This factsheet provides answers to FAQs documented during Learning Phase implementation of Treat All in 8 Districts of Zimbabwe. This FAQ is intended to support Ministry of Health and Child Care health managers and facility-based health care workers to optimise further roll-out of Treat All in Zimbabwe.

Q: WHAT is ‘Treat All’? What makes ‘Treat All’ different from previous guidelines?
A. ‘Treat All’ is a recommendation from the most recent WHO 2015 Guidelines that promotes an HIV test and treat approach. ‘Treat All’ means that all people who test positive for HIV are now eligible for Antiretroviral Therapy (ART), regardless of CD4 lymphocyte count or WHO clinical stage. Treat All is an important policy change for the country as it will increase the number of people living with HIV who are initiated on treatment earlier and will help achieve the nation’s 90-90-90 goals.

Q: WHO should start ART under Treat All?
A. Treat All applies to all HIV positive clients – infants, children, adolescents, women and men. Remember that Treat All applies both to those who tested HIV positive in the past, and those newly testing HIV positive.

New positives: All clients testing HIV positive should be initiated on ART.

Pre-ART mop up: All HIV positive clients that previously tested positive but were not eligible for ART under previous guidelines (CD4>500) should now be returned to care and initiated on ART.

Q: WHEN to start ART: Does Treat All mean all clients testing HIV positive should be initiated on the same day as diagnosis?
A. HIV-positive clients should be initiated on ART once they have received the recommended counselling sessions and have been assessed as ready to start by a health care worker. This may mean they are initiated on the same day, however some clients may take longer (up to 7 days). The benefit of Treat All is that clients are initiated on treatment as early as possible.

Q: WHY should ‘healthy clients’ now be initiated on ART when previous guidelines emphasised ART should only be for those ‘clinically eligible’? How do I explain this to clients?
A. Since the 2013 guidelines, research evidence has shown the benefits of early ART initiation when CD4 is greater than 500. HIV-related illness and risk of HIV transmission reduce when PLHIV start ART early. We now know that early HIV treatment through Treat All is important for increasing quality of life and health of PLHIV. Early HIV treatment also has benefits of preventing new HIV infections; known as Treatment as Prevention (TasP).
It is important for clients to understand that the benefits of early treatment can only be maintained through long term adherence and retention.

Q: **How: Does baseline CD4 count still need to be done for patients prior to ART initiation under Treat All?**

A. With the ministry rolling out of routine viral load testing as a preferred method for effective treatment monitoring, baseline CD4 count assessment will remain relevant particularly for stratifying newly diagnosed HIV positive clients who may need to be considered for cryptococcal infection screening, prophylaxis and/or treatment and also for continued monitoring of clients on ART together with clinical monitoring in areas where viral load is not accessible.

Q: **How: Does pre-ART counselling change with Treat All? What is the minimum standard?**

A. All clients should continue to receive the recommended pre-ART counselling prior to initiation as recommended in the Ministry of Health and Child Care *Operational and Service Delivery Manual for the Prevention, Care and Treatment of HIV in Zimbabwe*. These guidelines emphasise that patient readiness is the most important factor in determining if a patient should be initiated on ART. Adherence counselling after ART initiation should be on-going in order to improve treatment outcomes.

Patients have the choice to refuse to start ART if they are not ready and should be provided with additional counselling. It is important that all refusals are clearly documented in the ‘Reason for not starting ART’ column of the pre-ART register. A patient who is adequately prepared for ART through counselling and support will likely be ready and accept ART.

Q: **How: People at my facility are concerned that as more and more people access ART, ARV stocks will run out. How can this be avoided?**

A. **National level:** In August 2016, the Ministry of Health and Child Care conducted a quantification exercise to estimate the amount of resources needed for implementing Treat All. Resources are being mobilized through Global Fund and other funding partners; however there is a need to mobilise resources domestically for long-term sustainability. Resources from the AIDS levy will be used to cover some of the funding gaps that might arise.

**Facility level:** Before starting to implement Treat All, it is important for all health facilities to complete a site preparedness checklist which includes taking an inventory of current ARV stocks. All facilities should contact their District Pharmacy Manager to be aware of standard operating procedures for placing timely orders and where their Emergency Order Point (EOP) is in case of stock-outs.

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**Treat All Site Preparedness Checklist**

All health facilities should ensure the following:

- **All** staff on site (clinical and non-clinical) are aware of Treat All and correct any myths or misconceptions
- Work with Health Centre Committees and local leaders to increase awareness about Treat All and generate demand for HIV testing & services
- Ensure minimum stocks for all ART commodities
  - HIV test kits
  - First and second line ARVs
  - CD4 testing commodities (EDT tubes, cartridges)
  - Viral load monitoring commodities
- Identify and problem solve barriers to providing HIV testing for all clients with unknown HIV status at your health facility
- Ensure standard operating procedures for linking all clients testing HIV positive to care and treatment
- Contact patients in pre-ART register with no documented ART initiation for return to care and offer ART
- Ensure standard procedures for consistent, accurate and complete documentation of patient information including:
  - Contact details for follow-up
  - Entry point for HIV testing
  - Reason for ART initiation as ‘Treat All’
  - Referrals and outcomes of referrals
  - Side Effects
- Standard procedures for identifying patients defaulting from care and systems for patient follow-up
- Commitment and motivation to provide high quality HIV services for ALL clients regardless of age, sex or background – be sensitive to the needs of key populations in your area

For more information contact your District or Provincial Health Offices or OPHID Trust offices at 04-252772 or 04-700607
Visit OPHID’s website: http://ophid.co.zw/
Treat All Toolkit Annex II:

Treat All Site Preparedness Bottleneck Analysis Checklist

This checklist for use in Tool 2: Site Preparedness is intended to support health facility-level operational and service bottleneck analysis to identify barriers to optimal implementation of quality HIV testing, care and Treatment services under Treat All.

<table>
<thead>
<tr>
<th>Bottleneck question</th>
<th>Yes: Complete</th>
<th>No: Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Staff Composition for HIV Testing and ART initiation:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you know how many staff at your facility are trained in HIV testing and ART initiation?</td>
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<td></td>
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<tr>
<td>Is everyone trained providing these services?</td>
<td></td>
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<tr>
<td>Is there someone on duty capable of providing HIV tests and conducting ART initiations at all times of day?</td>
<td></td>
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</tr>
<tr>
<td><strong>2. Increasing HIV Test Rates &amp; Yields:</strong></td>
<td></td>
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<tr>
<td>Are systems in place to identify and document all clients with unknown HIV status seeking care from your facility for HIV testing?</td>
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</tr>
<tr>
<td>Are all clients with unknown HIV status accessing care at your facility offered HIV testing?</td>
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<tr>
<td>Is HIV testing conducted at multiple entry points?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is index-based contacting and testing being done at your health facility?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is HIV testing available at all times of day in your health facility?</td>
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</tr>
<tr>
<td>Are there key populations or particular groups in your community that may have difficulty accessing HIV testing, care and treatment services at your facility? If so, does this facility have targeted services/outreach to meet their needs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*See Tool 4: HIV Testing Services for tips to optimize HIV testing services under Treat All</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Documented linkage of all clients testing HIV positive to care and treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are all health care workers familiar with Standard Operating Procedures (SOPs) for documenting client information?</td>
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<tr>
<td>Are contact details for clients filled in accurately and completely enough to enable tracing if a client defaults from care (check HTS, ART registers &amp; Green Books)?</td>
<td></td>
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</tr>
<tr>
<td>Are all transfers and outcomes of clients recorded?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*See Tool 9 for tips on documenting and reporting client information under Treat All</td>
<td></td>
<td></td>
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<tr>
<td>4. ART initiation for all clients testing HIV positive</td>
<td></td>
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<td>-----------------------------------------------------</td>
<td></td>
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</tr>
<tr>
<td>Do all clients testing HIV positive at your facility have documented ART initiation?</td>
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<tr>
<td>Do clients that are not initiated on ART have documented reasons?</td>
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<tr>
<td>Are HIV positive clients previously ineligible for treatment being called back to care for ART initiation (pre-ART mop up?)</td>
<td></td>
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<tr>
<td>*See Tool 6: ART initiation.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Retaining clients in HIV care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are clients receiving ART counselling as recommended in the OSDM prior to initiation?</td>
</tr>
<tr>
<td>Are client preparedness efforts underway – are all clients aware of their next appointment and setting treatment goals?</td>
</tr>
<tr>
<td>Are differentiated models of care being provided to stable clients?</td>
</tr>
<tr>
<td>Is there an emphasis on client-centred care and linking clients to community-based support?</td>
</tr>
<tr>
<td>*See Tool 5: ART counselling and Client Preparedness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Identifying defaulters and returning them to care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are SOPs in place to regularly review registers/use Electronic Client Monitoring System (EPMS) reports to identify clients with missed appointments?</td>
</tr>
<tr>
<td>Are all clients in need of a Viral Load test identified?</td>
</tr>
<tr>
<td>Are systems in place for notifying community-based partners (VHWs or other CBOs) to conduct physical tracing of clients lost to follow up (and tracing outcomes recorded)?</td>
</tr>
<tr>
<td>*See Tool 7: Adherence and Retention</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Ensuring stocks of ART commodities for Treat All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are stock cards for all HIV and ART commodities (test kits, cotrimoxazole, ARVs, reagents, EDT tubes etc) completed and up-to-date?</td>
</tr>
<tr>
<td>Do health care workers at your facility know how to calculate minimum stocks?</td>
</tr>
<tr>
<td>Do health care workers know procedures for placing orders from Emergency Order Points?</td>
</tr>
<tr>
<td>Are the reasons for recent stock outs known and have measures been put in place to ensure no future stock outs?</td>
</tr>
<tr>
<td>Are documents available &amp; health care workers at familiar with the SOPs provided in the following documents?</td>
</tr>
<tr>
<td>2. Standard Operating Procedures Manual for the Zimbabwe ART Distribution System (ZADS)</td>
</tr>
</tbody>
</table>

Action plans should be developed to act on any items marked ‘no’ on this checklist. See Annex III.
Treat All Toolkit Annex IIIa

Treat All 7 Point Site Action Plan: FACILITY COPY

Complete this Action Plan to act upon barriers identified through use of the Treat All Bottleneck Analysis Checklist in Tool 2: Site Preparedness (Annex II).

It is recommended that two copies of this Action Plan be completed – one for storing at District-level and one for storing at Facility Level to enable ownership and outcome documentation of planned actions.

<table>
<thead>
<tr>
<th>1 Staff Composition for HIV Testing and ART Initiation</th>
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<tbody>
<tr>
<td>Barrier(s) identified:</td>
<td>Actions that can be taken immediately:</td>
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<thead>
<tr>
<th>2 Increasing HIV Test Rates &amp; Yields</th>
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<tbody>
<tr>
<td>Barrier(s) identified:</td>
<td>Actions that can be taken immediately:</td>
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<tr>
<th>3 Documented linkage of all patients testing HIV positive to care and treatment</th>
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<tbody>
<tr>
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<td><strong>Barrier(s) identified:</strong></td>
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<tr>
<th></th>
<th>Retaining Patients in Care</th>
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<tr>
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<td><strong>Barrier(s) identified:</strong></td>
<td><strong>Actions that can be taken immediately:</strong></td>
<td><strong>Actions that will require additional resources/time:</strong></td>
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Treat All Toolkit Annex IIIb:
Treat All 7 Point Site Action Plan: DISTRICT COPY

Complete this Action Plan to act upon barriers identified through use of the Treat All Bottleneck Analysis Checklist in Tool 2: Site Preparedness (Annex II).

It is recommended that two copies of this Action Plan be completed – one for storing at District-level and one for storing at Facility Level to enable ownership and outcome documentation of planned actions.

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<tr>
<td>Actions that will require additional resources/time: (by what date)</td>
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<td>Action taken: (date actioned)</td>
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<tr>
<td>4 ART initiation for all patients testing HIV positive</td>
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<td>------------------------------------------------------</td>
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<tr>
<td><strong>Barrier(s) identified:</strong></td>
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<tr>
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<td></td>
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<tr>
<td>6 Identifying Defaulters and Returning them to Care</td>
</tr>
<tr>
<td><strong>Barrier(s) identified:</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>7 Ensuring Stocks of all ART Commodities for Treat All</td>
</tr>
<tr>
<td><strong>Barrier(s) identified:</strong></td>
</tr>
</tbody>
</table>
Annex IV: Treat All Communication Materials

The following Information, Education and Communication (IEC) Materials were developed by OPHID to support community sensitization and client awareness of the shift to Treat All in Zimbabwe. If you would like to adapt these materials to your country or community setting and would like original copies, please email us at:

I. PATIENT PALM CARD

*Getting into care and on treatment has helped us learn more about HIV and how to live well with the virus. This has not only helped us live longer, but gave us an opportunity to live a healthier life.*

Ishamael and Patricia Mupesa

**Front of card**

**Back of card**

Visit your nearest clinic/hospital for more information and services.
II. TREAT ALL BANNER

For display at road shows, facility and community Treat All sensitization events

III. TREAT ALL TSHIRT DESIGN – SHONA & NDEBELE LANGUAGE

Shona Treat All Tshirt

T-shirts are an excellent way to raise visibility within communities during and after sensitization events.

Ndebele Treat All TShirt

Messages are most effective if translated into the predominant local language.
Meeting objectives

- To sensitise district stakeholders and community leadership on the Treat All initiative.

- To communicate Treat All key messages to the district stakeholders and community leadership and garner support for message dissemination to communities.
### Meeting Agenda

<table>
<thead>
<tr>
<th>Duration</th>
<th>Activity</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Arrival and Registration</td>
<td>FACE Partner District staff</td>
</tr>
<tr>
<td>5mings</td>
<td>Introductions</td>
<td>District HPO</td>
</tr>
<tr>
<td>5mins</td>
<td>Welcome remarks</td>
<td>DA/DHPO/designate</td>
</tr>
<tr>
<td>5 mins</td>
<td>Introducing FACE HIV program</td>
<td>FACE Partner Provincial Coordinator/designate</td>
</tr>
<tr>
<td>30 mins</td>
<td>Overview of Treat all, target group, key messages</td>
<td>FACE Partner Provincial Coordinator/designate</td>
</tr>
<tr>
<td>20 mins</td>
<td>Discussion in plenary: Questions, clarifications, concerns</td>
<td>DHPO/DAC</td>
</tr>
<tr>
<td>10 mins</td>
<td>Way forward</td>
<td>DHPO</td>
</tr>
</tbody>
</table>

### Introduction: Who are we?
- The Organization for Public Health Interventions and Development (OPHID) is a local organisation committed to developing, implementing and assessing innovative approaches and strategies to strengthen Maternal, Newborn and Child Health (MNCH) services in Zimbabwe and providing enhanced access for communities to comprehensive HIV prevention and care.
- FACE HIV Consortium: 3 partners (OPHID, KAPNEK and ZAPPT), collaborating with MOHCC supporting provision of quality PMTCT, TB and HIV care and treatment programs in 22 priority districts, covering 338 sites.
- Funding from PEPFAR, through USAID.

### What we do:
- The FACE HIV care and treatment program supports the MOHCC AIDS and TB program in its commitment to achieve the ambitious Global Treatment targets to have: 90% of PLHIV know their HIV status,
- 90% of people diagnosed and access treatment and 90% to achieve viral suppression by 2020.

### Background: WHO 2013 Guidelines

**Recommend starting ART based on clinical and/or immunological status**
- CD4 count < 500 and/or
- WHO Clinical stage 3 and 4
- Pregnant and breastfeeding women and children < 5 years are started ART regardless of clinical status and CD4 count.

### WHO 2015 Guidelines
- Launched at ICASA in Zimbabwe (December 2015)
- Recommends “Treat All” or “Test and Treat” approach
- Earlier treatment has better long-term results
- Everyone who tests HIV positive is now being recommended to be started on ART. (When the client is ready)

### MOHCC to Roll Out Treat All
- MOHCC has held stakeholder meetings to adapt new guidelines.
• OPHID is supporting MOHCC to pilot the Treat All approach in 7 districts - Manicaland- 4 districts (Mutare, Mutasa, Makoni and Chipinge) and Mat South (Gwanda, Bullima and Mangwe).
• Information from these districts will inform the national roll-out.

**Treat All is about:**

1. Testing and identifying HIV positives
2. Initiating newly diagnosed on ART
3. Bringing back to care and initiating Pre-ART Clients on ART
4. Providing ongoing care, treatment adherence support.

**Key Actions**

<table>
<thead>
<tr>
<th>Target</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>People of unknown Status</td>
<td>Mobilise everyone to know their status (positive or negative)</td>
</tr>
<tr>
<td>Newly identified/diagnosed as HIV positive</td>
<td>Provide counselling and initiate on treatment</td>
</tr>
<tr>
<td></td>
<td>Encourage family (partner and children) to be tested (index testing)</td>
</tr>
<tr>
<td>HIV positive and taking CTX-not yet started on ARVs</td>
<td>Call back immediately to facility to be counselled and initiated on treatment</td>
</tr>
<tr>
<td>HIV positive and never on CTX or ARVs</td>
<td>Call back immediately to facility to be counselled and initiated on treatment</td>
</tr>
<tr>
<td>HIV positive clients on treatment</td>
<td>Retain clients in care- provide ongoing counselling and support. Link from facility to community based support services.</td>
</tr>
</tbody>
</table>

**Treat All Campaign Slogan**


**Key messages**
HIV Treatment is now available for everyone who is HIV positive. Get On. Stay On. Live On.
- There is no more waiting period to get on HIV treatment if clients are ready to start.
- 

**Take Action Now:**
- Know your HIV status-get tested for HIV today.
- If HIV negative-learn about prevention strategies to suit your lifestyle
- If HIV positive, get on treatment early
- If Living with HIV and not yet on treatment-visit your nearest clinic/hospital.

**Stay on treatment**
• Always take your ARVs at the right time in the right dose.
• Keep all clinic appointments even when you are feeling well

Live On
• Healthy diet, healthy living, healthy mind will help PLHIV live healthy lives.

Focus on Priority Groups

While everyone who is HIV positive needs to be put on ART, we note that the following groups need an extra awareness to get tested and get on treatment

Men: men aged 24-50+ are at high risk of getting HIV.
• Yet they do not frequently visit clinics for testing or regular health checks.
• Many men come to the clinic when they are very sick.

Adolescents and young people
• Adolescents and Young people are at higher risk of acquiring HIV (intergenerational sex being one of the main drivers of HIV among young women)
• Stigma associated with HIV is such that people, especially young people living with the virus are reluctant to disclose their status even to their immediate family. For adolescents, this can result in isolation and loneliness, which makes it difficult to access care, treatment and support services available to them.

Children below 16 years
• Parental consent is required for children below 16 years to be tested for HIV.
• Early access to HIV treatment for children is important to ensure a healthy future for this generation.

Community Leadership Role

We need your support to:
• Spread the Treat All message to your constituencies.
• Mobilise your constituencies and communities for uptake of HIV testing and treatment services: All clinics and hospital in your areas now offer HIV testing and Treatment services to everyone. Encourage your communities to go for HIV testing and counselling at the clinics and in your communities in order to access HIV treatment.
• Come up with and support initiatives that show leadership support towards HIV testing, care and treatment services. These may include initiatives that uphold the rights of girls and young women, Orphans and Vulnerable children (DREAMS) as well as marginalised groups such as women and people living with disabilities.
• Improve adherence and retention of PLHIV in Care: Getting on ART is a lifelong commitment. ARVs are not a cure for HIV but they work to suppress the virus in the body. Adherence therefore means always taking ARVs at the right time, right dose. We need your support to emphasise this message to the community.
• Protect and support PLHIV through fighting stigma and discrimination against PLHIV and dealing with any harmful practices that can fuel the spread of HIV.

Discussion in plenary
• In your different roles, suggest how you are going to spread the message about Treat All to your constituencies.
• What are some of the barriers you are likely to face and how are you planning to get around them?
• Are there any concerns/areas that you need more clarification on?
• Is there anything else you would want to know about Treat All program.

Way forward
• Ask participants to come up with a meeting ‘declaration’ on taking Treat All Initiative to the community, clearly outlining the next steps.
Q: WHY is HIV retesting before ART initiation being recommended?

A. Recent reports of HIV status misclassification, with both false positive and false negative results have raised concerns that some individuals might be started on ART inappropriately. Zimbabwe has adopted the WHO 2015 guideline to retest all persons newly diagnosed as HIV positive, with a second specimen before ART initiation, to rule out potential misdiagnosis.

Q: WHAT is the magnitude of HIV status misclassification in Zimbabwe?

A. There is growing evidence that HIV rapid tests /algorithms provide incorrect results to many individuals tested in routine programmes. Globally, misclassification is about 0.2 - 10.5%. The Zimbabwe 2012 ANC surveillance survey found that routine PMTCT testing gave incorrect results as below:

- 8.8% of clients testing HIV positive were eventually confirmed as HIV negative
- 1.3% of clients testing HIV negative were eventually confirmed as HIV positive

Common sources of errors include: technical errors, mislabelling, poor record keeping, user errors, clerical errors, cross reactivity, incorrect or suboptimal testing algorithm, and lack of training.

Q: IS the recommendation for HIV retesting indicating a lack of capacity within our health system?

A. Misdiagnosis arises from various technical or clerical errors, including specimen mix-up through mislabelling and transcription errors, as well as random error either by the provider or of the test device. It does not necessarily mean that the test kits are of poor quality or that they have not been stored properly neither does it mean that health care providers are not competent enough. However, care should be taken to ensure that the integrity of test kits is maintained during transportation and storage. In addition, service providers should exercise extreme care when conducting HIV testing to minimise human error.

HIV retesting is not about confidence in the system, but it is about ensuring the right quality care is offered to our clients. Everything done by a human being is prone to error and HIV retesting reduces the chance of issuing incorrect HIV test results.

Q. HOW long after the first test is retesting done?

A. For newly diagnosed HIV positive clients, retesting can be done within a few (1 – 4) hours of the first test. Newly diagnosed HIV positive clients would be provided post-test counselling and linked to the health care provider who will initiate them on treatment. The retest should be conducted by a different provider. A new sample would be collected and tested using the same testing algorithm. World Health Organisation recommends that clients with HIV-inconclusive status (i.e. first test and retest results are discordant) be retested in 14 days.
Q. WHAT happens if there is only one nurse on duty and the other is away on leave? Is it not going to lead to delays in ART initiation?

A. If only one nurse is available at the facility, the nurse can retest the client using a new sample taken a few hours apart from the first sample. Absence of a second provider should not delay ART initiation.

Q. WHAT happens to all the clients currently on ART who were initiated without a retest? Are we going to retest all clients initiated on ART without a retest?

A. Clients started ART without retesting are NOT going to be retested as the presence of ARVs adversely affects the sensitivity of the test kits. ART suppresses viral replication which may extend to suppression of the immune response thus reducing HIV antibody production. This may result in negative results in clients who are HIV positive but on ART. Retesting is therefore not recommended for individuals on ART.

Q. ARE THERE enough resources for retesting given that sites have experienced stock outs of HIV test kits before?

A. The resources for HIV retesting are available; the Ministry of Health and Child Care embarked on a quantification exercise to ascertain the needs. In the long run, it is more expensive to falsely treat someone than it is to retest. HIV Test kits cost approximately USD $0.50 per single test, whereas full year treatment is USD $90-$120 not considering the cost incurred by the patient to access HIV treatment.

Q: WHAT do you say to a client who had a positive result, and then upon retest records negative result?

A. The client should be informed that their results are discordant, and that there is need to conduct a third tie-breaker test. The tie-breaker is to be conducted after 14 days at the same health facility using the same algorithm. If the result of the tie-breaker is negative, then the final result is issued as negative. If the result is positive, then the result is positive.

Q. DO our laboratories have the capacity to perform tie-breaker tests like Western Blot or DNA-PCR?

A. At this stage there is no need for using Western Blot as the tie-breaker. In cases where a tie-breaker test is needed, the client can be asked to return after 14 days for retesting using a third specimen and same tests.

Q. WHY NOT give the client a HIV result after the retest?

A. HIV retesting before ART is a quality assurance and quality improvement strategy. Only a small proportion of patients are expected to be issued an initial false positive or negative result. For this reason, the initial result has to be issued and a retest be conducted at the point of ART initiation.

Q. WILL retesting make clients lose confidence in the service provider?

A. Service providers should explain clearly to the clients the reason and value for retesting so as to instil confidence in the health system and HIV results being given. Clients should be told about HIV retesting during pre- and post-test counselling. Health care workers and counsellors should emphasise that HIV retesting is a way to reduce human error and avoid starting ART clients who do not need it. If errors are not avoided, HIV services will be expensive for both the clients and health delivery system. It will be important for the MOHCC and its partners to develop a communication strategy on HIV retesting.

Key Messages about HIV Retesting

1. A misdiagnosis, irrespective of its scale, is serious for the client, the health care provider and the health system as a whole.
2. Any incorrect diagnosis, whether a false-positive or a false-negative can have severe personal and public health consequences.
3. Retesting ensures that individuals are not needlessly placed on life-long ART (with potential side-effects, waste of resources, and psychological impact of misdiagnosis).
Provider Initiated Testing and Counselling (PITC) Implementation Guide

Providing HIV Testing Services (HTS) is the 1st critical step in addressing the continuum of HIV care and treatment. UNAIDS 90-90-90 targets (Fig. 1) also adopted by the Ministry of Health and Child Care, towards seeing the end of the AIDS epidemic underscore the importance of strengthening access to HTS.

The targets also demand effective linkages to treatment and care for all people diagnosed with HIV. In order to achieve the 1st 90, HTS must be provided to every client in contact with a health care facility. Figure 1: UNAIDS triple 90 targets

Every patient contact represents an opportunity to diagnose HIV.

Provider Initiated Testing and Counselling (PITC):

PITC services with an opt-out strategy should be provided to all adults, adolescent and children attending all health facilities as the recommended "standard of care". All HIV Testing Services in Zimbabwe should be conducted in accordance with the best interest of the client (child, adolescent or adult). HIV testing should never be coercive or mandatory, except in unique situations such as court orders.

PITC definition: refers to HTS that are routinely offered by health care providers to persons attending health care facilities as a standard component of medical care. PITC should be implemented at all entry points as indicated in table 1 below.

Table 1: PITC entry points and required documents

<table>
<thead>
<tr>
<th>Multiple Entry Points – PITC should be provided at ALL entry points within the health facility i.e.</th>
<th>The following documents should be kept at every entry point/department that is offering HTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ANC Clinic</td>
<td>HTC register</td>
</tr>
<tr>
<td>2. TB clinic</td>
<td>HIV rapid test request form</td>
</tr>
<tr>
<td>3. Outpatient and casualty department</td>
<td>HIV rapid test algorithms</td>
</tr>
<tr>
<td>4. Medical and surgical wards</td>
<td>Counselling register</td>
</tr>
<tr>
<td>5. OI/ART Clinic (adults and pediatric)</td>
<td></td>
</tr>
<tr>
<td>6. STI Clinic</td>
<td></td>
</tr>
<tr>
<td>7. Pediatric malnutrition clinic</td>
<td></td>
</tr>
<tr>
<td>8. Immunisation clinic</td>
<td></td>
</tr>
</tbody>
</table>

Advantages of PITC:

| Eliminates lengthy pre-test counselling | Eliminates written informed consent form |
| Normalizes HIV testing, reducing stigma | Removes client’s personal HTC motivation |
| Reduces missed opportunities for HTC    |                                           |

In partnership with:
How to practice Provider Initiated Testing and Counselling (PITC)

Pre-test information on HIV should be given as a group or individually after which the individual can decide whether to proceed or opt out of HIV testing. Group counselling session can be provided in the morning, and repeat mid-morning and afternoon for latecomers. Individual counselling can be provided preferably before and during patient consultation. Clients who opt out following group education should be further followed up with individual counselling in the consultation room. This is done to know and address the potential barriers to HIV testing and improve service delivery.

**HIV testing** is to be conducted using the MOHCC serial HIV testing algorithm. HIV testing is guided by 6 core principles (6Cs): Consent, Confidentiality, Counselling, Comfort for the woman in labour, Correct results and Connection-linkage to care and prevention services.

**Minimum requirements:** In general HIV testing sites should be clean, organized, well lit, and well ventilated with an environmental temperature that does not exceed that required by the test kits. The testing area should offer privacy and have the following equipment:

<table>
<thead>
<tr>
<th>Furniture: a table and 3 chairs</th>
<th>Test kits according to approved algorithm</th>
<th>Running water, wash-basin, soap and disposal towels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lockable cupboard</td>
<td>HIV Testing SOPs and algorithms</td>
<td>Disinfectant</td>
</tr>
<tr>
<td>Refrigerator or cooler box with ice (for storage of controls)</td>
<td>Gloves, cotton wool, methylated spirit/alcohol swabs</td>
<td>Blood collection tubes, lancets, tourniquet, vacutainer syringes</td>
</tr>
<tr>
<td>Functional First Aid Kit</td>
<td>Sharps containers and lined bins</td>
<td>PEP medication and SOP</td>
</tr>
</tbody>
</table>

- Absence of any of the requirements above does not justify stopping offering HTS; efforts should be made to ensure their availability by working closely with hospital management.

To ensure PITC is being done as expected the following columns should be added in the OPD register. These columns will help identification of patients eligible for a HIV test so that it can be done.

<table>
<thead>
<tr>
<th>HIV Status at presentation</th>
<th>If unknown, offer a HTS using PITC. HTS result 0, 1 OR opted out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown, 0 OR 1</td>
<td></td>
</tr>
</tbody>
</table>

Ideally if the client accepts the offer of a HTS, the testing should be conducted within the same department that has offered the test to reduce missed opportunities.

For more information on HTS contact MOHCC and/or FACE HIV Consortium partners (OPHID, KAPNEK, ZAPP) in your district.
Viral Load Monitoring Job Aide

All clients on antiretroviral therapy are expected to have routine viral load monitoring done according to the Ministry of Health and Child Care guidelines. Viral load is the gold standard for monitoring patients on ART because it is specific for the HIV virus unlike CD4 count which can be influence by other factors. VL is the best and to the earliest indicator for treatment success and treatment failure. The purpose of this job aide is to help health workers in patient and file management based on viral load results.

The colour of the sticker is dependent on the viral load result. Each sticker is to be placed on the patient’s OI/ART green booklet.

<table>
<thead>
<tr>
<th>Viral Load range</th>
<th>Sticker colour</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 999 copies/ml</td>
<td>Green</td>
</tr>
<tr>
<td>&gt;1000 copies/ml</td>
<td>Orange</td>
</tr>
</tbody>
</table>

Every pediatric should have a yellow sticker stuck on patient OI/ART file for easy identification

| Pediatric | Yellow |

Viral load result interpretation

1. **0 – 999 copies/ml**
   - SUPPRESSED viral load, good result
   - PATIENT IS TAKING MEDICATION WELL!
   - The virus is susceptible to the current ART regimen
   - Congratulate patient; Patient continues current medication

Please note **Target Not Detected/undetectable (TND) – means the level of HIV is too low to be measured** but does not mean that HIV has disappeared completely from your body! HIV is still present but in amounts too low to be measured or HIV is hiding in “sanctuary sites” like the cerebrospinal fluid or brain. VL tests only measure levels of HIV in the blood and not measure virus in the brain, genital fluids, gut or lymph nodes.

2. **>1000 copies/ml**
   - UNSUPPRESSED viral Load
   - Virus not suppressed by the current medication; why?
     - Poor adherence; low blood levels of ARVs or HIV drug resistance
   - DO NOT CHANGE ART regime based on one viral result.
   - Give patient monthly ARV resupply, this can be reviewed based on the frequency deemed necessary to improve adherence
   - Conduct Enhanced Adherence Counselling (EAC)
     - Minimum 2 EAC sessions, over a 3 months period
   - Repeat viral load after 3 months, only if adherence has improved
   - If second VL result is:
     - < 1000 continue ART;
     - > 1000 consider switching to 2nd or 3rd line ART

ACTION

Treat All Toolkit Annex VII: VL Monitoring Job Aide

- [PEPFAR](http://www.pepfar.gov)
- [USAID](http://www.usaid.gov)
- [AFRO](http://www.afro.org)
Routine Viral load Monitoring algorithm

Collect viral load sample:
- Routinely at 6 months after starting ART, 12 months after starting ART and then every 12 months (24, 36 months etc.)
- Any patient with clinical or immunological failure should be prioritised *
  - Give viral load key messages before client is bled for VL

**VL <1000 copies/ml**
- Maintain first-line therapy
- Schedule next VL testing at month 12 after ART initiation then yearly thereafter
- Offer client options for differentiated ART delivery for stable clients

**VL >1000 copies/ml**
- Assess for and address any possible causes of non-adherence and treatment failure
  - Refer for EAC

1st EAC session on day of result

2nd EAC session after 4 weeks
3rd EAC and additional sessions as required over the next 8 weeks

Repeat VL 12 weeks after result has been given

**VL <1000 copies/ml**
- Maintain current regimen
- Offer client options for differentiated ART delivery for stable clients
- Schedule next VL testing at month 12 and yearly

**VL >1000 copies/ml**
- Refer to clinician experienced in switching to 2nd line
- Gather information on patient from both clinicians and counsellors
- Switch to 2nd line within 2 weeks from receipt of 2nd high VL unless documented reason for delay
- Urgency of switch will be dependent on clinical condition of patient, CD4 or if a woman is pregnant or breastfeeding

*If there is evidence of clinical failure or immunological failure, the patient should be referred to an experienced clinician and a decision made on whether the patient should be switched earlier

Completion of this algorithm should take 6 months maximum
**Why is it good to have an undetectable viral load?**

Having an undetectable viral load is important for a number of reasons.

- First of all, because your immune system is able to recover and become stronger, it means that you have a very low risk of becoming ill because of HIV. It also reduces your risk of developing opportunistic infections.
- Secondly, having an undetectable viral load means that the risk of HIV becoming resistant to the anti-HIV drugs you are taking is very small.
- Finally, having an undetectable viral load reduces the risk of passing on HIV to someone else.

**What must I do if I am not virologically suppressed?**

A detectable or unsuppressed viral load is a viral load greater than 1000 copies/ml. The most common causes for a detectable viral load are insufficient levels of ARV drugs in your blood or that the virus does not respond any longer to the drugs you are taking. Your healthcare worker will determine why your viral load is not suppressed and advise you on what you need to do.

Please remember, it is very important that you take your medication at the same time every day and avoid traditional/herbal treatment that may interfere with these medications.

Failing to adhere to your treatment is the commonest cause of a detectable viral load.

**Steps to staying well on your ARVs:**

1. KNOW your viral load. Write it down in your clinic card or book and try to remember the viral load result.
2. If your virus is suppressed, then you will remain in good health if you continue taking your treatment.
3. If you are not suppressed, talk to a nurse or healthcare worker caring for you. Get advice on adherence, and then RE-CHECK your viral load. If this new result is still above 1000 copies/mL and you are taking your ARVs carefully, you may need to have your ARV medication changed UNDER THE SUPERVISION OF YOUR HEALTHCARE PROVIDER.

**Parting words**

If you are taking ART, follow your HIV care provider’s advice. Visit your HIV care provider regularly and always take your HIV medication as directed. This will give you the greatest chance of having an undetectable viral load. Taking other actions, like using a condom consistently and correctly, can lower your chances of transmitting HIV or contracting an STD even more. For more information, visit your nearest health facility.
Patient Education Pamphlet on Viral Load Monitoring

The purpose of this pamphlet is to provide information on viral load monitoring as a strategy of managing and monitoring clients on antiretroviral treatment. The pamphlet is earmarked for use by any group of patients and health workers.

What is a viral load?
The term “viral load” refers to the amount of HIV in a sample of your blood. When your viral load is high, you have more HIV in your body, and that means your immune system is not fighting HIV as well.

A viral load test is a laboratory test that measures the amount of viral particles in a millilitre or drop of blood. These particles are called “copies”.

Why is a viral load test important?
A viral load test helps provide information on your health status and provides information on how well your antiretroviral treatment is working to control the HIV virus.

A viral load test gives the best accurate and early indication on whether your treatment is working or not.

What happens if I do not have my viral load checked?
The healthcare worker will not know how good your health is whilst taking ARVs unless they can test the level of virus in the blood. A viral count will help your healthcare team to decide your best treatment options.

Taking ARVs which are not working for a long time can make your HIV more difficult to treat. Your healthcare team will decide your best treatment options based upon your viral count.

Goal of ART
The goal of ART is to move your viral load down, ideally to undetectable levels of less than 1000 copies/ml. For your antiretroviral medication to be effective it is very important for you to take your medication at the same time every day and avoid traditional/herbal treatment that may interfere with these medications.

In general, your viral load will be declared “undetectable” if it is under 1000 copies in a sample of your blood.

Having an “undetectable” viral load doesn’t mean that the virus is completely gone from your body, just that it is below what a lab test can find. You still have HIV and need to stay on ART to remain healthy.

What is a normal viral load?
There is really no such thing as a “normal” viral load. People who are not infected with HIV (HIV negative people) have no viral load at all, so there’s no “normal” range for reference. The aim of treatment is to have an “undetectable” viral load.

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What is an undetectable viral load mean?
If your viral load is less than 1000 copies/mL, everyone is happy. It means you are in good health and your HIV treatment is working.

An undetectable viral load is a viral load less than 1000 copies/ml. Having an undetectable viral load does not mean you have been cured of HIV. You still have HIV and you need to stay on treatment to keep your viral load suppressed.

Even when your viral load is undetectable, HIV can still exist in semen, vaginal fluids, breast milk, and other parts of your body. For this reason, you should continue to take your medication.

When and how often do I need a viral load test?
Your HIV care provider will order a viral load test after 6 and 12 months of starting ART. Afterwards your viral load will be done after every 12 months if there are no problems and your viral load remains “undetectable”. Your health care provider might also order a viral load test if you fall sick or continue to be unwell despite taking treatment as expected.

If your HIV viral load is not suppressed at any time:

- Continue taking your ARVs and talk to your counsellor or healthcare worker about any problem you may have with taking your medication.
- Re-check your viral load after 3 months and wait for your results and healthcare worker to advice.
Annex IX: Routine Register Review to Optimise Patient Retention in HIV Care & Treatment Job Aide

It is important that all client information is accurately, completely recorded at every stage of documentation.

Figure. OI/ART Client Flow and Register Documentation
CLIENT FOLLOW-UP

Client follow up is a very important component of client care and management. Retention of clients on ART maximizes positive client outcomes, tools such as adherence assessment, psychosocial support and routine review help to keel ART clients on the path to long term retention. Following a routine schedule to follow up clients who have missed scheduled review appointments will provide an effective way to have documented outcomes and early interventions for potential defaulters.

PRE-ART PATIENTS FOLLOW UP

In the Treat All phase, follow up of patients with undocumented outcomes in the Pre-ART register is important to reach all clients in need of ART. The following can be used as a guide to routine Pre_ART register follow up:

- Check Pre ART register every Friday
- Identify Patients with no documented outcome
- Pull out patients’ OI/ART booklets and check for contact details
- Follow up patients and document outcomes according to missed appointments guidance

ART PATIENTS FOLLOW UP

Follow up of patients on ART between 3 days after missed appointment and 90 days of missed appointment is crucial to identify and provide timely support to early and potential defaulters.

ART REGISTER

- Compile list of patients who missed their appointment date for at least 3 days at the end of each day from the appointment diary
- Send SMS reminder
- Follow up with phone call to patient’s phone or that of next of kin if there is no response to SMS after one day
- Document in Patients OI/ART booklet notes section

EPMS

- Check patients who have attended on visit date against EPMS appointment list print out at the end of each day/week
- Send SMS reminder
- Follow up with phone call to patient’s phone or that of next of kin if there is no response to SMS after one day
- Document in Patients OI/ART booklet notes section
- Document outcome in Patients OI/ART booklet and update OI/ART register in the case of LFTU, Deaths and transfer out
- Document in essential changes register
- Update EPMS record accordingly