had an estimated 1.4 million people living with HIV[viii] , of which an estimated 5% (77,000) were children under the age of 15 years. Under the National HIV Testing and Counselling Strategic Plan 2013-2015, the MOHCC set the goal to increase overall testing coverage to ensure that 85% of the population knew their HIV status by 2015.

In late 2015, the country adopted the UNAIDS 90-90-90 Global Fast Track targets with a goal to end AIDS by 2030. As part of this framework it is aimed that by 2020:

- **90% of all people living with HIV will know their HIV status;**
- **90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and**
- **90% of all people receiving antiretroviral therapy will have viral suppression.**[x]

The MOHCC has committed to not only increase testing coverage but also to prioritize strategies and testing initiatives that are more likely to identify those living with undiagnosed HIV infection in order to contribute to this global agenda. The adoption of this framework means provision of comprehensive HTS, which includes a full range of services that should be provided together with HIV testing. These services include counselling (pre-test information and post-test counselling); linkage to appropriate HIV prevention, treatment and care services, other clinical and support services, and coordination with laboratory services to support quality assurance and the delivery of correct results. HTS is the entry point for all HIV services and the MOHCC has committed to strengthening the program. Uptake of HTS is key in ensuring that the second and third 90s of the framework are achieved.

2. Review of the National HTS Strategic Plan 2013-2015

Between 2013 and 2015 implementation of the HTS programme was guided by the National HIV Testing and Counselling Strategic Plan 2013-2015. The MOHCC commissioned the review of this strategic plan in order to inform the new strategy for 2017-2020. The findings of this review are highlighted below according to the different strategic objectives from the 2013-2015 plan.

Strategic Objective #1: Strengthen leadership commitment to enhancing an enabling environment for HTS and related services

The Zimbabwe National Policy on HIV/AIDS promotes zero stigma and discrimination, and has enabled multi-sectorial participation in HIV responses. The government has created an enabling environment for HIV testing through the implementation of various national level policies that included the offering of routine HTS to all patients. In order to keep Zimbabwe up to date with international HIV testing standards, national HTS guidelines were harmonized to include emerging issues and changes. For example, Zimbabwe adopted the 2013 World Health Organisation (WHO) antiretroviral therapy (ART) guidelines, the 2015 revised WHO testing algorithm, HTS guidelines for children and adolescents, as well as the adoption of other policies and guidelines. Awareness of these guidelines was ensured by the timely printing and distribution of them nationally.

Strategic Objective #2: Establish a culture of evidence-based HIV testing and counselling programme planning, coordination, management, monitoring and evaluation at all levels

Over the 2010-2015 period, the MOHCC conducted various meetings and engagements with stakeholders in order to strengthen coordination and ensure a standardized approach to HTS implementation. Consultations were held so as to facilitate teamwork, HTS campaign planning and the launching of guidelines. Regular updates between programmes and sharing of lessons learnt were the epicentre of these meetings, with the overall aim of standardizing and coordinating the implementation of programs, which would lead to program efficiency and effectiveness. The District Health Information System (DHIS2) was launched in October 2013, which would serve as a platform to consolidate data and information between the MOHCC and multiple partners.

Strategic Objective #3: Increase utilization of HIV testing and counselling services through social and behaviour change communication

Whilst HTS campaigns were being conducted, community health workers, behaviour change facilitators and PLHIV played a key role in the mobilization of communities to access HTS. Influential community leaders were sensitized on the importance of knowing one's HIV status, which resulted in increased mobilization for communities to access HTS. Partners that included Africaid through its Zvandiri program provided HIV, sexual reproductive health and adolescent sexual reproductive health information through counselling, edutainment and life skills training. Materials such as games and books were also used to provide psycho-social support, especially for children, adolescents and young people.

Strategic Objective #4: Expand coverage of integrated HIV testing and counselling services through implementation of a variety of HIV testing and counselling models

The scale up of PITC coverage enabled healthcare workers (HCWs) to provide HIV related care, as well as increase access to linkages and post-test services for all clients. This was evidenced by the increase in the number of people opting in for HTS services over the 2010-2015 period. The routine offering of HIV testing has resulted in the reduction of stigma, as well as increase the confidence and comfort of clients, by enabling them to ask HIV related questions in public settings. Through working with partners, the MOHCC also increased client initiated testing and counselling (CITC) uptake, which resulted in the scale up of facilities that gave access to HTS and related services. HTS was also increased through various community based testing models such as campaigns, as well as other testing methods that targeted key and priority populations. These testing methods included the introduction of workplace testing for men and moonlight testing for sex workers.

Strategic Objective #5: Strengthen the national human resource capacity for HIV testing and counselling in line with the broader Human Resource for Health plan

The scale up of Primary Counsellor (PC) cadres to conduct HIV testing increased testing uptake and lessened the workload on traditional HCWs. PCs were also trained in the provision of other HTS related services and were perceived to provide better counselling services than traditional cadres. Other service providers were trained in more HIV programs over the period, which resulted in the building of their capacity to provide HTS. The trainings included couples' HIV testing and counselling, HTS and prevention for children and adolescents, additional counselling training and customer care. The MOHCC ensured that refresher training for all cadres was also conducted, as well as training to ensure that they were sensitized to and adhered to national guidelines. All of the aforementioned MOHCC training initiatives were conducted with the assistance of partners.

Strategic Objective #6: Strengthen facility and community-level HIV testing and counselling referral and linkage systems for appropriate follow-up prevention, treatment and care services

In 2013, the MOHCC rolled out the HTS register that was updated and disaggregated by age, sex and HTS entry point used for testing. The register was also designed to determine whether the client was a new HIV test or a retest, as well as facilitate linkages to care and client tracking. The MOHCC monthly return form was also re-designed to capture all data from various entry points to be consolidated into DHIS2, which was activated online in October 2013. Psychosocial services for clients who test HIV positive were also offered at the health facility level and were linked to community level services. Upon completion of facility based post-test support services, clients were linked with community based support groups and in some cases, Community Adherence Groups that offered support for stigma elimination, risk reduction, disclosure, family planning, adherence and positive living. Community based services also included support for retention in care and assisted medication refill/pick-ups. An increase in the number of Community Adolescent Treatment Supporters from 80 in 2013 to 100 in 2014 in Harare, Midlands, Manicaland and Bulawayo contributed to a 61% increase in the number of children reached with direct services (from 3,031 in 2013 to 5,009 in 2014). 48 Community support groups were formed in these same provinces, and have been instrumental in identifying children requiring opportunistic infection (OI)/ART services, as well as referring them to other service providers.

Strategic Objective #7: Reinforce the procurement and supply chain management systems to guarantee regular and consistent supplies for HIV testing and counselling services

In order to improve the supply chain management of HIV commodities including HIV test kits, the MOHCC logistic department carried out forecasting, quantification, and procurement, of HIV test kits and the Delivery Team Topping Up (DTTU) distribution system was used to ensure uninterrupted supply. In some years, such as 2014, no major stock outs of testing kits were reported across all facilities. The process of decentralising EID testing to Mutare and Bulawayo continued in 2013, which resulted in a steady increase in the number of EID samples processed, and the positivity rate to continue to decline.

Strategic Objective #8: Ensure quality assurance and quality control in the provision of HIV testing and counselling services at all levels

The MOHCC developed tools for comprehensive health facility assessment. This was done in order to ensure the availability of appropriate physical infrastructure, which is critical to the delivery of quality HTS services. In 2011, the MOHCC, working with National Microbiology and Reference Laboratory (NMRL), Zimbabwe National Quality Assurance Programme (ZINQAP) and Medical Laboratory and Clinical Scientists Council of Zimbabwe, with support from the Centre for Disease Control and Prevention (CDC), started working on developing detailed Standard Operating Procedures (SOPs) for Quality Assurance and Quality Control for rapid HIV testing. The SOPs informed and guided providers on the roles and responsibilities of the different stakeholders, including preparation and distribution of samples to all testing sites for proficiency testing. In 2013, the revised rapid HIV testing training manual included an additional section on quality improvement for rapid HIV testing. This was done to strengthen and ensure the provision of quality services. The use of Dried Tube Specimens (DTS) for proficiency testing for external quality assurance was also included in the training. ZINQAP has continued to provide an accelerated Proficiency Testing service with the goal to provide external quality assurance services to laboratories and testing sites in Zimbabwe. In 2014, a total of 109 out of 186 (59%) national public health laboratories participated in the ZINQAP EQA program. Ninety-seven per cent of the laboratories had satisfactory performance in EQA/PT program for HIV rapid testing (HIV diagnostics).

3. HIV Testing Services Strategy 2017-2020 Development Process

In January 2016, the MOHCC embarked on the process of developing a new HTS Strategy aligned to the changing national and global context. The following activities were conducted to review the previous strategy and formulate the new one:

HIV Testing Services Technical Working Group

The MOHCC set up a TWG to provide overall leadership and oversight during the strategy development process. The TWG had representation across all sectors including civil society, private service providers, non-governmental organisations, the UN organisations, and the public sector. The process was led by the National HIV Prevention Programme Manager with support from the Clinton Health Access Initiative (CHAI). The TWG was divided across six thematic areas key to the HTS program: (i) Management and Coordination, (ii) Service Delivery, (iii) Demand Generation, (iv) Strategic Information, (v) Supply Chain Management and (vi) Quality Assurance.

Document Review

A review of relevant documents was conducted in order to determine the current status of HIV testing services. The review focused on identifying strengths and weaknesses in the current policies and programme implementation, as well as identifying opportunities and threats anticipated for scaling up to reach the 90-90-90 global targets. The documents reviewed included:

- *Accelerated Action Plan for the National Scale-up of Infant, Paediatric and Adolescent ART in Zimbabwe: 2015-2018, MOHCC 2015*
- *Adolescent HIV Testing, Counselling and Care: Implementation for Health Providers and Planners. WHO, 2014.*
- *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. WHO, 2014.*
- *Consolidated Guidelines on HIV Testing Services. WHO, 2015.*
- *Multiple Indicator Cluster Survey 2014. Key Findings Report. ZIMSTAT, 2014.*
- *National Guidelines for HIV Testing and Counselling. MOHCC, 2014.*
- *National Guidelines for HIV Testing and Counselling in Children and Adolescents. MOHCC, 2014.*
- *National HIV Care and Treatment Strategic Plan 2013-2017. MOHCC, 2013.*
- *Smart Investment to End HIV AIDS in ZIMBABWE based on Hotspot Analysis. MOHCC, NAC, CDC, UNAIDS, WFP, 2014.*
- *The National HIV Testing and Counselling StrategyStrategic Plan. MOHCC, 2012.*
- *Zimbabwe Demographic and Health Survey (ZDHS) 2010-11. ICF International, MOHCC, 2012.*
- *Zimbabwe National HIV and AIDS Strategic Plan (ZNASP II) 2011-15. MOHCC, 2011.*

Key Informant Interviews

Key informant interviews with MOHCC AIDS and Tuberculosis (TB) Unit Programme Managers including HIV Prevention, Voluntary Medical Male Circumcision (VMMC), Sexually Transmitted Infections (STI), Comprehensive Condom Program, ART, and Prevention of Mother to Child Transmission (PMTCT), as well as national level partners, were conducted to review progress to date under the previous HTS Strategy. Discussions covered best practices for implementation, key challenges to implementation, as well as recommendations for the new Strategy.

Review of Programme Data

DHIS2 data from 2010 to 2015 were reviewed to analyse programme performance and trends in HIV testing services. There were some limitations to this analysis as the data were not disaggregated by age for children and adolescents from 2010 to 2013. In addition data at national level were consolidated and could not be linked to the entry points at service delivery level. To address these limitations at subnational level (province, district and health facility) data abstraction was also conducted together with analysis of data sourced from a number of key partners.

Sub-National Data Collection and Analysis

Sub-national data collection and analysis was conducted in four out of the ten provinces. The four provinces which were purposively sampled were, Manicaland, Mashonaland West, Matabeleland South and Midlands. Key informant interviews were conducted with provincial and district level officers as well as health facility staff and clients. Structured questionnaires were used to collect data from a total of 46 rural and urban health facilities. In addition focus group discussions with clients were conducted to solicit feedback on the HIV testing service provision at the various facilities.

Stakeholder Consultation

Two stakeholder consultation meetings were held. The first focused on identifying key areas of focus for the strategy and the second one involved a review of the draft strategy document. The stakeholders represented organisations and individuals with an interest in HTS including MOHCC staff from all levels of the health system, civil society, funding and implementing partners, UN organisations and organizations serving PLHIV and youths.

Findings from Consultative Process

From the review of the previous strategy and the consultative process indicated above, key challenges for the HTS programme were identified according to thematic areas. These challenges highlighted below were key considerations in formulating new strategies for the HTS Strategy 2017-2020.

Figure 1: Identified Gaps and Challenges Across HTS Implementation Thematic Areas

MANAGEMENT AND COORDINATION		
Gap Area	**Challenges**	**Impact of Gap on the Programme**
Human resources	Inadequate human resources to coordinate HTS at national level *Sub-national programmatic responsibilities unclearly defined at:* ***(i) Provincial Level:*** HIV officers identified at provincial level included the Provincial Epidemiology and Disease Control Officer (PEDCO), Provincial HIV/TB/MNCH Officer and the Provincial HIV/STI Focal Person. For most HIV officers at provincial level, there is limited focus on on-going HTS work, which is further compounded by programmatic silos. ***(ii) District Level:*** The composition of the HTS coordination structure was inconsistent and varied across all districts. Cadres included the District Medical Officer (DMO), District Nursing Officer (DNO), Health Promotion Officer (HPO), District Health Information Officer (DHIO), Matron, HIV Focal Person, Community Health Nurses, Lab staff and the Pharmacy Manager.	Suboptimal HTS programme coordination at national level Inadequate accountability for the performance of HTS all levels Existence of programme silos as sub-national officers remain unaware of the complete operational aspects of HTS
Funding for HTS Programme activities	• Insufficient funding to support planned HTS activities » Reliance on donor funding » Limited government funding • Inadequate coordination of partner efforts	Programme implementation that does not meet the HTS needs of the population Duplication of partner efforts, at times, in the same geographical location
Private sector engagement	• Inadequate coordination of private sector effort towards HTS	Limited opportunities to leverage on the strengths of the private sector.
SERVICE DELIVERY		
Gap Area	**Challenges**	**Impact of Gap on the Programme**
Provider Initiated Testing and Counselling (PITC)	Inconsistent implementation of PITC at different entry points	Missed opportunities for testing as not all clients are offered a test Neglected opportunities for identifying undiagnosed PLHIV
HTS Guidelines	Poor adherence to HTS policies and guidelines (e.g. the best interest of the child principle)	Sub-standard quality of service provided Missed opportunities for testing especially for children
Integration of HTS with other health services	Erratic integration of HTS into other health services e.g. expanded program for immunisation (EPI), TB, Sexual Reproductive Health, Key Populations, STI, Malnutrition	Missed opportunities for HIV testing Inefficient utilization of resources including human resources

Referral and Linkage Systems	Absence of a comprehensive system to track and ensure that clients tested for HIV are linked to appropriate post-test services	Weak follow up and support for referred clients
Human Resources	Inadequate staff establishment at health care facilities High workload on healthcare workers resulting in HTS not being prioritised High staff turnover Insufficient number of cadres trained in some aspects HTS e.g. Rapid HIV testing and HTS for children and adolescents	Sub-standard quality of service provision
Key Populations	Reduced access to HTS Limited capacity and confidence of health care workers to provide services for key populations Incomplete documentation of service delivery models for key populations Judgemental attitude of health workers e.g. towards young sex workers and MSMs	Missed opportunities for HIV testing Increased risk of continued HIV transmission
Priority Populations	Inadequate utilization of HTS Reduced access to HTS	Missed opportunities for HIV testing
Quality of counselling	Absence of a quality assurance system for counselling Inadequate service provider capacity to provide quality counselling	Counselling that does not adequately address the concerns of the clients
Private sector service delivery	Inadequate dissemination and awareness of HTS guidelines including the national algorithm Inadequate capacity to provide HTS	Inconsistent quality of service provided
DEMAND GENERATION		
Gap Area	**Challenges**	**Impact of Gap on the Programme**
Monitoring and Evaluation (M&E)	Limited M&E for demand generating activities	No local evidence to inform demand generation strategies
HTS Demand Generation for Key Populations	Insufficient knowledge on effective ways to mobilize key populations for testing	No targeted demand generation strategies for key populations Inadequate mobilisation of key populations for HTS
HTS Demand Generation for Priority Populations	Absence of targeted demand generation messages	Weak mobilization of priority populations for HTS
Funding for HTS demand generation	Limited funding for HTS demand generation activities	Reduced targeted HTS coverage

STRATEGIC INFORMATION		
Gap Area	**Challenges**	**Impact of Gap on the Programme**
Data management	Inconsistent consolidation of HTS data at health facility level in the National Reporting System. Parallel reporting systems between community (e.g. campaigns, galas, home testing) and facility testing strategies Use of non-standardised M&E tools by some partners Limited availability of facility level targets	Sub-standard data quality (under and over reporting) in the National Health Information System Data on some indicators missing in the National HIS Inadequate facility level indicator tracking
Human resources	Insufficient M&E skills for programme monitoring. Roles and responsibilities for M&E teams (Provincial M&E Officer, Provincial Health Information Officer) are overlapping at Provincial level.	Inadequate data collection and analysis to inform programme decisions Lack of accountability for routine program monitoring and performance tracking
Client tracking	Both paper based and electronic patient monitoring system (ePMS) inadequately equipped to conduct longitudinal client tracking. Absence of client unique identifiers across all programmes	Absence of evidence to make decisions to improve the linkage process
Data utilization	Inadequate utilisation of data for planning and decision making.	Inappropriate targeting of interventions.
Private sector data	Private sector data not reported in the national system	Misrepresentation of national HTS data
SUPPLY CHAIN MANAGEMENT		
Gap Area	**Challenges**	**Impact of Gap on the Programme**
HIV Test Kits and commodities stock management	Inadequate forecasting and quantification of test kits Private sector numbers not included in forecasting and quantification Absence of robust HIV testing stock management system Inadequately coordinated transportation system for HIV testing commodities	Over stocking leading to expiries Under stocking, leading to service interruptions
Early Infant Diagnosis *Refer to the Accelerated Action Plan for the National Scale-up of Infant, Paediatric and Adolescent ART in Zimbabwe: 2015-2018, MOHCC 2015*	Delays in the transportation of dried blood samples (DBS) and results Machine down times hamper lab testing procedures Poor reporting systems for rejected samples	Delays in infant diagnosis and linkages to appropriate treatment and care
QUALITY ASSURANCE		
Gap Area	**Challenges**	**Impact of Gap on the Programme**
Quality Assurance Systems	Internal Quality Controls not run according to standard at entry points (daily and before opening new kit)	Increased risk of misdiagnosis

4. HIV Testing Services Strategy 2017 -2020

Overview

The new HTS strategic framework aims to strengthen programme implementation through comprehensive approaches across six thematic areas: (i) management and coordination, (ii) service delivery, (iii) demand generation, (iv) strategic information, (v) supply chain management and (vi) quality assurance.

VISION:	A Zimbabwe where everyone knows their HIV status and is linked to appropriate high quality HIV prevention, care treatment and support services
GOAL:	To contribute to the prevention of new HIV infections and reduction of HIV-related morbidity and mortality for improved quality of life for all Zimbabweans by 2020
MISSION:	Provide high quality, equitable, appropriate, available, affordable, acceptable and accessible HIV testing services

Values

- **Quality:** Concern for quality will precede quantity to ensure clients receive appropriate counselling, receive correct results and are linked to appropriate care
- **Human rights:** Services will be provided in a manner that upholds the values and dignity of different population groups
- **Family centred:** Services will be structured to include all members of the household also considering the best interests of children
- **Inclusiveness:** HTS service provision will leave no one behind

Guiding Principles for HTS

In order for Zimbabwe to implement effective HTS approaches, the country will continue to emphasize the WHO principles to all models of HIV testing. These principles are referred to as the 5c's and consist of:

- **Consent:** People receiving HTS must give informed consent to be tested and counselled. (Verbal consent is sufficient; written consent is not required.) They should be informed of the process for HIV testing and counselling, and of their right to decline testing.
- **Confidentiality:** HTS must be confidential, meaning that what the HTS provider and the client discuss will not be disclosed to anyone without the expressed consent of the person being tested. Confidentiality should be respected, but it should not be allowed to reinforce secrecy, stigma or shame. Counsellors should discuss, among other issues, whom the person may wish to inform and how they would like this to be done. Shared confidentiality with a partner, family members, or trusted others and healthcare providers can be highly beneficial.

- **Counselling:** Pre-test information can be provided in a group setting, but an opportunity for private questions should be provided upon request. All HIV testing must be accompanied by appropriate and high-quality post-test counselling, based on the specific HIV test result and HIV status reported. Quality assurance (QA) mechanisms as well as supportive supervision and mentoring systems should be in place to ensure the provision of high-quality counselling.
- **Correct:** Providers of HIV testing should strive to provide high-quality testing services, and QA mechanisms should ensure that people receive an accurate diagnosis. QA may include both internal and external measures and should be carried out with support from the national reference laboratory. All people who receive a positive HIV diagnosis should be retested to verify their diagnosis before initiation of HIV care or treatment.
- **Connection:** Linkage to prevention, treatment and care services should include effective and appropriate follow-up, including long-term prevention and treatment support. Providing HTS where there is no access to care, or poor linkage to care, including ART, has limited benefit for those with HIV.

In addition, services will be provided in a manner that ensures the clients' physical and emotional Comfort. This will be considered as the 6th C for Zimbabwe.

HTS TARGETS 2017-2020

The success of the Zimbabwe HTS Strategy 2017-2020 will depend on reaching testing targets, which will be adapted for all sub-national levels and applied to selected service delivery points and targeted populations. Testing targets for children aged 0-14 years have been adapted from the *National Accelerated Action Plan for the National Scale-up of Infant, Paediatric and Adolescent ART in Zimbabwe: 2015-2018,* updated to account for performance in 2015 and the country's adoption of the Start Free, Stay Free AIDS Free Framework in 2016. Targets for adults and adolescents were set by a multi-stakeholder consultative effort in order to ensure that 90% of all people living with HIV will know their HIV status by 2020.

Total Testing Targets

In order to achieve the goal of identifying 90% of PLHIV, Zimbabwe will need to test 2 million paediatrics and 10,5 million adolescents and adults by 2020.

Target setting: 0-14 years[2]

Under the *Accelerated Action Plan for the National Scale-up of Infant, Paediatric and Adolescent ART 2015-2018,* the MOHCC set aggressive treatment scale up targets by considering a variety of case-finding strategies for children (0-14 years) to determine the optimal mix to ensure accelerated, cost-effective scale-up. In light of revised estimates for the number of children living with HIV, these targets have been amended. Targets for children were set to align with the objective of ensuring 95% of children living with HIV are enrolled in ART care by 2020, at which point they will be revised. The revised figures also reflect changes in yields, considering 2015 performance data, and year on year coverage targets for testing by entry point can be found in Annex 3.

Figure 2: Paediatric Expected Testing Population by Service Delivery Point

	2017	2018	2019	2020
EID through PMTCT	48,579	52,980	54,569	59,329
OPD Rapid testing	112,495	173,805	179,019	184,390
In patient	62,889	103,640	113,421	123,696
Growth	53,168	87,620	95,889	104,576
Malnutrition	14,244	23,474	25,690	28,017
PITC - Index testing	7,474	9,622	9,911	12,250
PITC - EPI	7,286	13,133	13,527	15,923
HTS campaigns for children/adolescents	51,312	52,851	54,437	56,070
TB	1,811	2,132	2,470	2,686
Total	**359,257**	**519,258**	**548,933**	**586,936**

2 Refer to Accelerated Action Plan for the National Scale-up of Infant Paediatric and Adolescent ART 2015-2018 pages 15-18 for detailed methodology

Figure 3: Paediatric Expected PLHIV Identifications by Service Delivery Point

	2017	2018	2019	2020
EID through PMTCT	899	625	286	130
OPD Rapid testing	3,934	3,872	1,773	766
In patient	5,196	5,456	2,654	1,214
Growth	1,859	1,952	950	434
Malnutrition	1,829	1,920	934	427
PITC - Index testing	419	344	157	82
PITC – EPI	116	133	61	30
HTS campaigns for children/adolescents	264	173	79	34
TB	164	123	63	29
Total	**14,681**	**14,598**	**6,958**	**3,147**

Figure 4: Adolescent and Adult Expected Testing Populations by Service Delivery Point

ADOLESCENT AND ADULT EXPECTED TESTING VOLUMES BY SERVICE DELIVERY POINT				
	2017	2018	2019	2020
Facility based testing strategies				
TB	117,290	127,981	135,620	153,991
ANC/PMTCT	433,834	457,042	488,571	528,174
STI	100,610	110,969	124,875	142,027
VMMC	111,962	91,860	76,371	60,308
Family Planning	193,933	204,494	218,678	472,903
Inpatient Ward	116,378	170,104	207,080	265,307
Index Female Partner Testing (facility-based)	2,515	2,118	2,072	3,290
Index Male Partner Testing (facility-based)	2,094	1,774	1,739	3,687
OPD	252,165	252,162	262,944	274,616
VCT	250,876	260,503	277,528	289,242
Population specific testing strategies				
Sex Workers	43,361	66,421	70,128	75,277
Prisoners	2,238	2,184	4,325	4,302
Community based testing strategies				
Index Female Partner Testing (community-based)	6,569	9,019	8,743	9,204
Index Male Partner Testing (community-based)	10,507	14,428	13,985	14,723
Workplace	57,981	56,660	55,637	54,561
Campaigns	210,181	220,968	236,497	248,190
Self-testing	186,622	220,968	551,827	827,299
Total	**2,099,117**	**2,269,655**	**2,736,619**	**3,427,101**

Target setting: 15 years +

HIV Testing Strategies

ART initiation will only be achieved through working with a variety of entry points to identify PLHIV. Zimbabwe considered a number of testing strategies for implementation, both existing strategies and new approaches recommended by the WHO 2015 Consolidated Guidelines on HTS. Based on these sources, 17 testing entry points were identified as suitable and potentially beneficial in the Zimbabwe context. The strategies considered are detailed in the Service Delivery section of this document. Multi-stakeholder consultations resulted in establishing the following testing coverage targets across the 17 service delivery points for adults:

Figure 5: Adolescent and Adult Expected PLHIV Identifications by Service Delivery Point

ADOLESCENT AND ADULT PLHIV IDENTIFICATIONS BY SERVICE DELIVERY POINT				
	2017	2018	2019	2020
Facility based testing strategies				
TB	13,390	11,200	10,415	10,880
ANC/PMTCT	12,406	9,799	9,111	9,016
STI	8,685	7,291	7,178	7,499
VMMC	420	257	185	134
Family Planning	3,196	2,519	2,340	4,629
Inpatient Ward	7,497	8,292	8,812	10,356
Index Female Partner Testing (facility-based)	439	288	249	365
Index Male Partner Testing (facility-based)	321	211	182	356
OPD	22,688	17,283	15,774	15,135
VCT	14,759	11,580	10,764	10,287
Population specific testing strategies				
Sex Workers	6,438	7,629	7,095	7,021
Prisoners	213	159	275	251
Community based testing strategies				
Index Female Partner Testing (community-based)	1,680	1,837	1,587	1,551
Index Male Partner Testing (community-based)	2,687	2,938	2,539	2,482
Workplace	2,063	1,745	1,566	1,443
Campaigns	4,523	3,559	3,311	3,179
Self-testing	4,016	3,559	7,725	10,597
Total	**105,422**	**90,144**	**89,109**	**95,183**

HTS STRATEGY STRATEGIC FRAMEWORK

The new strategic framework is structured along six thematic areas, which outline key programmatic priorities.

1. THEMATIC AREA 1: MANAGEMENT AND COORDINATION

Strategic Objective 1: Strengthen management and coordination of the HTS programme to improve efficiency and effectiveness

Strategic context: Management and coordination strategies will focus on enabling the implementation of HTS policies and strategies for all levels of the national healthcare structure in Zimbabwe. For external ministries, partners and sectors that will support implementation of the strategy, there will be a need to re-engage the National AIDS Council to facilitated increased and strengthened coordination of activities across all sectors. It is critical for the management and coordination of the HTS programme to remain dynamic and responsive to emerging implementation issues, in order to ensure that an enabling environment for HTS implementation remains. Leadership is key in ensuring HTS is provided in a manner that is coordinated efficiently within the MOHCC and across all implementing partners and sectors. Current and proposed coordination structures at all levels of health care facilities will be reviewed and evaluated.

STRATEGIES:

1.1: Strengthen the human resources structure and capacity to effectively manage and coordinate the HTS program at all levels of the health systems

Roles, responsibilities and a system of accountability for HTS performance will be reviewed and re-established across all levels of the healthcare sector in Zimbabwe.

Outcomes:

- Accountable and effective management and coordination of HTS activities at all levels, as well as a structure that allows for integrated HTS at all levels of the healthcare sectors

Implementation Priority Activities:

National Level:

- Support addition of cadres that will be a part of the HIV prevention TWG, and will be accountable for national HTS performance
- Revitalise the current HTS TWG that is part of the national HIV Prevention Forum
- Review job descriptions for HTS cadres and update them to ensure that they are aligned with the HTS strategic goals
- Develop and disseminate guidelines that will operationalise the HTS Strategy

Provincial level:

- Improve communication and delegation of HTS program implementation to the Provincial Medical Director, and the coordination of HTS activities to the Provincial HIV/TB/MNCH Officer and the HIV Focal Person.
- Provincial level coordination of sensitization, trainings and workshops on the HTS Strategy that include dissemination of up to date policies and guidelines, as well as support of districts
- On-going monitoring, analyses and use of strategic information to evaluate and act on provincial progress towards integrating HTS into routine services for identification and linkage purposes

District Level:

- District and Facility Health Executives will be responsible for the management and supervision of HTS, as well as delegating duties of optimising and distributing HCWs at facilities to the District Nursing Officer
- Incorporate HTS into regular facility support and supervision, performance evaluations and mentorship activities for nurses and PCs

Facility Level:

- Support facility managers at all primary level facilities to be responsible for ensuring the operationalization of HTS at facilities, as well as assigning a nurse to liaise with community level cadres
- Organise facility staff to offer integrated HTS including review of SOPs, use of job aides and coordination of activities
- Support community testing initiatives in testing, counselling, linkages to care and patient tracking

1.2 Strengthen the management of financial resources for the HTS program to deliver an efficient service that meets the needs of the population

Management of financial resources for the HTS program will focus on facilitating the efficient use of domestic resources, increasing public funding and engaging new sources of funding.

Outcomes:

- Effective mobilisation and efficient utilisation of financial resources for the HTS program

Implementation Priority Activities:

- Advocate for increased government funding for HTS activities
- Explore other domestic funding sources other than government e.g. Environmental Impact Assessment for infrastructural projects
- Engage other non-traditional external donors
- Strengthen integration of HTS in other programmes for efficient utilisation of limited resources
- Conduct a partner mapping exercise to in order to efficiently distribute partner effort and avoid duplication

1.3: Strengthen the engagement of the private sector to leverage on its strengths for delivery of HTS services

Vitalizing public private partnerships for HTS will focus on achieving universal access to HTS through engaging and building the capacity of private health providers to provide HTS aligned with national objectives.

Outcomes:

- HTS program benefits from the strengths (financial and capacity) of the private sector

***Implementation Priority Activities*:**

- Engage in public private partnerships with private sector service providers
- Engage professional bodies e.g. Zimbabwe Nurses Association, Zimbabwe Medical Association and Laboratory Scientists Council of Zimbabwe to effectively reach out to and coordinate private sector providers

2. THEMATIC AREA 2: SERVICE DELIVERY

Strategic Objective 2: Strengthen service delivery capacity to increase access to high quality HTS for all population groups

Strategic context: The revised service delivery approaches to HTS will focus on strategies that are targeted, aiming to strengthen identification of PLHIV, and increase coverage for testing. For HTS service delivery to be consistent and integrated at all levels, this will require the strengthening of linkage to prevention and treatment services, as well as the improvement of counselling and support services. Effective organisation of HTS will result in efficient resource utilisation including human resources.

STRATEGIES:

2.1: Ensure HTS guideline availability to all levels to enhance provision of good quality service

Strengthening PITC will require the establishment of clear dissemination methods for updated HTS guidelines, ensuring that all key players in strategy implementation are kept informed of changes as they occur.

Outcome:

- High quality service in all facilities that is consistent with the most recent guidelines

Implementation Priority Activities:

- District level meetings to disseminate new HTS guidelines
- Mentorship of service providers to support adherence to guidelines
- Include HTS guidelines in the curricula of other HIV trainings

- Timely distribution of adequate numbers of HTS guidelines copies to all health facilities
- Support and supervision to ensure all implementing partners are adhering to the national guidelines
- Develop communication tools to engage communities on HTS guidelines particularly for children and adolescents

2.2: Strengthen the implementation of PITC at all entry points to reduce missed opportunities for identifying undiagnosed PLHIV

Targeted opt-out approaches to PITC implementation will be strengthened at entry points where clients routinely access services and have a high potential of identifying those at highest risk of being infected with HIV.

Outcome:

- Reduced missed opportunities for HIV testing

Implementation Priority Activities:

- Scale up rapid HIV testing training to improve capacity of health care workers to provide quality HTS at all entry points, including for children and adolescents
- Operationalise PITC
- Identify clients for testing at all entry points (OPD, EPI, Inpatient wards, Family Planning, etc.)
- Use HIV screening tools for children and adolescents
- Increase access to EID for HIV exposed infants
- Provide mentorship to increase confidence of health service providers to offer HTS
- Conduct support and supervision to identify gaps and best practises
- Develop, print and distribute job aids and counselling tools to assist health workers to communicate HIV testing more effectively

2.3: Strengthen HTS integration as part of standard of care to reduce missed opportunities for HIV testing and ensure efficient utilization of resources including human resources

Testing will be provided as part of the routine standard of care services at entry points that draw key populations at risk of having HIV.

Outcome:

- HTS fully integrated into other health programmes

Implementation Priority Activities:

- Sensitize and train health facility mangers on integration of health services
- Mentorship to support planning of integration activities at health facility level

2.4: Strengthen linkages to post-test services to enable follow up and support of referred clients to complete the referral pathway

Standardisation of referral networks for all clients, as well as introduction of tools that better facilitate tracking and tracing of clients at facilities and communities will be implemented.

Outcomes:

- All clients tested are linked to and access appropriate post-test services

Implementation Priority Activities:

- Review of all existing guidance on HTS linkage to care mechanisms and development of revised linkage to care guidelines for HTS with clear protocols for clients who test HIV positive and those who test HIV negative
- Roll out of electronic patient monitoring system (ePMS) which includes a unique identifier for the clients
- Identify community cadres and expert clients to facilitate linkages to post-test services and follow up
- Scale up provision of client support services through peer to peer support groups
- Mentorship for implementation of linkages to strengthen service provider capacity to follow up and support referred clients
- Develop SOPs and distribute information education on communication (IEC) materials which facilitate the linkage process e.g. list of services available and location

2.5: Strengthen service provision for key populations to increase access to quality HTS

Service delivery models that cater to the needs of populations at increased risk of HIV will be scaled up.

Outcomes:

- Key populations have increased access to quality HTS

Implementation Priority Activities:

- Conduct size estimations for key populations
- Conduct targeted testing in hotspots for key populations
- Provide flexible hours for HTS
- Scale up key populations peer support groups
- Train community based health workers to support referral and linkages to post-test services for key populations
- Train and mentor care providers at all levels to provide services that are acceptable to key populations
- Research, document and disseminate testing models that reach key populations, e.g.:

- » Sex workers: Moonlight clinics
- » Men at risk of having HIV: Self-testing
- » People in prisons: Prison testing
- » Long distance truck drivers: testing campaigns at selected truck stops

2.6: Strengthen service provision for priority populations to increase access and utilisation of HTS

Service delivery models for populations that have been prioritised for the HIV response will be scaled up.

Outcomes:

- Priority populations with improved access and utilisation of HTS

Implementation Priority Activities:

- Scale up implementation of the family centred approach
- Roll out index case testing
- Integrate HTS in other services for example VMMC, EPI, reproductive health
- Integrate HTS into Adolescent Sexual Reproductive Health services
- Scale up peer led Adolescent and Youth Friendly services
- Conduct community testing including outreach campaigns
- Conduct workplace testing to target men
- Roll out HIV self-testing with appropriate linkage to post-test services
- Consolidate and disseminate guidance on a comprehensive package of youth friendly services
- Capacitate service providers at all levels to provide adequate services appealing to children, adolescents and young people
- Train school health masters on life skills, sexuality, HIV & AIDS education
- Research, document and disseminate community testing models that target priority populations, e.g.:
  - » Infants and children: growth monitoring, EPI outreach, malnutrition clinics
  - » Older Children and adolescents: HTS campaigns, community adolescent testing
  - » Young people (men and women): HTS campaigns in tertiary institutions, vocational training centres and informal workplaces
  - » Men: workplaces (formal and informal), campaigns
  - » Couples: Community based index testing outreach campaigns
  - » Partner testing e.g. within ANC and PNC

2.7: Strengthen the quality of counselling in HIV testing services provision to effectively respond to clients' concerns

Improving quality of counselling for HTS will be key to ensuring comfort of clients accessing HTS and improving uptake of testing services.

Outcomes:

- Improved quality of counselling services

Implementation Priority Activities:

- Train service providers on standardised counselling quality assurance tools
- Disseminate and distribute counselling job aids
- Mentorship of service providers to provide quality HTS counselling
- Provide refresher trainings on counselling for service providers

2.8: Enhance the capacity of the private sector to provide standardised quality HTS

Aligning the private sector initiatives to those of the MOHCC will play a critical role in strengthening and extending the shared responsibility to the HIV/AIDS response, with the ultimate goal being standardised access to prevention, treatment and care services across public and private facilities.

Outcomes:

- Standard quality HTS provided in the private sector

Implementation Priority Activities:

- Include private sector providers in dissemination meetings for guidelines and policies
- Scale up training of Rapid HIV testing in the private sector
- Provide mentorship for all aspects of HTS in the private sector
- Disseminate HTS guidelines through professional organisations e.g. Zimbabwe Nurses Association (ZINA), Zimbabwe Occupational Nurses Association (ZONA) and Zimbabwe College of Primary Care Physicians.

2.9 Enhance the implementation of current community approaches to HTS that are targeted, whilst allowing for the introduction of new innovative models

Targeted community testing will be based on approaches that consider HIV geographical location, prevalence, incidence and the utilisation of facilities to access further HTS.

Outcomes:

- Scaled-up implementation of evidence based community testing interventions for improved case identification of PLHIV, as well as linkages to treatment, care and support services

- Decreased client load for initial HIV testing at public institutions and the presentation of clients that are most likely to test HIV positive for confirmatory testing at the facility level

Implementation Priority Activities:

- Improve targeting of community campaigns through analyses that factor in ART coverage, testing coverage, prevalence and incidence
- Utilize various sources of data such as the results of hotspot mapping exercises and supporting partner data to inform targeted community testing campaigns
- Develop and disseminate comprehensive community based HIV testing SOPs with clear guidelines on implementation of different community testing models, including index case testing and self-testing
- Use of index case testing as a community based testing method, whilst rolling out SOPs to both facilities and communities
- Timely adoption of a national roll-out plan for HIV self-testing (HIVST) that sensitizes administrators and HCWs on the testing method and it's relation to HTS service delivery models

Strategic Objective 3: Strengthen the national human resource capacity for HTS in line with the broader Human Resource for Health Plan

Strategic Context: A key consideration moving forward is capacity building for existing human resources, as well as securing additional resources to scale-up quality HTS at all levels. Key considerations under this objective are the need to ensure that all cadres are made aware of HTS and that non-traditional cadres are also trained to provide HIV testing at all service delivery points, and potentially in communities as well. The extension of HTS training to key health cadres will allow for standardized capacity building of the entire health workforce to be able to provide adequate HTS, regardless of posting following training.

3.1: Establish universal awareness of the program, its key components and considerations through standardized integration of HTS into pre-service training

This will enable the strengthening of service integration and provide guidance for service integration models, including ways in which they can be adapted at varying service delivery levels.

Outcomes:

- Increased capacity to provide HTS at all service delivery levels nationally
- Reduction of in-service training costs

Implementation Priority Activities:

- Review curricula for pre-service training and develop HTS modules
- Standardise HTS as a key component of pre-service training

3.2: Sustain on-going site based training and capacity building as part of in-service training for HCWs

While HTS training will be incorporated in pre-service training, on-going capacity building on site for cadres already deployed in the field is necessary to ensure that HCWs are equipped to provide scaled-up of testing services, and that these services are carried out in line with national objectives.

Outcomes:

- Provision of HTS by qualified service providers at all service delivery levels

Implementation Priority Activities:

- Update training curricula in line with revised WHO guidelines for HTS, including guidelines for children and adolescents, as well as key and other priority populations
- Map previous training initiatives and identify remaining capacity building gaps by district
- Develop training plans to address gaps, targeted at areas with low testing capacity
- Roll-out self-directed training that includes all aspects of the HTS curriculum for all levels of service delivery and health facility

3.3: Support scale-up of additional PCs for providing testing services in the facility

At the facility level, the already established PC cadre will be utilized and numbers increased to provide adequate capacity for testing.

Outcomes:

- Increased human resources to provide HTS at facility level

Implementation Priority Activities:

- Mobilize resources for additional recruitment and training of PCs to develop a distribution and placement plan for PCs within the system based on potential reachable population for testing
- Revise curricula for PC training
- Deploy additional PCs as per the national need

3.4: Increase human resources for providing services at the community level

The community will be involved in the selection of a preferred cadre to provide testing in order to ensure successful integration and buy-in from the community, as well as to ensure community confidence that the selected cadre will maintain confidentiality of clients tested.

Outcomes:

- Increased human resources to conduct testing within the community setting

Implementation Priority Activities:

- Review of community cadres providing health services, identification and national endorsement of appropriate cadre to provide testing services
- Resource mobilization for training and maintenance of cadres to provide HTS within the community
- Provide appropriate HTS training for community cadres

THEMATIC AREA 3: DEMAND GENERATION

3.

Strategic Objective 4: Strengthen the demand generation for HTS based on local evidence to effectively reach out to all population groups

Strategic context: Demand generation activities should be informed by evidence to effectively address the uniqueness of the different populations that access HTS.

STRATEGIES:

4.1: Ensure effective coordination of demand generation activities for HTS

In order to understand existing demand generation strategies that are currently being employed, it will be necessary for implementing partners to submit and document the effectiveness of demand generation activities.

Outcomes:

- Effective coordination and strategic guidance of HTS demand generation activities across all programs
- Adequate funding for effective demand generation strategies for HTS

Implementation Priority Activities:

- Conduct partner mapping exercises of all HTS demand generation stakeholders
- Develop TORs for demand generation TWG
- Invite key representatives to establish a demand generation TWG
- Hold quarterly HTS demand generation TWG meetings, review evidence from existing strategies and provide recommendations for changes going forward
- Develop and cost a HTS Demand Generation Communications Plan, facilitated through the TWG
- Mobilize resources and implement against the HTS Demand Generation Communications Plan

4.2 Strengthen appropriate and targeted messaging to effectively reach out to priority populations

- Strategies for each priority population are presented in Figure 6 below.

Figure 6: Demand Generation Strategies for Priority Populations

Priority Population	Demand Generation Strategy
Infants and Children	Training of HCWs to increase awareness and knowledge of testing for children will be required, as well as the targeting of mothers and caregivers through inter-personal communication and health education
Adolescents and Young People	Establishing youth friendly centres, scale up of mobile health activities and increased social media presence for HTS demand generation. To meet the physical and psychological needs of this group, HCWs must be well versed in disclosure adherence counselling and support, sexual and reproductive health services, mental health support and social services
Males	Workplace, VMMC and couples testing should be implemented to encourage men to access HTS. In addition, community based initiatives such as road shows, local dramas, home based testing and mobile HIV testing will likely increase testing uptake
Couples and sexual partners	Establish a support group for mobilisers to assist with reaching couples for testing. Couples can also be reached through index-case testing, during pregnancy and through messaging that encourages HIV testing before marriage, as well as testing both partners when pregnant women access ANC.

Strategies for each key population are presented in Figure 7 below.

Figure 7: Demand Generation Strategies for Key Populations

Key Population	Demand Generation Strategy
Sex Workers	Peer to peer models where sex workers recruit other sex workers, as well as moonlight services should be used to mobilise this population within communities. Healthcare workers at facilities where sex workers access HTS need to be trained to ensure there is no stigma against them.
Prisoners	Scale up of HTS in prison settings
Truck Drivers	Raise awareness and conduct testing campaigns at selected truck stops
Men at substantial risk of HIV infection, Persons that Inject Drugs, Transgender Individuals	Research will need to be conducted to determine the size and specific needs of these groups as there is currently limited evidence on effective demand generation strategies that mobilise them

Outcomes:

- Targeted messages for priority and key populations

Implementation Priority Activities:

- Engage key and priority populations in developing targeted messaging
- Distribute messages and materials for key and priority populations to all HTS delivery points
- Involve priority and key populations in the evaluation of demand generation activities and messaging

- Utilize appropriate multi-media and Interpersonal communication channels for reaching target audiences
- Ensure that sero-discordant key and priority populations are enrolled on pre-exposure prophylaxis
- Conduct continuous research of demand generation strategies that will increase testing uptake for key and priority populations

THEMATIC AREA 4: STRATEGIC INFORMATION

4.

Strategic Objective 5: Strengthen the strategic information of HTS to provide evidence for effective decision making

Strategic context: M&E will be conducted through a system that monitors, evaluates and reports on facility and community based HTS. For improved quality and consistency of information, there is a need for collaboration between the MOHCC, partners and donors on implementing a single M&E system that will be used to strengthen reporting and monitoring of the HTS program. Strategic information collected should provide data that enables informed decision making at all levels of health facility in Zimbabwe

STRATEGIES:

5.1: Promote data demand, dissemination and utilization at all levels

Data will be captured from various sources such as surveys, DHIS2 and other reports used in program monitoring, review, planning, advocacy and policy development.

Outcomes:

- A responsive management system, which makes decisions for program implementation and course correction based on evidence from performance monitoring and progress reporting
- Management accountability based on activities conducted and measurable outcomes

Implementation Priority Activities:

- Conduct a needs assessment for the HTS programme (including M&E needs) across all levels and implementing partners in order to determine areas that need capacity building
- Conduct capacity building exercises in response to the identified needs from the assessment
- Review job descriptions of health care workers to ensure that each role has at least 5% M&E (data collection, analysis and evaluation) responsibilities in order to be able to effect adaptive changes, which will be determined by the broad HTS M&E
- Analyse data at all levels for use in making management decisions and corrective measures
- Conduct periodic programme reviews of performance in the form of weekly updates, project/activity review and comprehensive semi-annual review workshops (including the HTS TWG review of performance bi-annually)
- Improve data quality and availability
- Monitor, evaluate, and communicate results of data use interventions by engaging data users and data producers in participatory M&E sessions bi-annually at all levels

5.2: Strengthen facility (public and private) and community based HTS information management systems for robust evidence generation.

This will be done to ensure an efficient M&E system that accurately captures data and reduces data variances across all levels of the national program and implementing partners.

Outcomes:

- Strategic information systems with the capacity to provide evidence for decision making

Implementation Priority Activities:

- Sensitise and train private sector HTS providers on the national M&E system
- Conduct routine HTS M&E support and supervision for facility (public and private) and community based testing
- Align HTS indicators and tools according to national needs and revised guidelines
- Develop indicators and tools for monitoring the implementation of HTS at community level
- Develop and roll-out the facility based HTS ePMS, which is integrated with the deployed ART electronic patient monitoring system modules
- Develop an electronic community based system for reporting HIV testing services which is linked to the facility based systems
- Develop a system for all implementing partners to report through the national HIS

5.3: Strengthen the human resources capacity for M&E to enable effective data analysis to inform decision making

There will be a need to sensitize cadres on the importance of M&E, as well as identify cadres to be assigned M&E roles across all levels of healthcare facilities in Zimbabwe.

Outcomes:

- Programme data analysis that can be used for decision making

Implementation Priority Activities:

- Train M&E team members and service providers at all levels of the health system to effectively carry out tasks
- Mentorship to support M&E team members and service providers
- Review the M&E structure at provincial level to improve coordination of M&E activities at that level

5.4 Reinforce effective monitoring and evaluation of programme linkages and client tracking mechanisms to provide evidence for improving the linkages

Causes of leakages along the HIV testing cascade will need to be initially determined using program data and then eliminated to minimize patient losses along the HTS cascade.

Outcomes:

- M&E system that provides evidence to improve the client linkages and referral system

Implementation Priority Activities:

- Standardize tools to effectively and efficiently track clients from HIV testing through to prevention, care, treatment and support services
- Train service providers to effectively document linkages and tracking activities
- Conduct paediatric HIV case surveillance for infants tested using deoxyribonucleic acid polymerised chain reaction (DNA/PCR) to document linkage to care
- Revise National Health Management Information system (HMIS) indicators to incorporate linkage and access to care indicators (Provincial M&E, as well as HIV focal person)

5.5: Strengthen utilisation of data to make programme decisions at all levels of the health system to enable appropriate targeting of interventions

Reviewing performance against set goals and targets will make it easier to monitor progress and determine corrective action to take when necessary.

Outcomes:

- A responsive management system, which make decisions for program implementation and course correction based on evidence

Implementation Priority Activities:

- Conduct mentorship for data analysis and utilization at all levels
- Support and supervision to support facility managers to use local data for decision making
- Conduct a mid-term evaluation of performance and targets in order to assess progress based on set targets

5.6: Strengthen M&E for HTS demand generation to produce local evidence to inform activity planning and implementation

Continuous monitoring of the effectiveness of demand generation strategies implemented will be critical to ensuring that the programme can dynamically respond to changing societal needs.

Outcomes:

- Effective demand generation activities which are evidence informed

Implementation Priority Activities:

- Involve key stakeholders in the development of demand generation indicators and data collection tools
- Identify operational research questions on demand generation
- Develop and cost an HTS Demand Generation Communications Strategy

5. THEMATIC AREA 5: SUPPLY CHAIN MANAGEMENT

Strategic Objective 6: Strengthen the Supply Chain Management Systems for HTS commodities to ensure their adequate availability to meet programme needs

Strategic context: Procurement and supply chain management (SCM) systems must be adequately managed in order to minimise HTS service interruptions at facilities. Interruptions are caused by factors such as stock outs and ruptures of testing commodities, as well as costly wastages through product expiry. SCM should be done using a system that accurately quantifies and forecasts commodity needs at all levels of healthcare facilities in Zimbabwe. The SCM system should ensure that adequate stock levels are maintained at all levels and should be responsive to changes in consumption patterns.

STRATEGIES:

6.1: Strengthen the HIV testing kits stock management systems to ensure adequate stocks are kept at all levels of the health system including the private sector as well as at every HIV testing entry point

As the revised algorithm is rolled out across the country, the implementation plan will include sensitization, quantification of old and new test kits to be used and re-training to ensure close management of this transition, introduction of new developments in this space and on-going support for commodity management for HTS.

Outcomes:

- Adequate stocking of HIV testing kits and commodities (no over or under stocking) at all levels including all HIV entry points

Implementation Priority Activities:

- Provide mentorship on commodity ordering and stock management processes
- Review and improve stock management systems for HTS commodities at all levels (national, provincial, district, facility and entry point))
- Develop a transport system to redistribute HIV testing kits at district and health facility levels
- Include private sector consumption in forecasting and quantification for HIV testing kits and commodities

6.2: Ensure timely access to EID testing services

To ensure timely provision of EID services for all exposed infants, the MOHCC will develop an integrated sample transportation system that will be aimed at addressing inefficiencies and delays posed by the current system

Outcome:

- Achieve a 28 day turnaround times for DBS EID testing, and results delivery for all exposed infants tested

Implementation Priority Activities:

- Mobilise resources for servicing and maintaining existing EID equipment, and develop regular schedules for routine maintenance of EID equipment
- Roll-out mHealth solutions to reduce results turnaround time, including distribution of Frontline SMS phones to remote sites with difficulty in accessing GPRS/3G networks and GPRS printers for results transmission to facilities with good GPRS/ 3G network reception
- Pilot of integrated sample transportation system
- Development of sample transportation guidelines and national roll-out of integrated system

6.3 Evaluate and effectively deploy new testing technologies

As Zimbabwe moves towards roll-out of POC EID devices, as well as implementation of HIV self-testing, there will be a need to effectively deploy these new technologies as well as continuously explore the possibility of additional innovations and their impact on HIV in the country.

Outcome:

- Systematic approaches to facilitate introduction of innovative technologies developed and implemented

Implementation Priority Activities:

- Collaborate with Directorate of Laboratory Services (DLS) in reviewing guidelines to ensure that new equipment that is procured or donated has a service and maintenance plan
- Support national review process for new HIV testing technologies and innovations in collaboration with the DLS and other relevant departments
- Develop POC placement plans and deployment strategies that complement existing equipment and adequately address the testing needs in areas with high volumes of

exposed infants

- Develop mechanisms for integrating POC reporting into regular M&E health information systems
- EID
  - » Site mapping (hard-to-reach; high volumes) where ordinarily EID is not accessible
  - » Increase number of sites with access to EID testing services from 1,400 to 1,800
- HIVST
  - » Collation and analysis of evidence generated from the on-going HIVST and other projects to inform national scale up
  - » Rapid development of evidence based roll out plans for new initiatives and approaches for HTS beginning with HIVST

6. THEMATIC AREA 6: QUALITY ASSURANCE

Strategic Objective 7: Strengthen the quality assurance for HIV testing to minimise the risk of HIV misdiagnosis

Strategic context: In addition to the quantification, forecasting and distribution of HTS commodities, the availability of appropriate physical infrastructure and equipment is also critical to the delivery of quality HIV testing services. The MOHCC has developed tools for comprehensive health facility assessment that ensure all sites conducting HIV testing have sufficient space both for confidential counselling, equipment and testing services. Quality HTS should be provided so as to minimise the risk of adverse events, such as misdiagnosis of HIV, which have negative effects on both the individual and the overall healthcare system.

STRATEGIES:

7.1 Ensure quality of HIV test kits and reagents

Systematic monitoring of test kit performance, as well as quality of testing, will be prioritized and routinely monitored to ensure quality service provision of HTS.

Outcomes:

- All testing sites registered and participating in EQA
- All batches or lots go through post-shipment quality checks
- All lots have been used for post-market surveillance, once distributed to testing facilities

Implementation Priority Activities:

- Scale up the current HIV dried tube specimens EQA programme to all testing facilities and testing sites
- Strengthen the programme for lot/ batch testing of HIV testing kits before shipment to the testing sites once shipped into the country
- Conduct post-market surveillance when kits are being used in the field

7.2 Ensure that HTS is being conducted efficiently, with adherence to quality control at all testing sites

There is need to improve strategic information collected for quality assurance and quality control in order to ensure that facilities are adhering to set standards of testing.

Outcomes:

- Available internal quality control (IQC) and EQA reports at facility, district and provincial laboratories
- Increased number of testing sites with EQA files at the facility

Implementation Priority Activities:

- Perform quarterly lab scientist visits to all facilities
- Share performance reports for IQC and EQA in order to track performance and address site challenges
- Establish an EQA committee at the district and provincial levels to track IQC and EQA performance. Committee members must include lab staff and nurse supervisors

5. Cost Analysis

Cost of Targeted Testing at Entry Points

Overall, the total cost of targeted testing will be USD55 million (excluding HR Costs) over the strategy implementation period (approximately 53% of the total strategy cost). The cost per test at the testing entry point depends on whether the test is facility based, community based, index case, self-test or a test that involved an EID component. The cost per test is also dependant on whether the test yields a positive or negative result, where a positive result has a higher cost per test. This is due to confirmatory tests that have to be conducted after a positive result is recorded. The cost per test, whether positive or negative, is divided into two components, namely:

- **Commodities:** which covers the costs of the specific reagents to be consumed at each entry point
- **Operational:** which covers any overhead expenses that will be incurred in order to conduct the test, e.g. travel expenses for community based testing

At each entry point, the total cost is calculated as the multiplication of the estimated population to test and the unit cost per test. The only exception to this methodology is the ANC/PMTCT entry point, whereby the population is assumed to be tested 3 times per year. Summaries of the estimated total cost of testing over the 2017-2020 period, and the cost per positive identified at each entry point are shown in figures 8 and 9 below:

Figure 8: Target Setting Model Implementation Cost by Entry Point

	2017	2018	2019	2020
Adolescents and Adults				
TB	225,593	242,545	255,483	289,088
ANC/PMTCT	2,314,351	2,446,490	2,618,729	2,833,124
STI	190,546	207,741	232,687	263,943
VMMC	202,256	165,849	137,853	108,846
Family Planning	352,946	371,265	396,642	857,303
Inpatient Ward	217,710	315,391	382,591	489,180
Index Female Partner Testing (facility-based)	4,999	4,124	3,999	6,317
Index Male Partner Testing (facility-based)	4,115	3,420	3,328	7,023
OPD	478,549	472,820	490,657	511,020
VCT	467,830	481,816	511,638	532,247
Index Female Partner Testing (community-based)	13,619	18,202	17,439	18,233
Index Male Partner Testing (community-based)	21,785	29,117	27,897	29,167
Sex Workers	137,106	207,656	218,226	233,621
Prisoners	4,260	4,104	8,088	8,020
Workplace	176,400	172,095	168,832	165,468
Campaigns	636,323	667,712	714,111	749,104
Self-testing	738,956	871,637	2,173,534	3,255,833
Adolescents and Adults Sub total	6,090,510	6,637,403	8,332,911	10,336,360
Paediatrics				
EID through PMTCT	1,460,860	1,593,196	1,640,992	1,784,123
OPD Rapid testing	206,937	317,381	324,557	333,171
In patient	118,859	192,588	207,251	224,246
Growth	1,598,839	2,634,887	2,883,554	3,144,771
Malnutrition	428,347	705,916	772,537	842,519
PITC - Index testing	13,915	17,708	18,031	22,167
PITC – EPI	219,098	394,925	406,772	478,829
HTS campaigns for children/adolescents	154,456	158,986	163,650	168,510
TB	3,438	3,973	4,520	4,872
Paediatrics Sub Total	4,204,749	6,019,559	6,421,864	7,003,207
Total	**10,392,092**	**12,701,542**	**14,783,597**	**17,360,743**

Figure 9: Cost per Positive Identified per Entry Point

	2017	2018	2019	2020
Adolescents and Adults				
TB	$16.85	$21.65	$24.53	$26.57
ANC/PMTCT	$186.55	$249.68	$287.42	$314.22
STI	$21.94	$28.49	$32.41	$35.20
VMMC	$481.07	$645.41	$743.68	$813.45
Family Planning	$110.43	$147.40	$169.51	$185.20
Inpatient Ward	$29.04	$38.04	$43.42	$47.24
Index Female Partner Testing (facility-based)	$11.38	$14.30	$16.05	$17.30
Index Male Partner Testing (facility-based)	$12.82	$16.24	$18.29	$19.74
OPD	$21.09	$27.36	$31.10	$33.76
VCT	$31.70	$41.61	$47.53	$51.74
Index Female Partner Testing (community-based)	$8.11	$9.91	$10.99	$11.75
Index Male Partner Testing (community-based)	$8.11	$9.91	$10.99	$11.75
Sex Workers	$21.30	$27.22	$30.76	$33.27
Prisoners	$19.99	$25.87	$29.39	$31.89
Workplace	$85.52	$98.62	$107.83	$114.64
Campaigns	$140.67	$187.62	$215.69	$235.62
Self-testing	$183.99	$244.92	$281.36	$307.23
Paediatrics				
EID through PMTCT	$1,624.25	$2,549.64	$5,735.59	$13,674.88
OPD Rapid testing	$52.60	$81.97	$183.06	$435.00
In patient	$22.87	$35.30	$78.09	$184.72
Growth	$859.90	$1,349.81	$3,036.49	$7,239.64
Malnutrition	$234.24	$367.69	$827.14	$1,972.09
PITC - Index testing	$33.21	$51.53	$114.60	$271.77
PITC – EPI	$1,886.23	$2,960.87	$6,660.68	$15,880.51
HTS campaigns for children/adolescents	$585.31	$918.18	$2,064.18	$4,919.98
TB	$20.97	$32.32	$71.38	$168.72

The total cost per entry point and cost per positive identified increase annually over the strategy implementation period. This is caused by attrition, whereby over time, HIV positive yields continue to decline. This implies that as more HIV positive people are identified annually, an increasing number of tests have to be conducted in order to keep identifying HIV positive patients. A summary of the testing costs by cost category is shown in Figure 10.

Figure 10: Target Setting Testing Cost by Cost Category

	2017	2018	2019	2020
HTS Strategy Targeted Testing Costs				
Commodities				
Facility Based	4,806,303	5,247,214	5,596,052	6,490,566
Community Based	703,480	776,606	809,191	842,221
Self-Testing	646,007	761,474	1,898,317	2,843,139
EID	3,090,622	4,442,689	4,755,267	5,210,786
	9,246,412	11,227,982	13,058,827	15,386,712
Operational				
Community Based	436,208	477,162	500,965	521,881
Self-Testing	92,949	110,163	275,217	412,694
EID	616,522	886,235	948,588	1,039,456
	1,145,679	1,473,560	1,724,770	1,974,031
Total Testing Costs	**10,392,092**	**12,701,542**	**14,783,597**	**17,360,743**

Cost of Programmatic Activities that will Support Targeted Testing

The programmatic activities were costed using an activity based approach, whereby each activity under the different sub objectives was costed using specific budget assumptions. For some of the activities that were cross cutting, these items were costed only once as they incorporated activities that were part of other objectives and sub objectives (e.g. mentorships for various aspects of the HTS Strategy). A summary of the program activity costs of the HTS strategy are shown in Figure 11 below:

Figure 11: Breakdown of HTS Strategy Program Activity Costs

	2017	2018	2019	2020
HTS Strategy Targeted Testing Costs				
Administration & Management	$177,850	$135,350	$135,350	$135,350
Capital Medical/Laboratory Equipment	$514,400	$266,900	$266,900	$266,900
Communication	$1,995,350	$1,670,350	$1,630,350	$1,630,350
Community Outreach Events	$42,900	$42,900	$42,900	$42,900
Health Worker Salaries/Benefits	$5,400,000	$6,480,000	$7,560,000	$7,560,000
Planning & Policy Meetings	$660,205	$411,100	$293,350	$293,350
Research, M&E, QA and Supervision	$329,440	$529,440	$329,440	$529,440
Technical Assistance	$62,400	$47,600	$0	$6,800
Training	$2,734,108	$1,876,208	$1,966,208	$1,876,208
Total Cost for Program Activity Costs	**$11,916,653**	**$11,459,848**	**$12,224,498**	**$12,341,298**

The major driver of the programme activity costs will be the human resources element, which is solely attributed to the scale up and support of additional PC's over the years. 1,500 PC's will deployed in 2017 and will increase to 1,800 in 2018, and 2,100 in 2019 and 2020.

Costs by Thematic Areas of Implementation

Overall, it will cost approximately USD103 million to implement the HTS Strategy. The annual major cost driver will be the cost of targeted testing at each of the entry points, rising from being 46% of total costs in 2017 to being 58% of total costs by 2020. All of the thematic areas of implementation costs are for program activities, with the exception of service delivery, which includes the cost of targeted testing. A more detailed breakdown of the thematic areas of implementation costs are shown in the implementation framework as part of Appendix 2.

The total annual costs of the strategy thematic areas of implementation are shown in Figure 12.

Figure 12: Cost by Thematic Area of Implementation

	2017	2018	2019	2020
Management and Coordination	$711,780	$481,600	$481,600	$481,600
Service Delivery				
Targeted Testing Costs	$10,392,092	$12,701,542	$14,783,597	$17,360,743
Program Activity Costs	$7,577,132	$8,105,982	$9,275,982	$9,185,982
Demand Generation	$1,070,850	$1,091,700	$1,038,100	$1,038,100
Strategic Information	$2,015,701	$1,131,676	$907,626	$1,114,426
Supply Chain Management	$386,680	$494,380	$366,680	$366,680
Quality Assurance	$154,510	$154,510	$154,510	$154,510
Training	$22,308,745	$24,161,390	$27,008,095	$29,702,041
Total Cost	**$22,211,912**	**$24,116,810**	**$26,979,273**	**$29,680,864**

Resource Mapping and Gap Analysis

A summary of the total resources available for the HTS Strategy are shown in Figure 13, where USD 37 million total resources are available over 2017-2020.

Figure 13: Total Resources Allocated for HTS Strategy

	2017	2018*	2019*	2020*
Administration & Management	2,582,934	1,653,930	1,653,930	1,653,930
Capital Medical/Laboratory Equipment	215,117	115,117	115,117	115,117
Communication	230,730	176,096	176,096	176,096
Community Outreach Events	2,942,074	974,731	974,731	974,731
Drugs, Medical Supplies and Other Health Commodities	2,613,555	538,221	538,221	538,221
Health Worker Salaries/Benefits	2,738,787	2,439,281	2,439,281	2,439,281
Training	1,004,778	670,062	670,062	670,062
Infrastructure	2,197,264	243,584	243,584	243,584
Planning & Policy Meetings	9,089	9,089	9,089	9,089
Research, M&E, QA and Supervision	345,547	293,060	293,060	293,060
Technical Assistance	176,536	60,565	60,565	60,565
Total Cost	**15,056,411**	**7,173,735**	**7,173,735**	**7,173,735**

*Includes only NAC and USAID resources, with both resources allocated in 2017 assumed to remain constant till 2020

The total resources budgeted and funding gaps per cost category for the HTS Strategy are shown in Figures 14 and 15 below.

Figure 14: Total Resources Budgeted for HTS Strategy per Cost Category

	2017	2018*	2019*	2020*
Administration & Management	$1,323,529	$1,608,910	$1,860,120	$2,109,381
Capital Medical/Laboratory Equipment	$514,400	$266,900	$266,900	$266,900
Communication	$1,995,350	$1,670,350	$1,630,350	$1,630,350
Community Outreach Events	$42,900	$42,900	$42,900	$42,900
Drugs, Medical Supplies and Other Health Commodities	$9,246,412	$11,227,982	$13,058,827	$15,386,712
Health Worker Salaries/Benefits	$5,400,000	$6,480,000	$7,560,000	$7,560,000
Infrastructure	$0	$0	$0	$0
Planning & Policy Meetings	$660,205	$411,100	$293,350	$293,350
Research, M&E, QA and Supervision	$329,440	$529,440	$329,440	$529,440
Technical Assistance	$62,400	$47,600	$0	$6,800
Training	$2,734,108	$1,876,208	$1,966,208	$1,876,208
Total Costs for HTS Strategy	**$22,308,745**	**$24,161,390**	**$27,008,095**	**$29,702,041**

* Includes only NAC and USAID resources, with both resources allocated in 2017 assumed to remain constant till 2020

Figure 15: Total Funding Gap for HTS Strategy per Cost Category

	2017	2018*	2019*	2020*
Administration & Management	1,259,404	45,020	(206,190)	(455,451)
Capital Medical/Laboratory Equipment	(299,283)	(151,783)	(151,783)	(151,783)
Communication	(1,764,620)	(1,494,254)	(1,454,254)	(1,454,254)
Community Outreach Events	2,899,174	931,831	931,831	931,831
Drugs, Medical Supplies and Other Health Commodities	(6,632,857)	(10,689,762)	(12,520,607)	(14,848,491)
Health Worker Salaries/Benefits	(2,661,213)	(4,040,719)	(5,120,719)	(5,120,719)
Infrastructure	1,004,778	670,062	670,062	670,062
Planning & Policy Meetings	1,537,059	(167,516)	(49,766)	(49,766)
Research, M&E, QA and Supervision	(320,351)	(520,351)	(320,351)	(520,351)
Technical Assistance	283,147	245,460	293,060	286,260
Training	(2,557,572)	(1,815,643)	(1,905,643)	(1,815,643)
Total	**(7,252,334)**	**(16,987,656)**	**(19,834,361)**	**(22,528,306)**

* Includes only NAC and USAID resources, with both resources allocated in 2017 assumed to remain constant till 2020

Annex 1: Results Framework

STRATEGIC OBJECTIVE	1: Strengthen management and coordination of the HTS programme to improve efficiency and effectiveness	2: Strengthen service delivery capacity to increase access to high quality HTS for all population groups	3: Strengthen the national human resource capacity for HIV Testing Services in line with the broader Human Resource for Health Plan	4: Strengthen the demand generation for HTS based on local evidence to effectively reach out to all population groups	5: Strengthen the strategic information of HTS to provide evidence for effective decision making.	6: Strengthen the Supply Chain Management Systems for HTS commodities to ensure their adequate availability to meet programme needs	7: Strengthen the quality assurance for HIV testing to minimise the risk of HIV misdiagnosis
OUTCOMES	Strengthened human resources structure and capacity to effectively manage and coordinate the HTS program at all levels of health system Strengthened management of financial resources for the HTS program to deliver an efficient service that meets the needs of the population Strengthened engagement of the private sector and the leveraging of its strengths for HTS service delivery	HTS guidelines available at all levels for enhanced provision of good quality service Strengthened implementation of PITC at all entry points to reduce missed opportunities for identifying undiagnosed PLHIV Strengthened HTS integration as part of standard of care, the reduction of missed opportunities for HIV testing and efficient utilization of resources Strengthened linkages to post-test services, follow up and support of referred clients Strengthened service provision for key populations and increased access to quality HTS Strengthened service provision for priority populations, as well as increased access and utilisation of HTS Strengthened quality of counselling in HTS service provision to effectively respond to clients' concerns Enhanced capacity of the private sector to provide standardised quality HTS Enhanced implementation of current community approaches to HTS that are targeted, whilst allowing for the introduction of new innovative models	The establishment of universal awareness of the program, its key components and considerations through standardized integration of HTS into pre-service training Sustained on-going site based training and capacity building as part of in-service training for HCWs The scale-up of additional PCs for providing testing services in the facility An increase in human resources for providing services at the community level	Effective coordination of demand generation activities for HTS Appropriate and targeted messaging strengthened that effectively reaches out to priority populations	Data demand, dissemination and utilization at all levels Strengthened facility (public and private) and community based HTS information management systems for robust evidence generation. Strengthened human resources capacity for M&E to enable effective data analysis that will inform decision making Reinforced monitoring and evaluation of programme linkages and client tracking mechanisms to provide evidence for improving linkages Strengthened utilisation of data to make programme decisions at all levels of the health system, enabling appropriate targeting of interventions Strengthened M&E for HTS demand generation, producing evidence to inform activity planning and implementation	Strengthened HIV testing kits stock management systems to ensure adequate stocks are kept at all levels of the health system including the private sector as well as at every HIV testing entry point Timely access to EID testing services Evaluated and effectively deployed new testing technologies	Ensured quality of HIV test kits and reagents Ensuring HTS being conducted efficiently, with adherence to quality control at all testing sites

OUTPUTS	Accountable and effective management and coordination of HTS activities at all levels Structures that allow for integrated HTS at all levels of the healthcare sector Effective mobilisation and efficient utilisation of financial resources for the HTS program HTS program reaping of benefits from the strengths (financial and capacity) of the private sector	Good quality service in all facilities that is consistent with the most recent guidelines Reduced missed opportunities for HIV testing HTS fully integrated into other health programmes All clients tested are linked to and access appropriate post-test services Key populations have increased access to quality HTS Priority populations have improved access and utilisation of HTS Improved quality of counselling services Standard quality HTS provided in the private sector Scaled-up implementation of evidence based community testing interventions, as well as improved case identification of PLHIV, linkages to treatment, care and support services Decreased client load for initial HIV testing at public institutions and the presentation of clients that are most likely to test HIV positive for confirmatory testing at the facility level	Increased capacity to provide HTS at all service delivery levels nationally A reduction of in-service training costs Increased human resources to provide HTS at facility level Increased human resources to conduct testing within the community setting	Appropriate and targeted messaging strengthened that effectively reaches out to priority populations Effective coordination and strategic guidance of HTS demand generation activities across all programs Adequate funding for effective demand generation strategies for HTS Targeted messages for priority and key populations	A rresponsive management system, which makes decisions for program implementation and course correction, based on evidence from performance monitoring and progress reporting Management accountability based on activities conducted and measurable outcomes Strategic information systems with the capacity to provide evidence for decision making Programme data analysis that can be used for decision making AnM&E system that provides evidence that improves the client linkages and referral system Responsive management system that enables decisions making for program implementation and course correction based on evidence Effective demand generation activities which are evidence informed	Adequate stocking of HIV testing kits and commodities (no over or under stocking) at all levels including all HIV entry points 28 day turnaround times for DBS EID testing, and results delivery for all exposed infants tested Systematic approaches to facilitate the introduction of innovative technologies developed and implemented	All testing sites registered and participating in EQA All batches or lots go through post-shipment quality checks All lots being used for post-market surveillance, once distributed to testing facilities Available IQC and EQA reports at facility, district and provincial laboratories Increased number of testing sites with EQA files at the facility

Annex 1: Results Framework

MANAGEMENT AND COORDINATION																
Strategic Objective 1: Strengthen management and coordination of the HTS programme to efficiency and effectiveness									**Frequency per Annum**				**Annual Cost**			
Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
1.1 Strengthen the human resources structure and capacity to effectively manage and coordinate the HTS program at all levels of the health systems	***1.1.1 National Level:***															
	1.1.1.1 Retain existing cadres and support the addition of cadres that will be a part of the HIV prevention TWG, and will be accountable for national HTS performance	Assume cost of $2,500-2700 per month for 4 cadres	$2,700	per person	48			1	x	x	x	x	$129,600	$129,600	$129,600	$129,600
	1.1.1.2 Revitalise the current HTS TWG that is part of the national HIV Prevention Forum	Conduct 2 day overnight national level meeting with 80 participants annually	$250	per person for 2 days	80	1			x		x		$20,000	$20,000	$20,000	$20,000
	1.1.1.3 Review job descriptions for HTS cadres and update them to ensure that they are aligned with the HTS strategic goals	Conduct an overnight national level review meetings with 50 participants	$250	per participant	50	1			x				$12,500	$12,500	$12,500	$12,500
	1.1.1.4 Develop and Disseminate guidelines that will operationalise the HTS Strategy	Print HTS strategy for 2,500 entry points, as 2,500 copies of guidelines	$10	per guideline	5,000	1			x				$50,000	$0	$0	$0
	1.1.2 Provincial Level:															
	1.1.2.1 Improve communication and delegation of HTS program implementation to the Provincial Medical Director, and the coordination of HTS activities to the Provincial HIV/TB/ Maternal and Neonatal Child Health Officer and the HIV Focal Person.	MOHCC and partners to lead this process, no additional costs							x	x	x	x				
	1.1.2.2 Provincial level coordination of sensitization, trainings and workshops on the HTS Strategy that include dissemination of up to date policies and guidelines, as well as support of districts	Conduct 2 day overnight provincial level meeting with 4 officials per district, 4 officials per province and 5 total facilitators. Sensitization will cover all aspects of the strategy.	$220	per meeting	13			63	x				$180,180	$0	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
	1.1.2.3 On-going monitoring, analyses and use of strategic information to evaluate and act on provincial progress towards integrating HTS into routine services for identification and linkage purposes	MOHCC and partners to lead this process, no additional costs							x	x	x	x	$0	$0	$0	$0
	1.1.3 District Level:															
	1.1.3.1 District and Facility Health Executives will be responsible for the management and supervision of HTS, as well as delegating duties of optimising and distributing HCWs at facilities to the District Nursing Officer	MOHCC and partners to lead this process, no additional costs							x	x	x	x				
	1.1.3.2 Incorporate HTS into regular facility support and supervision, performance evaluations and mentorship activities for nurses and PCs	Support visit at district level by a provincial/national official, and also a support visit from district to facility level. 5 days per quarter for provincial/national to district visit, and then once every 2 months for district to facility. 5 people per visit	$550	p/p per provincial level visit	5		10		x	x	x	x	$110,000	$110,000	$110,000	$110,000
			$375	p/p per district level visit	5			15	x	x	x	x	$168,750	$168,750	$168,750	$168,750
			$1.50	per litre	200			15	x	x	x	x	$27,000	$27,000	$27,000	$27,000
	1.1.4 Facility Level:															
	1.1.4.1 Support facility managers at all primary level facilities to be responsible for ensuring the operationalization of HTS at facilities, as well as assigning a nurse to liaise with community level cadres.	Already costed as part of support and supervision costs (activity 1.1.3.2)							x	x	x	x				
	1.1.4.2 Organise facility staff to offer integrated HTS including review of SOPs, use of job aides and coordination of activities	MOHCC and partners to lead this process, no additional costs							x	x	x	x				
	1.1.4.3 Support community testing initiatives in testing, counselling, linkages to care and patient tracking	Already costed as part of support and supervision costs (activity 1.1.3.2)							x	x	x	x				

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
1.2 Strengthen the management of financial resources for the HTS program to deliver an efficient service that meets the needs of the population	1.2.1 Advocate for increased government funding for HTS activities	MOHCC and partners to lead this process, no additional costs							x	x	x	x				
	1.2.2 Explore other domestics funding sources other than government e.g. Environmental Impact Assessment for infrastructural projects	Conduct a national level advocacy meeting annually with policy makers and 30 participants in total	$25	per participant	30	1				x			$750	$750	$750	$750
	1.2.3 Engage other non-traditional external donors	MOHCC and partners to lead this process, no additional costs							x	x	x	x	$0	$0	$0	$0
	1.2.4 Strengthen integration of HTS in other programmes for efficient utilisation of limited resources.	MOHCC as well as the provincial, district and facility level to lead this process, no additional costs							x	x	x	x	$0	$0	$0	$0
	1.2.5 Conduct a partner mapping exercise to in order to efficiently distribute partner effort and avoid duplication	Conduct a national level half day advocacy meeting with 50 participants	$25	per participant	50	1			x	x	x	x	$5,000	$5,000	$5,000	$5,000
1.3 Strengthen the engagement of the private sector to leverage on its strengths for delivery of HTS services	1.3.1 Engage in public private partnerships (PPPs) with private sector service providers	Conduct a national level engagement meeting quarterly with 30 participants	$25	per participant	30	1			x	x	x	x	$3,000	$3,000	$3,000	$3,000
	1.3.2 Engage professional bodies e.g. Zimbabwe Nurses Association (ZINA), Zimbabwe Medical Association (ZIMA) and Laboratory Scientists Council of Zimbabwe to effectively reach out to and coordinate private sector providers	Conduct a national level engagement meeting quarterly with 50 participants	$25	per participant	50	1			x	x	x	x	$5,000	$5,000	$5,000	$5,000
	Total Cost												**$711,780**	**$481,600**	**$481,600**	**$481,600**

SERVICE DELIVERY																
Strategic Objective 2: Strengthen service delivery capacity to increase access to high quality HTS for all population groups									**Frequency per Annum**				**Annual Cost**			
Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
2.1 Ensure HTS guideline availability to all levels to enhance provision of good quality service	2.1.1 District level meeting to disseminate new HTS guidelines	Already costed as part of provincial level coordination and sensitizations (activity 1.1.2.2)							x				$0	$0	$0	$0
	2.1.2 Mentorship of service providers to support adherence to guidelines	There's a team of 5 mentors in every district to go back and forth to facilities. Assume facilities in 32 districts will be visited annually, and each visit lasts for 5 days	$375	allowance for 5 mentors per week	32			32	x	x	x	x	$384,000	$384,000	$384,000	$384,000
			$1.50	per litre	6400			32	x	x	x	x	$307,200	$307,200	$307,200	$307,200
	2.1.3 Include HTS guidelines in the curricula of other HIV trainings	MOHCC to lead this process, no additional cost							x	x	x	x				
	2.1.4 Timely distribution of adequate numbers of HTS guidelines copies to all health facilities	Printing already costed as part of guideline dissemination (activity 1.1.1.4), and dissemination already costed as part of sensitization meetings (activity 1.1.2.2)							x							
	2.1.5 Support and supervision to ensure all implementing partners are adhering to the national guidelines	Already costed as part of support and supervision activities (activity 1.1.3.2)							x	x	x	x				
	2.1.6 Develop communication tools to engage communities on HTS guidelines particularly for children and adolescents	Already costed as part of assistance of healthcare workers to conduct HIV testing more efficiently (Activity 2.2.2.6)							x	x	x	x				

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
2.2 Strengthen the implementation of PITC at all entry points to reduce missed opportunities for identifying undiagnosed PLHIV	2.2.1 Scale up rapid HIV testing training to improve capacity of health care workers to provide quality HTS at all entry points, including for children and adolescents	Train 5,000 HCWs on rapid HIV testing and ART initiation. Rapid HIV testing takes 5 days to train. Cost is $12,500 for 25 trainees and 5 facilitators. Assume 1,000 workers are trained per year. Costs include printing of manuals ($25), transport, accomodation, gloves, cryotubes, cotton wool, bleach (JIK), black plastic sheeting, stationery, conference. Training includes a theory and practical exam.	$12,500	per 25 trained	40	1			x	x	x	x	$500,000	$500,000	$500,000	$500,000
	2.2.2 Operationalise PITC:															
	2.2.2.1 Identify clients for testing at all entry points (OPD, EPI, Inpatient wards, Family Planning)															
	2.2.2.1.1 Inpatient Ward (Paediatric and Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$336,568	$507,978	$589,842	$713,426
		Operational							x	x	x	x	$0	$0	$0	$0
	2.2.2.1.2 OPD (Paediatric and Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$685,486	$790,202	$815,214	$844,190
		Operational							x	x	x	x	$0	$0	$0	$0
	2.2.2.1.3 Family Planning (Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$352,946	$371,265	$396,642	$857,303
		Operational							x	x	x	x	$0	$0	$0	$0
	2.2.2.1.4 TB (Paediatric and Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$229,031	$246,517	$260,002	$293,960
		Operational							x	x	x	x	$0	$0	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
	2.2.2.1.5 ANC/PMTCT (Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$2,314,351	$2,446,490	$2,618,729	$2,833,124
		Operational							x	x	x	x	$0	$0	$0	$0
	2.2.2.1.6 STI (Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$190,546	$207,741	$232,687	$263,943
		Operational							x	x	x	x	$0	$0	$0	$0
	2.2.2.1.7 VCT (Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$467,830	$481,816	$511,638	$532,247
		Operational							x	x	x	x	$0	$0	$0	$0
	2.2.2.2 Use HIV screening tools for children and adolescents	Print 3 screening tools per facility per annum	$10	per copy	6,000	1			x				$60,000	$60,000	$60,000	$60,000
	2.2.2.3 Increase access to EID for HIV exposed infants	Already costed as part of EID testing (activity 2.2.2.3.1)							x	x	x	x				
	2.2.2.3.1 EID through PMTCT (Paediatric Targets)								x	x	x	x				
		Commodities							x	x	x	x	$1,217,909	$1,328,237	$1,368,084	$1,487,412
		Operational							x	x	x	x	$242,950	$264,959	$272,908	$296,711
	2.2.2.4 Provide mentorship to increase confidence of health service providers to offer HTS	Already costed as part of mentorship activities (activity 2.1.2)"							x	x	x	x	$0	$0	$0	$0
	2.2.2.5 Conduct support and supervision to identify gaps and best practises	Already costed as part of support and supervision activities (activity 1.1.3.2)							x	x	x	x				
	2.2.2.6 Develop, print and distribute job aids and counselling tools to assist health workers to communicate HIV testing more effectively	2,500 copies of job aids and counselling tools to be printed. For adolescents, counselling tools consist of the following books: (our story, ZVANDIRI, red ribbons and roses, soldier game, HTS for children training manual).	$70	per set of books	2,500	1			x				$175,000	$0	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
2.3 Strengthen HTS integration as part of standard of care to reduce missed opportunities for HIV testing and ensure efficient utilization of resources including human resources	2.3.1 Sensitize and train health facility managers on integration of health services	Already costed as part of mentorship activities (activity 2.1.2)"							x	x	x	x	$0	$0	$0	$0
	2.3.2 Mentorship to support planning of activities at health facility level	Already costed as part of mentorship activities (activity 2.1.2)"							x	x	x	x	$0	$0	$0	$0
2.4 Strengthen linkages to post-test services to enable follow up and support of referred clients to complete the referral pathway	2.4.1 Review of all existing guidance on HTS linkage to care mechanisms and development of revised linkage to care guidelines for HTS with clear protocols for clients who test HIV positive and those who test HIV negative	Hire a local consultant to review guidelines for 10 days, as well as 2 validation workshops with 35 participants, printing of 2,000 copies of the guidelines	$680	per day of consultancy work	10	1			x				$6,800	$0	$0	$0
			$250	per person	35	1				x		x	$8,750	$0	$0	$0
			$10	per copy printed	2,000	1			x				$20,000	$0	$0	$0
	2.4.2 Roll out an electronic client monitoring system which includes a unique identifier for the clients	Already costed as part of ePMS setup costs (activity 5.2.5)							x	x	x	x	$0	$0	$0	$0
	2.4.3 Identify community cadres and expert clients to facilitate linkages to post-test services and follow up	MOHCC to lead process, no additional Costs							x	x	x	x	$0	$0	$0	$0
	2.4.4 Scale up provision of client support services through peer to peer support groups	Overnigh district level training workshop with 30 participants per district	$110	per person	30			13	x	x	x	x	$42,900	$42,900	$42,900	$42,900
	2.4.5 Mentorship for implementation of linkages to strengthen service provider capacity to follow up and support referred clients	Already costed as part of mentorship activities (activity 2.1.2)"							x	x	x	x	$0	$0	$0	$0
	2.4.6 Develop SOPs and distribute IEC materials which facilitate the linkage process e.g. list of services available and location	Print 2,000 copies of SOP's and IEC materials	$20	per set	2,000	1			x				$40,000	$0	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
2.5 Strengthen service provision for key populations to increase access to quality HTS	2.5.1 Conduct size estimations for key populations	MOHCC to lead this process, no additional costs							x	x	x	x	$0	$0	$0	$0
	2.5.2 Conduct targeted testing in hotspots for key populations	Already costed as part of campaigns testing (activity 2.6.6.1)							x	x	x	x	$0	$0	$0	$0
	2.5.3 Provide flexible hours for HTS	MOHCC to lead this process, no additional costs							x	x	x	x	$0	$0	$0	$0
	2.5.4 Scale up key populations peer support groups	Already costed as part of the scale up of client support (activity 2.4.4)							x	x	x	x	$0	$0	$0	$0
	2.5.5 Train community based health workers to support referral and linkages to post test services for key populations	Conduct an overnight district level workshop with 30 participants per district.	$110	per participant	30			13		x			$42,900	$42,900	$42,900	$42,900
	2.5.6 Train and mentor service providers at all levels to provide services that are acceptable to key populations	Already costed as part of mentorship activities (activity 2.1.2)"							x	x	x	x	$0	$0	$0	$0
	2.5.7 Research, document and disseminate testing models that reach key populations e.g.															
	2.5.7.1 Sex workers: Moonlight clinics								x	x	x	x	$0	$0	$0	$0
	2.5.7.1.1 Sex Workers (Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$84,976	$127,803	$133,917	$143,121
		Operational							x	x	x	x	$52,130	$79,853	$84,309	$90,500
	2.5.7.1.2 Men at risk of having HIV: Self-testing	Already costed as part of PITC access in service delivery (activity 2.6.6.3.1)											$0	$0	$0	$0
	2.5.7.1.3 People in prisons: Prison testing (Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$4,260	$4,104	$8,088	$8,020
		Operational							x	x	x	x	$0	$0	$0	$0
	2.5.7.1.4 Long distance truck drivers: testing campaigns at selected truck stops	Already costed as part of campaign testing (activity 2.6.6.1)							x	x	x	x	$0	$0	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
2.6 Strengthen service provision for priority populations to increase access and utilisation of HTS	2.6.1. Scale up implementation of the family centred approach	Healthcare workers to be mentored on the family centred approach. Mentorship already costed as part of activity 2.1.2							x	x	x	x	$0	$0	$0	$0
	2.6.2 Roll out of index case testing															
	2.6.2.1 Index Female Partner Testing (facility-based) Adult Targets								x	x	x	x				
		Commodities							x	x	x	x	$4,999	$4,124	$3,999	$6,317
		Operational							x	x	x	x	$0	$0	$0	$0
	2.6.2.2 Index Male Partner Testing (facility-based) Adult Targets								x	x	x	x				
		Commodities							x	x	x	x	$4,115	$3,420	$3,328	$7,023
		Operational							x	x	x	x	$0	$0	$0	$0
	2.6.2.3 Index Testing (Paediatric Targets)								x	x	x	x				
		Commodities							x	x	x	x	$13,915	$17,708	$18,031	$22,167
		Operational							x	x	x	x	$0	$0	$0	$0
	2.6.3 Integrate HTS in other services for example VMMC, EPI, RH															
	2.6.3.1 VMMC (Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$202,256	$165,849	$137,853	$108,846
		Operational							x	x	x	x	$0	$0	$0	$0
	2.6.4 Integrate HTS into Adolescent Sexual Reproductive Health services	Conduct a national level half day coordination meeting per quarter with 30 participants	$25	per person	30	1			x	x	x	x	$3,000	$3,000	$3,000	$3,000
	2.6.5 Scale up peer led Adolescent and Youth Friendly services	Already costed as part of training of community based health workers to support referral and linkages to post-test services for key populations (activity 2.5.5)								x						

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
	2.6.6 Conduct community testing including outreach campaigns															
	2.6.6.1 Targeted Campaigns that target key & priority populations Campaigns (Adult and Paediatric Targets)								x	x	x	x				
		Commodities							x	x	x	x	$476,407	$497,507	$527,994	$551,826
		Operational							x	x	x	x	$314,372	$329,191	$349,767	$365,787
	2.6.6.2 Conduct workplace testing to target men															
	2.6.6.2.1 Workplace (Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$106,694	$103,977	$101,944	$99,874
		Operational							x	x	x	x	$69,706	$68,118	$66,889	$65,594
	2.6.6.3 Roll out HIV self-testing with appropriate linkage to post-test services															
	2.6.6.3.1 Self-testing (Adult Targets)								x	x	x	x				
		Commodities							x	x	x	x	$646,007	$761,474	$1,898,317	$2,843,139
		Operational							x	x	x	x	$92,949	$110,163	$275,217	$412,694
	2.6.6.4 Consolidate and disseminate guidance on a comprehensive package of youth friendly services	Already costed as part of development, printing and distribution of job aids to assit health workers to communicate HIV testing more effectively (acivity 2.2.2.6)							x							
	2.6.6.5 Capacitate service providers at all levels to provide adequate services appealing to children, adolescents and young people	Already costed as part of campaign testing (activity 2.6.6.1)							x	x	x	x	$0	$0	$0	$0
	2.6.6.6 Train school health masters on life skills, sexuality, HIV & AIDS education	Train 25 to 30 people annually across 13 districts for 1 day. Training to be conducted by 2 district level trainers	$27	per person	32			13			x		$11,232	$11,232	$11,232	$11,232

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
continues: **2.6 Strengthen service provision for priority populations to increase access and utilisation of HTS**	2.6.6.7 Research, document and disseminate community testing models that target priority populations e.g.															
	2.6.6.7.1 Infants and children: growth monitoring, EPI outreach, malnutrition clinics												$0	$0	$0	$0
	2.6.6.7.1.1 PITC - EPI (Paediatric Targets)								x	x	x	x				
		Commodities							x	x	x	x	$182,661	$329,246	$339,123	$399,197
		Operational							x	x	x	x	$36,437	$65,679	$67,649	$79,632
	2.6.6.7.1.2 Growth (Paediatric Targets)								x	x	x	x				
		Commodities							x	x	x	x	$1,332,942	$2,196,688	$2,404,001	$2,621,775
		Operational							x	x	x	x	$265,897	$438,199	$479,554	$522,996
	2.6.6.7.1.3 Malnutrition (Paediatric Targets)								x	x	x	x				
		Commodities							x	x	x	x	$357,110	$588,517	$644,059	$702,403
		Operational							x	x	x	x	$71,237	$117,398	$128,478	$140,116
	2.6.6.7.1.4 Older Children and adolescents: HTS campaigns, community adolescent testing	Already costed as part of targeted testing campaigns (activity 2.6.6.1)							x	x	x	x	$0	$0	$0	$0
	2.6.6.7.1.5 Young people (men and women): HTS campaigns in tertiary institutions, vocational training centres and informal workplaces	Activity already costed as part of targeted testing campaigns and workplace testing (activities 2.6.6.1 and 2.6.6.2.1)							x	x	x	x	$0	$0	$0	$0
	2.6.6.7.1.6 Men: workplaces (formal and informal), campaigns	Already costed as part of workplace testing (activity 2.6.6.2.1)							x	x	x	x	$0	$0	$0	$0
	2.6.6.8 Couples: Community based index testing outreach campaigns															
	2.6.6.8.1 Index Female Partner Testing (community-based) Adult Targets								x	x	x	x				
		Commodities							x	x	x	x	$13,619	$18,202	$17,439	$18,233
		Operational							x	x	x	x	$0	$0	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
	2.6.6.8.2 Index Male Partner Testing (community-based) Adult Targets								x	x	x	x				
		Commodities							x	x	x	x	$21,785	$29,117	$27,897	$29,167
		Operational							x	x	x	x	$0	$0	$0	$0
	2.6.6.8.3 Partner testing e.g within ANC and PNC	Activity already costed as part of targeted testing at the ANC/ PMTCT entry point (2.2.2.1.5)							x	x	x	x				
2.7 Strengthen the quality of counselling in HIV testing services provision to effectively respond to clients' concerns	2.7.1 Train service providers on standardised counselling quality assurance tools	One day workshop per district for 30 participants	$75	per person per 3 day workshop	30			13	x				$29,250	$29,250	$29,250	$29,250
	2.7.2 Disseminate and distribute counselling job aids	Included under job aid and counselling tools distribution costs (activity 2.2.2.6)							x							
	2.7.3 Mentorship of service providers to provide quality HTS counselling	Already costed as part of mentorship activities (activity 2.1.2)							x	x	x	x				
	2.7.4 Provide refresher trainings on counselling for service providers	Activity already costed as part of training on standardised counselling quality assurance (activity 2.7.1)							x							
2.8 Enhance the capacity of the private sector to provide standardised quality HTS	2.8.1 Include private sector providers in dissemination meetings for guidelines and policies	Print 2,000 guidelines	$10	per guideline printed	2,000	1			x				$20,000	$0	$0	$0
	2.8.2 Scale up training of Rapid HIV testing in the private sector	Activity already costed as part of rapid HIV test training (activity 2.2.1)							x	x	x	x	$0	$0	$0	$0
	2.8.3 Provide mentorship for all aspects of HTS in the private sector	Already costed as part of mentor-ship activities (activity 2.1.2)							x	x	x	x	$0	$0	$0	$0
	2.8.4 Disseminate HTS guidelines through professional organisations e.g. Zimbabwe College of Primary Care Physicians (ZCPCP), Zimbabwe Occupational Nurses Association (ZONA) and Zimbabwe Nurses Association (ZINA)	Meetings already costed as part of engagement meetings (activity 1.3.2) and printing of guidelines to be disseminated already costed as part of guideline printing (activity 2.2.2.6)							x				$0	$0	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
2.9 Enhance the implementation of current community approaches to HTS that are targeted, whilst allowing for the introduction of new innovative models	2.9.1 Improve targeting of community campaigns through analyses that factor in ART coverage, testing coverage, prevalence, incidence, etc.	Hire a national level consultant over a 10 day period	$680	per consulting period	10	1					x		$6,800	$0	$0	$0
		Conduct 2 national level half day workshops with 30 particpants	$125	per particpant	30	1				x		x	$3,750	$0	$0	$0
	2.9.2 Scale-up implementation of evidence based community testing interventions for improved case identification of PLHIV, as well as linkages to treatment, care and support services	Already costed as part of targeted testing campaigns (activity 2.6.6.1)							x	x	x	x	$0	$0	$0	$0
	2.9.3 Develop and disseminate comprehensive community based HIV testing SOPs with clear guidelines on implementation of different community testing models, including index case testing and self-testing	Hire a national level consultant over a 10 day period	$680	per consulting period	10	1				x			$6,800	$0	$0	$0
		Conduct a national level workshop with 30 participants	$125	per participant	30	1				x			$3,750	$0	$0	$0
		printing costs	$10	per guideline printed	2,000	1			x				$20,000	$0	$0	$0
	2.9.4 The use of index case testing as a community based testing method, whilst rolling out SOPs to both facilities and communities	Index case testing already costed as part of targeted testing (activities 2.6.2.1 and 2.6.2.2). Printing of 2,000 SOPs to be costed	$10	per copy printed	2,000	1			x	x	x	x	$20,000	$0	$0	$0
		Conduct a sensitization meeting per province with 30 participants	$35	per participant	30		10			x			$10,500	$0	$0	$0
	2.9.5 Timely adoption of a national roll-out plan for HIVST that sensitizes administrators and HCWs on the testing method and it's relation to HTS service delivery models	Train 1 mentor per district on HIVST through a 2 day Harare based workshop	$250	per mentor trained	63			1	x				$15,750	$0	$0	$0
		Launch HIVST through a national level MOHCC meeting. Assume 2 people per province and 50 participants in total.	$25	per national level participant	30	1						x	$750	$0	$0	$0
			$125	per provincial level participant	20	1						x	$2,500	$0	$0	$0
Total Cost													**$12,133,724**	**$14,082,024**	**$16,164,079**	**$18,741,225**

SERVICE DELIVERY																
Strategic Objective 3: Strengthen the national human resource capacity for HIV Testing Services in line with the broader Human Resource for Health Plan																
Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
3.1 Establish universal awareness of the program, its key components and considerations through standardized integration of HTS into pre-service training	3.1.1 Review curricula for pre-service training and develop HTS modules	National level semi-annual review meetings with 50 participants over 3 days	$375	per participant	50	1			x				$37,500	$0	$0	$0
	3.1.2 Standardise HTS as a key component of pre-service training	Already costed as part of the review of pre service training and development of HTS modules (activity 3.1.1)							x							
3.2 Sustain on-going site based training and capacity building as part of in-service training for HCWs	3.2.1 Update training curricula in line with revised WHO guidelines for HTS, including guidelines for children and adolescents, as well as key and other priority populations	Hire a regional consultant over a 10 day period, as well as conduct 2 national level workshops with 50 participants. Workshops to occur over a 3 day period	$800	per day	10	1			x				$8,000	$0	$0	$0
			$375	per participant	50	1			x				$37,500	$0	$0	$0
	3.2.2 Map previous training initiatives and identify remaining capacity building gaps by district	MOHCC and partners to lead this process, no additional costs							x	x	x	x	$0	$0	$0	$0
	3.2.3 Develop training plan to address gaps, targeted at areas with low testing capacity	Hire a local consultant to develop a training plan over a 10 day period	$680	per day	10	1						x	$6,800	$0	$0	$0
	3.2.4 Roll-out self-directed training that includes all aspects of the HTS curriculum for all levels of service delivery and health facility	For start of blended learning, conference package for 2 days and 1,000 people per year will be needed. Someone to coordinate the trainings will be needed (cost of $2,000 per month). 300 tablets will be needed for blended learning.	$220	per person trained	100		10		x	x	x	x	$220,000	$220,000	$220,000	$220,000
			$2,000	per month	12	1			x	x	x	x	$24,000	$24,000	$24,000	$24,000
			$300	per tablet	300	1				x			$90,000	$0	$90,000	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
3.3 Support scale-up of additional PCs for providing testing services in the facility	3.3.1 Mobilize resources for additional recruitment and training of PCs to provide HTS	PC trainings already costed as part of rapid HIV test training (activity 2.2.1) and self-directed training on HTS (activity 3.2.4). Deploy a total of 1,500 PC's in 2017, 1800 in 2018 and 2,100 in 2019 and 2020														
		2017	$3,600	per PC salary deployed per year	1500			1	x	x	x	x	$5,400,000			
		2018	$3,600	per PC salary deployed per year	1800			1	x	x	x	x		$6,480,000		
		2019 & 2020	$3,600	per PC salary deployed per year	2,100			1	x	x	x	x			$7,560,000	$7,560,000
	3.3.2 Develop a distribution and placement plan for PCs within the system based on potential reachable population for testing	Hire a local consultant over a 5 day period	$3,400	per consulting period	1	1					x		$3,400	$0	$0	$0
	3.3.3 Revise curriculum for PC training	Hire a local consultant over a 5 day period	$3,400	per consulting period	1	1					x		$3,400	$0	$0	$0
	3.3.4 Deploy additional PCs	MOHCC and partners to lead process										x	$0	$0	$0	$0
3.4 Increase human resources for providing services at the community level	3.4.1 Review of community cadres providing health services, identification and national endorsement of appropriate cadre to provide testing services	Hire a local consultant over a 5 day period	$680	per consulting period	5	1					x		$3,400	$0	$0	$0
	3.4.2 Resource mobilization for training and maintenance of cadres to provide HTS within the community	MOHCC and partners to lead this process, semi-annual national level TWG meetings with development/funding partners. Budget lunches for 30 participants	$25	per participant	30	1				x		x	$1,500	$1,500	$1,500	$1,500
	3.4.3 Deploy additional PCs	Included as part of deployment of PC's (activity 3.3.1)							x	x	x	x	$0	$0	$0	$0
		Total Cost											**$5,835,500**	**$6,725,500**	**$7,895,500**	**$7,805,500**

DEMAND GENERATION																
Strategic Objective 4: Strengthen the demand generation for HTS based on local evidence to effectively reach out to all population groups									**Frequency per Annum**				**Annual Cost**			
Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
4.1 Ensure effective coordination of demand generation activities for HTS	4.1.1 Conduct partner mapping exercises of all HTS demand generation stakeholders	Conduct a national level half day meeting for 50 participants	$25	per participant	50	1			x				$1,250	$1,250	$1,250	$1,250
	4.1.2 Develop TORs for Demand Generation TWG	National level TWG meeting for 30 participants	$25	per participant	30	1					x		$750	$0	$0	$0
	4.1.3 Invite key representatives to establish Demand Generation TWG															
	4.1.4 Hold quarterly HTS demand generation TWG meetings, review evidence from existing strategies and provide recommendations for changes going forward	5 officials from each province to attend overnight Harare based meeting.	$125	per participant (district and provincial)	45	1			x	x	x	x	$5,625	$5,625	$5,625	$5,625
			$25	per participant (national level)	5	1			x	x	x	x	$125	$125	$125	$125
	4.1.5 Develop and cost an HTS Demand Generation Communications Plan, facilitated through the TWG	Hire national level consultant over a 10 day period	$680	per consulting period	10	1					x		$0	$6,800	$0	$0
	4.1.6 Mobilize resources and implement the HTS Demand Generation Communications Plan	Print 2,000 copies of the communications plan	$10	per copy printed	2,000	1						x	$0	$20,000	$0	$0
		Disseminate copies of the communications plan	$16	per package	2000	1						x	$32,000	$0	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
4.2 Strengthen appropriate and targeted messaging to effectively reach out to priority populations	4.2.1 Engage key and priority populations in developing targeted messaging	Conduct annual national level half day meeting with 30 participants	$25	per participant	30	1					x		$750	$750	$750	$750
		Hire a consultant to develop target messaging	$680	per consulting period	10	1					x		$0	$6,800	$0	$0
	4.2.2 Distribute messages and materials for key and priority populations to all HTS delivery points	Leave a budget to print 2,000 copies of materials	$10	per copy printed	2,000	1					x		$0	$20,000	$0	$0
	4.2.3 Involve priority and key populations in the evaluation of demand generation activities and messaging	Activity already costed as part of the engagement of key and priority populations in developing targeted messaging (activity 4.2.1)									x		$0	$0	$0	$0
	4.2.4 Utilize appropriate multi-media and Interpersonal communication channels for reaching target audiences	Cost a mass media campaign involving various forms of media.	$1,030,350	per mass media campaign involving multiple media channels	1	1			x	x	x	x	$1,030,350	$1,030,350	$1,030,350	$1,030,350
	4.2.5 Ensure that sero-discordant key and priority populations are enrolled on pre-exposure prophylaxis	Included as part of training of mentors (activity 2.9.5)							x	x	x	x	$0	$0	$0	$0
	4.2.6 Conduct continuous research of demand generation strategies that will increase testing uptake for key and priority populations	Activity already costed as part of demand generation TWG meetings (activity 4.1.4)							x	x	x	x	$0	$0	$0	$0
Total Cost													**$1,070,850**	**$1,091,700**	**$1,038,100**	**$1,038,100**

STRATEGIC INFORMATION																
Strategic objective 5: Strengthen the strategic information of HTS to provide evidence for effective decision making.									**Frequency per Annum**				**Annual Cost**			
Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
5.1 Promote data demand, dissemination and utilization at all levels	5.1.1 Conduct a needs assessment for the HTS programme (including M&E needs) across all levels and implementing partners in order to determine areas that need capacity building	Hire a national level consultant over a 10 day period	$680	per day	10	1				x			$6,800	$0	$0	$0
	5.1.2 Conduct capacity building exercises in response to the identified needs from the assessment	Already costed as part of M&E training (activity 5.3.1)							x	x	x	x				
	5.1.3 Review job descriptions of health care workers to ensure that each role has at least 5% M&E (data collection, analysis and evaluation) responsibilities in order to be able to effect adaptive changes, which will be determined by the broad HTS M&E	Conduct 1 national level meetings for 50 participants over a 3 day period	$375	per participant	50	1			x				$18,750	$0	$0	$0
	5.1.4 Analyse data at all levels for use in making management decisions and corrective measures	MOHCC to lead this process, no additional costs							x	x	x	x	$0	$0	$0	$0
	5.1.5 Conduct periodic programme reviews of performance in the form of weekly updates, project/activity review and comprehensive semi-annual review workshops (including the HTS TWG review of performance bi-annually)	Conduct semi-annual national level meetings in Harare with 30 provincial and district officials, as well as 20 national level participants. Budget to assume 2 day semi-annual review meeting	$250	per participant	30	1				x		x	$7,500	$7,500	$7,500	$7,500
			$50	per participant	20	1				x		x	$1,000	$1,000	$1,000	$1,000
	5.1.6 Improve data quality and availability	Already costed as part of periodic program reviews (activity 5.1.5)								x		x	$0	$0	$0	$0
	5.1.7 Monitor, evaluate, and communicate results of data use interventions by engaging data users and data producers in participatory M&E sessions bi-annually at all levels	Already costed as part of periodic program reviews (activity 5.1.5)								x		x	$0	$0	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
5.2 Strengthen facility (public and private) and community based HTS information management systems for robust evidence generation.	5.2.1 Sensitise and train private sector HTS providers on the national M&E system	Sensitisation training with 50 private sector officials through a 1 day workshop, budget for lunches only	$25	per participant	50	1			x				$1,250	$0	$0	$0
	5.2.2 Conduct routine HTS M&E support and supervision for facility (public and private) and community based testing	Already costed as part of support and supervision activities (activity 1.1.3.2)							x	x	x	x				
	5.2.3 Align HTS indicators and tools according to national needs and revised guidelines	Already costed as part of periodic program reviews (activity 5.1.5)								x		x	$0	$0	$0	$0
	5.2.4 Develop indicators and tools for monitoring the implementation of HTS at community level	Conduct a workshop with all partners that are involved in community interventions to come up with agreed indicators. Workshop will be a Harare based meeting, with 1 provincial and 1 district official per province, and 80 participants in total. Print 10,000 copies of the tools and indicators	$125	per participant	80	1				x			$10,000	$0	$0	$0
			$25	per participant	7	1							$175	$0	$0	$0
			$10	per copy printed	10000	1			x				$100,000	$0	$0	$0
	5.2.5 Develop and roll-out the facility based HTS ePMS, which is integrated with the deployed ART electronic patient monitoring system modules	This will require a laptop for each facility, a router, trainings as well as support and supervision visits from national to provincial level, as well as from district to facility level											$0	$0	$0	$0
		Procurement of Equipment	$550	per laptop and router procured	450			1			x		$247,500	$0	$0	$0
		Communication	$600	cost of mobile/ adsl data per facility per year	450			1			x		$270,000	$270,000	$270,000	$270,000
		Training (13,500 for 35 people per province)	$13,500	per 35 people trained	1		10				x		$135,000	$0	$0	$0
		Support and supervision of ePMS system (already costed as part of facility support and supervision in activity 1.1.3.2)										x				

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
	5.2.6 Develop an electronic community based system for reporting HIV testing services which is linked to the facility based systems	Costs Will Consist Of:											$0	$0	$0	$0
		Training Cost ($13,500 Per Province for 35 people	$13,500	per 35 people trained	1		10				x		$135,000	$0	$0	$0
		Communication	$600.00	cost of mobile/ adsl data per facility per year	450			1	x	x	x	x	$270,000	$270,000	$270,000	$270,000
		Support and supervision of ePMS system (already costed as part of facility support and supervision in activity 1.1.3.2)							x	x	x	x				
		Training for 1,000 VHW's over a 4 day period	$440	per participant	1000			1		x			$440,000	$0	$0	$0
	5.2.7 Develop a system for all implementing partners to report through the national HIS	All partners receive access to DHIS2 user rights											$0	$0	$0	$0
5.3 Strengthen the human resources capacity for M&E to enable effective data analysis to inform decision making	5.3.1 Train M&E team members at all levels of the health system to effectively carry out tasks	Train M&E team members. Assume 500 healthcare workers will be trained per annum	$385	per participant	500			1	x	x	x	x	$192,626	$192,626	$192,626	$192,626
	5.3.2 Mentorship to support M&E team members	Already costed as part of mentorship activities (activity 2.1.2)							x	x	x	x	$0	$0	$0	$0
	5.3.3 Review M&E structure at provincial level to improve coordination of M&E activities at that level	Hire a national level consultant over a 20 day period	$680	per day	20		1		x				$13,600	$0	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
5.4 Reinforce effective monitoring and evaluation of programme linkages and client tracking mechanisms to provide evidence for improving the linkages	5.4.1 Standardize tools to effectively and efficiently track clients from HIV testing through to prevention, care, treatment and support services	Revise M&E tools in 2020 after new guidelines are launched by hiring a consultant over a 10 day period	$680	per consulting period	10	1						x	$0	$0	$0	$6,800
	5.4.2 Train service providers to effectively document linkages and tracking activities	A three day annual provincial training workshop per province for 50 people	$330	per person trained	50		10				x		$165,000	$165,000	$165,000	$165,000
	5.4.3 Conduct paediatric HIV case surveillance for infants tested using DNA PCR (deoxyribonucleic acid polymerised chain reaction) to document linkage to care	Conduct operational research	$200,000	per study	1	1			x	x	x	x	$0	$200,000	$0	$200,000
	5.4.4 Revise National HIMS indicators to incorporate linkage to care indicators (Provincial M&E, as well as HIV focal person to be involved)	Conduct a national level half day TWG meeting semi-annually for 30 participants.	$25	per participant	30	1					x		$1,500	$1,500	$1,500	$1,500
5.5 Strengthen utilisation of data to make programme decisions at all levels of the health system to enable appropriate targeting of interventions	5.5.1 Conduct mentorship for data utilization at all levels	Already costed as part of mentorship activities (activity 2.1.2)							x	x	x	x	$0	$0	$0	$0
	5.5.2 Support and supervision to support facility managers to use local data for decision making	Already costed as part of M&E support and supervision (activity 5.2.2)							x	x	x	x	$0	$0	$0	$0
	5.5.3 Conduct a mid-term evaluation of performance and targets in order to assess progress based on set targets	Hire a national level consultant over a 10 day period, with a 3 day workshop to validate results. Workshop to include 20 national level participants and 4 officials per province	$680	per day	10	1				x			$0	$6,800	$0	$0
			$75	per national level participant	30	1				x			$0	$2,250	$0	$0
			$375	per provincial level participant	40	1				x			$0	$15,000	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
5.6 Strengthen M&E for HTS demand generation to produce local evidence to inform activity planning and implementation	5.6.1 Involve key stakeholders in the development of demand generation indicators and data collection tools	Already costed as part of quarterly demand generation meetings (activity 4.1.4)							x	x	x	x	$0	$0	$0	$0
	5.6.2 Identify operational research questions on demand generation	MOHCC and partners to lead this process, no additional costs							x	x	x	x	$0	$0	$0	$0
	5.6.3 Develop and cost an HTS Demand Generation Communications Strategy	Already costed as part of demand generation communications plan development (activity 4.1.5)									x		$0	$0	$0	$0
Total Cost													**$2,015,701**	**$1,131,676**	**$907,626**	**$1,114,426**

SUPPLY CHAIN MANAGEMENT																
Strategic Objective 6: Strengthen the Supply Chain Management Systems for HTS commodities to ensure their adequate availability to meet programme needs									**Frequency per Annum**				**Annual Cost**			
Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
6.1 Strengthen the HIV testing kits stock management systems to ensure adequate stocks are kept at all levels of the health system including the private sector as well as at every HIV testing entry point	6.1.1 Provide mentorship on commodity ordering and stock management processes	Already costed as part of mentorship activities (activity 2.1.2)							x	x	x	x	$0	$0	$0	$0
	6.1.2 Review and improve stock management system for HTS commodities at all levels (national, provincial, district, facility and entry point)	Hire a national level consultant over a 10 day period. Conduct 2 national level validation meetings with 30 participants.	$6,800	per consulting period	1	1			x	x	x	x	$0	$6,800	$0	$0
			$25	per participant	30	1				x		x	$0	$1,500	$0	$0
	6.1.3 Develop a transport system to redistribute HIV testing kits at district and health facility levels	Hire a national level consultant over a 10 day period. Conduct 2 provincial level validation meetings with 30 participants.	$6,800	per consulting period	1	1				x			$0	$6,800	$0	$0
			$110	per participant	30		10			x			$0	$66,000	$0	$0
	6.1.4 Include private sector consumption in forecasting and quantification for HIV testing kits and commodities	Conduct 2 national level meetings annually with 50 participants from the private sector	$25	per participant	50	1			x	x	x	x	$2,500	$2,500	$2,500	$2,500
6.2 Ensure timely access to EID testing services	6.2.1 Mobilise resources for servicing and maintaining existing EID equipment, and develop regular schedule for routine maintenance of EID equipment	Current service costs are being absorbed into the cost of the reagents, no additional cost							x	x	x	x	$0	$0	$0	$0
	6.2.2 Rollout mHealth solutions to reduce results turnaround time, including distribution of Frontline SMS phones to remote sites with difficulty in accessing GPRS/3G network and GPRS printers for results transmission to facilities with good GPRS/ 3G network reception	Distribute 100 phones and 100 SMS printers to sites per year. Include communication costs of $10 for each facility. Conduct semi-annual training workshops in each district with 30 participants	$1,785	per printer	100			1	x	x	x	x	$178,500	$178,500	$178,500	$178,500
			$50	per phone	100			1	x	x	x	x	$5,000	$5,000	$5,000	$5,000
			$10	per month for communica-tion	100			1	x	x	x	x	$12,000	$12,000	$12,000	$12,000
			$27	per participant	30			63		x		x	$51,030	$51,030	$51,030	$51,030
	6.2.3 Pilot of integrated sample transportation system	Pilot of integrated sample transportation system already in progress. Conduct 2 coordination meetings per quarter in each province, with 2 participants from each province	$110	per participant	20		10		x	x	x	x	$44,000	$44,000	$44,000	$44,000
	6.2.4 Development of sample transportation guidelines and national roll-out of integrated system	Hire a national level consultant over 20 days and print 2,000 copies of guidelines	$10	per guideline	2,000	1					x		$20,000	$0	$0	$0
			$680	per day	20	1				x			$0	$13,600	$0	$0

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
6.3 Evaluate and effectively deploy new testing technologies	6.3.1 Collaborate with Directorate of Laboratory Services (DLS) in reviewing guidelines to ensure that new equipment that is procured or donated has a service and maintenance plan	MOHCC and partners to lead this process, no additional costs							x	x	x	x				
	6.3.2 Support national review process for new HIV testing technologies and innovations in collaboration with DLS and other relevant departments	National level TWG meeting per annum with 30 participants	$25	per participant	30	1			x	x	x	x	$750	$750	$750	$750
	6.3.3 Develop POC placement plan and deployment strategies that complement existing equipment and adequately addresses the testing needs in areas with high volumes of exposed infants	MOHCC and PMTCT to lead this process, no additional costs								x	x		$0	$0	$0	$0
	6.3.4 Develop mechanisms for integrating POC reporting into regular M&E health information systems	Conduct 1 training workshop per province with 30 participants	$110	per participant	30		10			x			$0	$33,000	$0	$0
	6.3.5 EID:												$0	$0	$0	$0
	6.3.5.1 Site mapping (hard-to-reach; high volumes) where ordinarily EID is not accessible	MOHCC, PMTCT, SI to lead this process, no additional costs								x			$0	$0	$0	$0
	6.3.5.2 Increase number of sites with access to EID testing services from 1,400 to 1,800	Procure 3 additional POC devices per year	$23,800	per device	3			1	x	x	x	x	$71,400	$71,400	$71,400	$71,400
	6.3.6 HIV Self-Testing (HIVST):												$0	$0	$0	$0
	6.3.6.1 Collation and analysis of evidence generated from the on-going HIVST and other projects to inform national scale up	2 national level TWG meetings per annum with 30 participants	$25	per participant	30	1			x	x	x	x	$1,500	$1,500	$1,500	$1,500
	6.3.6.2 Rapid development of evidence based roll out plans for new initiatives and approaches for HTS beginning with HIVST	Included in analysis of HIVST and other projects costs (activity 6.3.6.1)	$25	per participant	30	1			x	x	x	x	$0	$0	$0	$0
Total Cost													**$386,680**	**$494,380**	**$366,680**	**$366,680**

QUALITY ASSURANCE																
Strategic Objective 7: Strengthen the quality assurance for HIV testing to minimise the risk of HIV misdiagnosis									**Frequency per Annum**				**Annual Cost**			
Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
7.1 Ensure quality of HIV test kits and reagents	7.1.1 Scale up the current HIV dried tube specimens EQA programme to all testing facilities and testing sites	MOHCC and NMRL to lead this process; additional costs will arise from the costs of ensuring that all facilities that did not have the service have adequate equipment and commodities for the service provision							x	x	x	x	$0	$0	$0	$0
	7.1.2 Strengthen the programme for lot/ batch testing of HIV testing kits before shipment to the testing sites once shipped into the country	2 national level half day coordination meetings per annum with 30 participants	$25	per participant	30	1				x		x	$1,500	$1,500	$1,500	$1,500
	7.1.3 Conduct post-market surveillance when kits are being used in the field	MOHCC and NMRL to lead this process, one 5 day provincial visit per annum for 3 people	$550	per person	3		1				x		$1,650	$1,650	$1,650	$1,650

Strategy	Activities	Budget Assumptions	Unit Cost	Unit	Qy	National	Province	District	Q1	Q2	Q3	Q4	2017	2018	2019	2020
7.2 Ensure that HTS is being conducted efficiently, with adherence to quality control at all testing sites	7.2.1 Perform quarterly lab scientist visits to testing facilities	Quarterly visits at all levels (national to provincial, provincial to district, district to facility) 5 national, 5 provincial, 6 district officials. Monthly visits for districts (go and come back same day), provincial 5 days, national 5 days											$0	$0	$0	$0
		National to Provincial	$550	per person	5		1		x	x	x	x	$11,000	$11,000	$11,000	$11,000
		Provincial to District	$375	per person	6			1	x	x	x	x	$9,000	$9,000	$9,000	$9,000
		District to Facility	$85	per person	6			1	x	x	x	x	$2,040	$2,040	$2,040	$2,040
	7.2.2 Share performance reports for IQC and EQA in order to track performance and address site challenges	Prepare and distribute samples for IQC to all facilities and testing sites utilising the available sample transportation system (no additional cost)							x	x	x	x				
	7.2.3 Establish an EQA committee at the district and provincial levels to track IQC and EQA performance. Committee members must include lab staff and nurse supervisors	MOHCC to lead this process, committees meet once per month at district level and quarterly at provincial level. 10 people per provincial committee and 10 people per district committee	$20	per person	10		1		x	x	x	x	$800	$800	$800	$800
			$17	per person	10			63	x	x	x	x	$128,520	$128,520	$128,520	$128,520
Total Cost													**$154,510**	**$154,510**	**$154,510**	**$154,510**

Annex 3: Testing coverage targets for adult, adolescent and paediatric entry points

	2017	2018	2019	2020
Adults and Adolescents				
TB	85%	90%	90%	95%
ANC/PMTCT	99%	99%	99%	99%
STI	80%	85%	90%	95%
VMMC	99%	99%	99%	99%
Family Planning	10%	10%	10%	20%
Inpatient Ward	50%	70%	80%	95%
Index Female Partner Testing (facility-based)	10%	10%	10%	15%
Index Male Partner Testing (facility-based)	5%	5%	5%	10%
OPD	15%	15%	15%	15%
VCT	4%	4%	4%	4%
Index Female Partner Testing (community-based)	30%	50%	50%	50%
Index Male Partner Testing (community-based)	30%	50%	50%	50%
Sex Workers	40%	60%	60%	60%
Prisoners	15%	15%	30%	30%
Workplace	1%	1%	1%	1%
Campaigns	3%	3%	3%	3%
Self-testing	3%	3%	7%	10%
Paediatrics				
EID through PMTCT	85%	90%	90%	95%
OPD Rapid testing	10%	15%	15%	15%
In patient	50%	80%	85%	90%
Growth	50%	80%	85%	90%
Malnutrition	50%	80%	85%	90%
PITC - Index testing	20%	25%	25%	30%
PITC - EPI	40%	70%	70%	80%
HTS campaigns for children/adolescents	1%	1%	1%	1%
TB	70%	80%	90%	95%

Footnote references

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