AN ADDENDUM TO THE NATIONAL TUBERCULOSIS AND LEPROSY STRATEGIC PLAN 2024-2026

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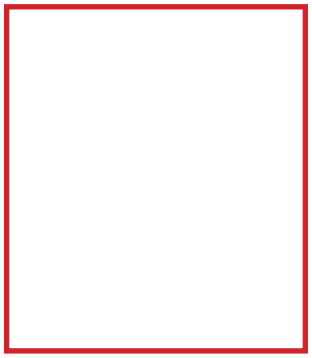
Foreword



The Ministry of Health and Child Care through the National TB and Leprosy Programme has developed an addendum of the National Strategic Plan for Tuberculosis and Leprosy (TB-NSP) covering (2023-2026) in the quest to accelerate the TB intervention towards TB elimination by 2035. In this addendum, attention is drawn to important priorities established in the 2022 midterm review report by external reviews put together by the World Health Organization to be addressed between 2023 and 2026. The addendum seeks to outline clear strategies and activities to be conducted in response to the notable systemic and critical gaps and challenges faced in the implementation of the strategic plan thus far.

The strategies under the addendum will focus much more on improving the coverage of TB interventions regarding TB case finding for both drug-susceptible and drug-resistant TB and enhance the quality of care to achieve the desired treatment outcomes thereby helping the country achieve the End of TB goals and objectives.

This NSP is taking a deliberate approach to strengthening the delivery of TB services across the country, targeting to serve all TB high-risk populations. Through this strategic plan access to quality TB services will be enhanced for all vulnerable populations. The updated NSP has included service provisions for Leprosy. Aiming at increased proficiency in early case detection, and reduction of disability associated with Leprosy towards the attainment of Zero disability.

The updated NSP will not only focus on enhancing case detection and curative services but has also prioritized TB prevention and infection control as core and critical essentials of TB control.

The NSP was updated with the full participation and collective contribution of all the key stakeholders including the representatives of civil society. On behalf of the Ministry of Health and Child Care (MoHCC), we sincerely express our profound gratitude and appeal for continued support in the fight against TB.

It is, therefore, my hope that this Strategic plan will guide our TB control efforts in the coming years and help us to consolidate our gains toward Ending TB by 2035.

Air Commodore (Dr) J. Chimedza
Secretary for Health and Child Care

Acknowledgement

The development of the addendum to the TB NSP to cover the implementation period 2023-2026 is a product of inclusive engagement among key stakeholders in the national TB-HIV response. The various TB-HIV experts drawn from the Ministry of Health and Child Care, our partners, and civil society put in a great effort, and dedicated their time to provide strategic approaches to enhance service delivery at the same time ensure quality in all services.

While it may not be possible to recognize everyone, who was involved in this undertaking individually, special acknowledgments go to the National TB and Leprosy Programme Manager who ably led the team in this process, the WHO National Programmed officer, and all our partners.

Special thanks also go to all our health workers in the line of duty, who have committed their lives to serve our patients despite the current challenging environment. Patients deserve special mention as the intended beneficiaries of this strategy. Last, but not least, a big thank you to the core writing team, who meticulously put together this strategy with technical assistance and costing of the interventions from Dr. Patrick Saili Lungu, Dr Mamuka Djibuti, and Mr Christopher Chiwevu and Dr Lazarus Muchabaiwa respectively. This undertaking could not have been possible without technical assistance from the Union Zimbabwe Trust and funding and technical support from the United States Agency for International Development (USAID), the World Health Organisation (WHO), Elizabeth Glazer Pediatric Foundation (EGPAF), and the Clinton Health Access Initiative (CHAI) and International Organization for Migration

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Executive Summary

The need to develop an addendum to the TB and Leprosy NSP for 2021-2025 and extend the coverage period to end in 2026 came from the recognition of the major gaps and challenges and the less likelihood to achieve the strategic goals and objectives. The development of this addendum is informed by the finding of external and local reviewers of the 2022 mid-term review of the NSP. It is also alive to lost milestones brought about by the disruption of TB services during the peaks of Covid-19 where we saw a decline in TB case finding hence changing the landscape in the epidemiological profile of the TB epidemic in Zimbabwe and the Southern Africa region at large. This plan has incorporated the global developments and emerging evidence in the response, such as shorter preventive therapy for TB as well as the need to rapidly scale up shorter, more patient-friendly all-oral regimens for DR-TB, which includes BPaL/BPaLM among other notable innovations. This addendum has incorporated strategies aimed at enhancing patient-centred care and approaches.

Prominently safeguards human rights and promotes social protection, minimizing catastrophic costs related to TB. Findings from the External Mid-term TB Programme Review and Epidemiological analysis informed areas of priority focus for the TB programme till 2026. The process of developing this strategic plan was participatory, with the involvement of key stakeholders through consultative workshops and key informant interviews. A comprehensive programmatic SWOT analysis clarified critical gaps that informed priority interventions. These include, among others: the need to close the coverage gap for molecular diagnostics, and the intentional focus on special attention to key populations and emerging co-morbidities to optimize case finding and treatment outcomes. The strategic plan deliberately targets childhood TB and scale up integrated TB-HIV client-centred model of care, integrate TB and NCDs. Rollout of new drugs and shorter regimens for DR-TB and patients will be supported at the community level to address adverse effects from DR-TB medicines and identify those failing regimens in a timely manner. Facility based on-site training and mentorship will be promoted as a best practice to help build the much-needed clinical competencies that will be about a high index of suspicion and improved treatment outcomes for TB. This strategic plan will enhance the use of data for decision-making and action for a comprehensive and more robust response to TB. The plan will promote the use of technology to bring about efficiencies in the Electronic Health Record (EHR) and virtual platform for E-learning and coordination. The NSP has not only focused on TB, it has also included strategies that will enhance the response to the Leprosy burden toward Zero Leprosy disability in line with the global approaches. This NSP has also prioritized improvement in programme coordination and recognises the critical role of the community in TB response. Strategies have been formulated to support the community TB response and equally bring about improved programme coordination and multisectoral response. The followings are the TB-specific Strategic Goals and eight strategic objectives for the next 4 years. The vision of the National TB Programme is to see a Zimbabwe “free of TB” with a goal of an 80% reduction in TB incidence and mortality by 2026. All strategic interventions are aligned to the conceptual framework of the three pillars of the End TB Strategy and the layout of this national TB and Leprosy strategic plan is informed by the WHO Toolkit of 2015. The cost to implement this strategy is to the tune of $USD135,675,008 inclusive of $USD215,997 for leprosy elimination.

LIST of Abbreviations

aDSM	Active Drug Safety Monitoring
AIDS	Acquired Immuno-Deficiency Syndrome
ASMs	Artisanal Small-scale Miners
ART	Anti-Retroviral Therapy
ARV	Antiretroviral
BSL-3	Biosafety Level 3
CHW	Community Health Worker
CHAI	Clinton Health Access Initiative
CI	Contact Investigation
CPT	Co-trimoxazole Preventive Therapy
CSO	Civil Society Organisation
COVID-19	Corona Virus Disease
DHE	District Health Executive
DHIS2	District Health Information Software 2
DM	Diabetes Mellitus
DMO	District Medical Officer
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment, Short course
DR-TB	Drug Resistant Tuberculosis
DST	Drug Susceptibility Testing
EGPAF	Elizabeth Glazier Pediatric AIDS Foundation
EHR	Electronic Health Record
EHT	Environmental Health Technician
EQA	External Quality Assurance of AFB microscopy
FDC	Fixed Dose Combination
G2D	Grade 2 Disability
GDF	Global Drug Facility
GFATM	Global Fund Against AIDS, Tuberculosis and Malaria
GoZ	Government of Zimbabwe
HIV	Human Immunodeficiency Virus
HP	Isoniazid/Rifapentine

HRH	Human Resources for Health
IPC	Infection Prevention and Control
HCW	Health Care Worker
LF-LAM	Lateral Flow Lipoarabinomannan Assay
LPA	Line Probe Assay
MB	Multibacillary leprosy
MCAZ	Medicines Control Authority of Zimbabwe
MDR-TB	Multi- Drug Resistant Tuberculosis
MDT	Multidrug therapy
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MGIT	Mycobacteria Growth Indicator Tube
MNCH	Maternal New born Child Health
MoHCC	Ministry of Health and Child Care
MTB	Mycobacteria Tuberculosis
NatPharm	National Pharmaceutical Company of Zimbabwe
NSP	National Strategic Plan
NTBRL	National Tuberculosis Reference Laboratory
NTLP	National Tuberculosis Control Programme
OHSC	Occupational Health Service Centre
PB	Paucibacillary leprosy
PEDCO	Provincial Epidemiology Disease Control Officer
PHC	Primary Health Care
PHE	Provincial Health Executive
PLHIV	People Living with HIV
PMD	Provincial Medical Officer
PMDT	Programmatic Management of Drug Resistant TB
PMTCT	Prevention of Mother to Child Transmission
PPM	Public Private Mix
RIF	Rifampicin
RH	Rifampicin/Isoniazid
RR	Rifampicin Resistant
SARS	Severe Acute Respiratory Syndrome

SORT-IT	Structured Operations Research Training Initiative
STPZ	Stop TB Partnership Zimbabwe
STS	Specimen Transport System
SWOT	Strengths Weakness Opportunities Threats
TB	Tuberculosis
TOT	Training of Trainers
TPT	Tuberculosis Preventive Therapy
UNICEF	United Nations Children Fund
UNHLM	United Nations High Level Meeting
USAID	United States Agency for International Development
VHW	Village Health Worker
WHO	World Health Organization
X-DR TB	Extensive Drug Resistance Tuberculosis

1. Background

1.1 TB Country Profile

Zimbabwe's health system has faced difficulties in recent years including disruptions caused by the current COVID-19 pandemic. Since 2011, there has been a notable decline in TB notifications, however, the highest decline in TB notifications was noted in 2020. COVID-19 impacted negatively on the TB program from 2020 through to 2021; the country experienced a 26% decline in TB notification in 2020 compared to 2019 with a slight improvement of 3% in 2021 compared to 2020. This is against the backdrop of a declining TB incidence which had decreased by 50% between 2011 and 2021. TB incidence had declined from 384/100,000 in 2011 to 190/100,000 in 2021. Due to the devastating effects of the covid-19 TB case detection declined in 2020 and 2021, which resulted in an increase in TB incidence from 190/100,000 to 194/100,000 population as documented in 2022 WHO Global TB report[1]. For instance, in 2018 the gap between estimated incidence and case notification was 16% and in 2021 the gap increased to 43.2%. It's worth noting that the widening gap between TB incidence and notification started in 2018, got worse in 2020 and as of 2022, the country missed 12,500 TB cases. The gap between incidence and notification in 2018 is attributed to a country wide health worker strike and after this period, COVID 19 service delivery disruption amidst weak health system and low case finding efficiency accounted for this gap. For instance, during this period, there was limited contact investigation (37% only) for pulmonary TB and childhood TB cases throughout the whole country thereby affecting case-finding treatment and care services within the country.

The treatment success rate for all forms of drug-susceptible TB has been improving, the programme recorded a treatment success rate of 88% in 2021 from 83% in 2018. The programme is using the 4 fixed-dose combination for adults and child-friendly formulation for children to foster treatment adherence.

While there has been notable progress made with TB/HIV co-infection with a reduction from 62% in 2018 to 50% in 2021, at least 50% of the notified TB patients are co-infected with HIV. The main interventions implemented by the NTLP under the umbrella of TB/HIV include HIV testing among TB patients which currently stands at 98% versus the WHO AFRO average of 89%[2]. Of the TB/HIV co-infected patients, 93% receive TB/ART co-treatment versus the WHO AFRO average of 92%. Other interventions include the provision of TB Preventive Treatment (TPT) to PLHIV which currently stands at 57% based on the NTP annual report for 2021 versus 71% at the WHO AFRO level. The NTLP will need to put in measures to accelerate the uptake of TPT in PLHIV and other risk populations. Starting with approaches to attain full saturation for PLHIV.

Of great concern to the NTLP is that DR TB case detection has been declining. A total of 243 DR-TB cases were identified in 2021, against a target of 477. Those enrolled in treatment were 93% of the identified cases. From January to June 2022, the program identified 135 patients (out of a target of 232), and 118 (87%) were enrolled in treatment. The second gap in the programmatic management of DR TB, besides missing DR TB patients, some of the patients diagnosed with DR TB are not linked to care.

1 WHO Global TB Report-2022
https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&entity_type=%22country%22&lan=%22EN%22&iso2=%22ZW%22

2 https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&lan=%22EN%22&entity_type=%22group%22&group_code=%22AFR%22

The management of DR-TB was decentralized beyond the capacity of the health system capacity to all district and mission hospitals and this included TB presumption, specimen collection and linkage to rapid molecular test using Integrated Specimen Transportation (IST), and referral, diagnosis, treatment, and patient monitoring. In addition to the hospitalization in extenuating circumstances, ambulatory care was provided to DR-TB patients, with DOT available at the nearest health facility, regardless of level. Noteworthy is the progress with decentralization, the treatment success rate for DR TB has been declining. In 2011 DR TB treatment success rate was 84% and dropped to s 42% for the 2019 cohort. The programme has fully transitioned to all oral regimens with 95% of the notified DRTB patients receiving the oral short regimen in 2021. The programme is yet to revise the guidelines to include BPaL/BPaLM. Great efforts are made to initiate second-line TB medicines across the country within 72 hours of diagnosis.

The country has a robust TB laboratory network supported by 2 national TB reference laboratories. The 2 reference laboratories are equipped with technologies to perform TB culture (solid and liquid), phenotypic drug susceptibility testing (DST), and genotypic DST (HAIN Line probe Assay. The laboratories perform these tests for specimens referred from patients with GeneXpert Rifampicin resistance results to confirm multi-drug resistance TB (MDR-TB). As a result of COVID-19 the workload at both laboratories decreased in 2021, however, the workload started to increase in 2022. In the entire network, the country has 156 GeneXpert and 20 Truenat machines. Access to molecular TB diagnostics remains highly constricted.

1.2 Rationale for the amendment of the National Strategic Plan

The National Strategic Plan (NSP) is a strategic document that provides guidance to all national health authorities in managing and implementing appropriate TB interventions, while being part of a collective movement towards ending TB, and the overall global health-related Sustainable Development Goals. The strategic plan is a formalized road map towards a set goal and spells out where the National TB and Leprosy Programme (NTLP) is going over the next five years, and how it will get there. It is a management tool that helps the NTLP do a better job, focusing the energy, resources, and time of everyone in the same direction. The NTLP in 2022 conducted a mid-term review of the performance of the 2020-2025 TB National Strategic Plan (TB NSP). The midterm review revealed a number of systematic gaps and underperformance in a number of programme indicators. COVID-19 had devastating effects on the performance of the programme's strategic plan. If the systematic gaps observed during the mid-term review are not addressed and mitigation measures are not put in place, the underperformance in critical indicators may continue.

The NTLP will be submitting a concept note to the global fund for a funding request to cover the years 2024-2026. As the country prepares the concept note for the funding request from the global fund it is imperative to update the strategies, interventions and activities to guide the TB response in line with the challenges, gaps and situation of the ground. This addendum will not only include new interventions and activities but bring about the NSP being aligned to the time frame of the global fund grants. This updated strategic plan will inform resource mobilization efforts and provide a shared platform for engaging key stakeholders in this fight.

1.3 National Strategic Plan Addendum Development Process

The development of the addendum to the TB and Leprosy NSP draws key lessons mainly from the Mid-term TB Programme Review and Epidemiological and Surveillance assessment for TB of 2022. Other resource documents reviewed during the process of developing the addendum were; a population-based TB Patient Cost Survey (2018)[3]; a report of a national assessment of the TB diagnostic network of Zimbabwe (2020); Global Perspectives (Global TB report, United Nations High-Level Meeting (UNHLM) recommendations and targets, the 2022 rapid communication from the WHO on DR-TB and the national TB guidelines The outline of this strategy is based on the "Toolkit to develop a NSP for TB prevention, care, and control", World Health Organization (WHO-2022)[4].

The development of this strategy was inclusive and participatory, with the involvement of key stakeholders in the national TB response. From the 11th to the 13th of January 2022, a consultative stakeholders' workshop was convened to put together national priorities in the national TB response. Participants in the aforementioned workshop included Provincial and District Health Executives, the private sector, City and Prison Health authorities, staff from IOM, and all the TB partners working in Zimbabwe including the civil society led by Stop TB Partnership were present. Working teams were formed around key thematic areas which included; Health Systems Support, TB treatment and care, PMDT, TB in vulnerable populations, Leprosy, TB Medicines and Supply chain, TB/HIV and prevention, Community, and PPM. The approaches used in the workshop included presentations, group work, and plenary sessions.

3 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8519355/
4 https://apps.who.int/iris/bitstream/handle/10665/153811/9789241507974_eng.pdf

2. Key Achievements, challenges and gaps identified during the Mid-Term Review

2.1 Programme Management

2.1.1 Achievements

Multi-sectorial Accountability Framework is ready to be launched
Commitment to HR support by the GoZ
Successful launch of the MDR-TB patient support system in Zimbabwe
Multi-sectoral engagement focusing on MDR-TB patient support system
Partner workplans are aligned to NSP and are reviewed and approved by NTP/MoHCC
The country is implementing various innovations/best practices. These include:

a) Coordination via WhatsApp platforms
b) Use of Routine data quality Assessment Application (RDQA application) during support supervisions to foster improvement in data quality
c) Implementation of Quality Management Systems in Harare by NMRL
d) Conduction of support supervision peripheral labs by NMRL/BRIDH

2.1.2 Challenges and Gaps

There were some challenges that were noted to be affecting/preventing effective TB control. These include:

a) Inadequate funding to implement all key interventions, particularly TB case finding, Childhood TB, Urban TB, and DR -TB. due to a funding gap of US$62,371,396 (42.7%)
b) High staff attrition (up to 50% for clinical staff) resulting in loss of institutional memory and skills
c) Although TB services are meant to be free, some health facilities charge consultation fees and user fees related to chest x-rays, average of USD 12 for adults and USD 6 for children – limiting services access and utilization.
d) Low incentives for CHWs negatively affected their motivation to perform their duties.
e) Existence of multiple versions of guidelines, registers and quarterly reporting templates resulting into unstandardized activity implementation and collection as well as reporting of key TB data variables
f) General lack of comprehensive support supervision checklist covering all TB thematic areas for effective TB support at sub-national level
g) Macroeconomic environment challenges have resulted into increased operational and patient out of pocket costs
h) NMRL was condemned since 2016 due lack of negative pressure system and the containerized lab is being procured to address this gap, but its placement location is still under contention
i) Low engagement of community actors (NGOs, CSOs, CBOs, Private providers) since these are yet to be mapped out
j) The frequency/schedule of support supervision is not well defined for all levels and generally, NSP/NTP priorities and guidelines are not well disseminated to sub-national level leading to unstandardized implementation of TB activities
k) Capacity deficits in the complimentary cadres and supervisors required for a comprehensive TB response

l) Inadequate transport capacities for effective control; largely constrained by fuel, old fleet of cars, and obsolete motorcycles most of which have surpassed the 5 year optimum usage and 10 year decommissioning thresholds resulting in high operational costs.
m) Lack of decommissioning plans for Computers, Laptops, Printers, Motorcycles, Motor Vehicles and other value depleting assets resulting in over reliance on obsolete equipment which may no longer be serving their purpose.
n) Disruptions in the supply chain of key commodities – EHRZ, TPT (short regimen) and Xpert Cartridges
o) Recording and reporting is largely paper based, contributing to low data quality and eHR TB module is not fully developed and rolled.

2.2 TB Case Finding, Treatment and Care

2.2.1 Achievements

a) Good and available reliable Integrated Spacemen Transportation services linked to WHO Recommended Diagnostic tests (GeneXpert and Truenat).
b) Targeted screening for active TB in high-risk groups and hard to reach areas has been decentralized to the provinces with the use of the mobile trucks with radiological and laboratory services.
c) NTP achieved the set targets for Treatment success of all forms of TB, the proportion of new and relapse TB patients tested using WRD at time of diagnosis, and the proportion of notified TB cases contributed by community referrals.

2.2.2 Challenges and Gaps

a) There is no differentiated case finding approaches for urban and rural areas.
b) Low notifications and suboptimal systematic active case finding across all provinces of the country.
c) High staff attrition of health care workers.
d) Medicines stockouts of RHZE (first line medicines)
e) Lack of standardized referral pathway between the public and the private sector.
f) Low community contribution to case finding through community health workers.
g) Lack of mechanisms to support DSTB patients in care.
h) High data demands/ documentation requirements versus available human resources resulting in compromised quality of data and patient care.
i) Death audits are not conducted routinely or as part of quality improvement measures in most provinces
j) Some facilities did not have up to date national guidelines and/or tools (such as 2016 TB guidelines and Presumptive registers).
k) Although the knowledge on TB is high among HCWs, index of suspicion for active TB remains low. About 30% of estimated TB cases are missed.
l) TB contact tracing activities are not adequately being administered due to inadequate training, lack of reliable and consistent transportation system for EHT/CHWs, shortage of human resources for contact tracing that is, EHTs and CHWs, missed opportunity to trace some patients following wrong information/addresses being provided and disease related stigma and discrimination.
m) Lack of TB Contact Investigation comprehensive and standardized national guidelines and availability of the necessary resources at national and subnational level.
n) Unavailability of national resources for robust implementation of a comprehensive Contact Investigation strategy and periodical reviews of the intervention.

o) No TB Contact Investigation focal point to link CI with all stakeholders and ensure robust implementation.
p) Lack of Incentives/ or lunch allowances for EHTs conducting contact investigation of patients in long distances from their stations.
q) TB associated stigma in the community is high possibly due to weak community involvement and participation in TB control activities.
r) Health care workers' motivation and retention is low due to factors such as remuneration, job stability, training/supervision and work-load.
s) Insufficient psychosocial support for patients.

2.3 TB/HIV

2.3.1 Achievements

a) Active mechanisms in place for delivery of integrated TB and HIV services at national level and at community-facility levels
b) High coverage of TPT uptake among PLHIV
c) High coverage of HIV testing among TB notified cases
d) High TB/ART co-treatment among TB/HIV co-infected patients
e) TB/HIV focal points at the national and provincial levels
f) TB-HIV services are delivered as One Stop Shop Model especially in PHC settings or with linkages between TB & HIV units
g) GeneXpert multiplexing was available for TB/EID/Viral load/COVID 19

2.3.2 Challenges and Gaps

a) Higher level facilities (e.g., provincial hospitals) were not fully implementing the One Stop Shop TB/HIV care Model
b) Coordination meetings and joint support and supervision on TB/HIV collaborative activities were not regularly conducted at subnational level particularly at the district level.
c) There was sub-optimal integrated screening for TB and other comorbidities including TB/DM because of limited availability of tools and supplies.
d) Based on data reviewed while in the field, the yield of TB screening among HIV patients was low i.e., less than 1%. However, TB remained the main cause of death among PLHIV.
e) Mortality statistics by HIV status among TB patients were not readily available despite tracking of mortality statistics in DHIS.
f) Partner support and coordination was fragmented at the subnational level (provincial level and below)
g) There was no national indicator to track implementation and outcomes of TB Infection control.
h) Coverage of TPT among PLHIV was just 57% (293,574 out of 514,493) all target for 2021 was achieved.
i) Further, there was limited knowledge among health workers on the use of 3HP. In addition, data on the percentage of PLHIV initiated on shorter TPT regimens was not available (not routinely analyzed).
j) Documentation of TPT outcomes (i.e., completed, stopped, died, and developed TB while on TPT) was sub-optimal.

2.4 TB laboratory network and case finding

2.4.1 Achievements

a) Access to TB diagnostic services available at all health service tiers of testing using Xpert MTB/RIF ultra, Truenat, TB LF-LAM FL & SL DST (genotypic & phenotypic)
b) The human resources for TB diagnostics and external quality assessment were largely sufficient, however gaps were identified in Harare and Bulawayo metropolitan provinces;
c) The IST has been rolled out and is functional in the entire diagnostic pathway
d) Multiplexing of TB, HIV (VL, EID) and COVID-19 testing at all GeneXpert sites visited.
e) GeneXpert machines connected to GxAlert / Aspect and sending performance data on real time basis

2.4.2 Challenges and gaps

a) The two reference labs require more staff
b) Comprehensive National TB Diagnostic algorithm not available in facilities
c) QMS training for technical staff at the reference laboratories
d) Suboptimal use of stool as specimen for the diagnosis of TB in children using the GeneXpert.
e) TB module for LIMS only available at NMRL, NTBRL, BRIDH and is missing in all the other testing sites
f) Suboptimal data analysis (Making Sense of TB Data) at facility level
g) Long TAT's of laboratory results especially culture & DST results
h) Stock outs or limited stock of Xpert MTB/RIF ultra-cartridges at most facilities
i) Low staff morale leading to high staff turnover especially at lower-level sites
j) Sub optimal coverage of X-ray diagnostic services at all GeneXpert sites
k) TAT for laboratory results ranges between 4-21 days for some referring sites prompting periodic reviews of the intervention to ensure continued improvement of the strategy.

2.5 Programmatic Management of Drug-Resistant TB (PMDT)

2.5.1 Achievements

a) Guidelines contain well-defined priorities and high-risk groups for DR-TB to enhance case finding
b) Well-coordinated PMDT program
c) PMDT focal person and TA at national level
d) Implemented STR in 2018, mSTR in 2019 and injection free regimen in 2020 up to date
e) Plans are underway to transit to BPaL/BPalM regimen
f) High achievement (93%) of DST testing and results reporting for TB patients
g) Documented result for at least Rifampicin among the total number of notified in 2020
h) Reduction in initial LTFP from 16% in 2016 to 6% in 2021

2.5.2 Challenges and gaps

a) Low DR - TB case notification - 51% of the expected target number of 477 cases (2021) but only 31% of the total expected 780 cases, low treatment initiation, 87% (Jan-June 2022), plus low treatment success rate of 42% and high unfavorable DR-TB Treatment Outcomes for the 2019 cohort; 35% patients were not evaluated 18% died 4% loss to follow - 4% and 1% failed treatment (figure 10). Generally, declining DR-TB treatment success rates (figure 11)
b) Stock rupture of patient treatment booklets/treatment cards, GeneXpert Ultra cartridges, and some DR-TB medicines
c) Suboptimal patient monitoring, which includes nutritional assessments, laboratory tests, and ECG and aDSM; including documentation gaps
d) Long TAT (>12 weeks) for Culture & DST and no results tracking mechanisms
e) Centralized and suboptimal coverage of patient treatment enablers; 70% receiving (cash transfers and food hampers)
f) Cash transfers and food hampers (US$25.00 and US$20) were inadequate to mitigate catastrophic costs and support patient livelihood during DR-TB treatment
g) No national PMDT/Clinical DR - TB Expert and Cohort review meetings schedule resulting in non-routine cohort reviews, death audits and ultimately compromises the quality of care for DR TB patients
h) No DRTB Expert Patient strategy to ensure adherence among DRTB patients being inspired by HCW DRTB survivors.
i) Lack of updated DHIS2 - DR-TB modules to accommodate the revised DR - TB recording and reporting tools
j) Lack of data validation, no data disaggregation by treatment regimen
k) High initial loss to follow-up or death before treatment initiation
l) sub-optimum monitoring of treatment for adverse drug events and high unfavourable treatment outcomes

2.6 Key Vulnerable Populations

2.6.1 Achievements

a) TB/HIV bidirectional testing- The TB and HIV across the country are well integrated and services are provided all under one roof.
b) Screening of inmates for TB and HIV on admission – This was observed in only one province
c) Outreaches for ASM and risk groups with an integrated approach (TB/DM, NCDs) – TaS4TB, BOHS
d) Occupational health centers for ASMs – TPT amongst at risk groups
e) Integrated TB and silicosis screening in major public hospitals, a good example is the case of Gweru and Gwanda Provincial Hospitals that has a well-established integrated TB and Silicosis screening clinic for high risk groups. The public are well informed about the services under this establishment which brings about ease of access.
f) The NTLP has established centers of excellence for Childhood TB
g) Usage of stool for TB diagnostics is in place
h) TB/DM bidirectional screening is being practiced in some settings
i) Use of CXR to diagnose childhood TB in centers of excellence
j) Childhood TB TWG is in place and provides guidance to approaches in Childhood TB, this is coupled with the involvement of the Pediatric Association of Zimbabwe

k) Staff clinics/wellness clinics for TB screening and HIV testing
l) Re-assignment of staff LHIV to reduce potential exposure to TB, this is voluntarily done

2.6.2 Challenges and Gaps

a) Sub-optimal use of gastric lavage and stool for childhood TB diagnosis
b) Limited HCW capacity on childhood TB, leading to low confidence and low index of suspicion of childhood TB
c) Knowledge gaps in the community on childhood TB and risk groups
d) Sub-optimal screening in prisons and limited involvement of uniformed forces
e) Limited community-based screening activities amongst high-risk groups in other districts
f) Limited integration of Childhood TB screening into routine activities (MNCH, contact tracing)
g) Suboptimal cross border collaboration
h) Limited coverage and resources for TB/DM bidirectional screening
i) Low IST coverage for private facilities
j) Sub-optimal use of Mantoux leading to expiries.
k) No protective gear for ASMs, low risk perception
l) Limited access to radiology services – user fees, distance
m) Limited capacity to interpret radiologic films esp. in children
n) Low contact tracing and TPT services for children
o) Low contact investigation for TB index cases in prisons and linking to their families of origin.
p) No peer support groups for children and adolescents.
q) No job aides for childhood TB
r) Major data deficits across all provinces regarding number of cases of TB detected among risk population and those linked to care and started on TB treatment

2.7 Supply Chain Management and aDSM

2.7.1 Achievements

a) Ancillary medicines used in managing common side effects were available at the health facilities
b) There is adequate capacity within the NTLP, DPS and DLS for quantification of TB medicines and diagnostics.
c) The supply chain management systems are in place across all levels of the health systems
d) Electronic temperature and humidity monitoring systems are installed and used in the NatPharm warehouses and medicines are stored systematically on shelves and pallets.
e) At the NatPharm inventory is managed using an electronical based tool known as Microsoft Dynamics Navision and the stock cards are no longer in use.

2.7.2 Challenges and Gaps

a) Uneven stock levels (overstocks/understocked) across the facilities and NATPHARM, some facilities have certain medicines and may be overstocked and others just close-by did not have the same medicine.

b) The ZAPS ordering system uses the consumption-based method to auto generate order quantities and does not consider the notification and planned enrolment/scale up. The use of a high max stock level (7 months) for ordering gives room for large medicine volumes in some the facilities that may eventually lead to overstock.
c) Underutilisation of electronic stocks reports/records to inform decisions for stock repositioning. Stock balances can be viewed using the output from the ZAP tool and this can be used for stock management/ repositioning to avoid overstocks/understocks.
d) Emergency orders placed by Central/Referral/provincial/ District Hospitals are often not validated and order quantities often exceed the allowed stock level resulting in overstocks in these facilities.
e) The CITY MEDICAL STORES/Pharmacy in Harare and Bulawayo maintain additional stock levels that are not recognised in the system design and their order quantities are not necessarily regulated. Hence, they maintain high volumes of stocks contributing to overstocks and expiry.
f) Incomplete regimen course for DR-TB patient implying that the patient would have to move to another facility to get the remaining medicines. Hence these patients incur additional costs which builds into the catastrophic cost.
g) There is no mechanism to monitor the quantity issued/dispensed by the facility compared with the patients' enrolments. There are no records at the TB referral/central hospitals to capture the medicines prescribed and quantity of medicines dispensed to the patients and stock cards are also not maintained at the dispensaries.
h) Delayed ordering/commencement of procurement processes affects availability of supplies resulting in stock ruptures as was the case for RHZE-4FDC.
i) Knowledge gap in the management and use of TB medicines and not all the health workers the use of the new regimens resulting in slow uptake of 3HP and 3RH TPT regimens, quantification outputs.
j) ADRs identified during aDSM are not being reported. Some facilities do not have the reporting forms or are not trained to use the e-reporting platforms.

2.8 Community TB

2.8.1 Achievements

a) Close collaboration between the NTP and CSOs implementing Key & Vulnerable Population targeted case finding models (Objective 1, 3 & 4)
b) Started implementing palliative care and community led interventions for DR-TB patients (Objective 2 & 5
c) Community Rights and Gender assessment report is available (2022) (Objective 5
d) A community led national TB partnership (Stop TB Partnership) was launched in 2019
e) TB survivor network now in place and active. (Objective 3 & 5 & 6
f) TB Champions from different sectors across the country launched and active.
g) Incentivizing CHWs – this facilitated increased community case finding (Objective 1, 2, 4 & 5)
h) Introduction of Community digital technology
i) Community Led Monitoring for TB- One Impact Zimbabwe
j) Community Hotspot mapping pilot- Enhanced Targeted screening
k) Incentivized (RBF) Community active case finding

2.8.2 Challenges and Gaps

a) Broader Social determinants of TB and inequities (CRG Barriers) are not adequately pronounced, prioritized and addressed and are not adequately monitored and evaluated
b) Limited access to funding opportunities to address the social determinants and inequalities related to TB
c) The CTBC and ACSM guidelines and training curriculum were last reviewed in 2016 and integrated into the 5th edition of the TB and Leprosy guidelines, hence outdated.
d) The review team noted, Ineffective referral system between health facility and communities and vise versa resulting in:
i. Underutilization of the referral slips by the HCWs at HF level
ii. Uneven distribution of the referral books in other districts
iii. At community level, there are 3 CHWs cadres providing case finding and case holding services VHWs, NGO CHWs and Family DOT members, however coordination and oversight structure to allow effective integrated service delivery and intersectoral referrals is weak

2.9 PPM Framework and MAF TB

The reviewers noted that there are structures, efforts being made in PPM with huge opportunities and potential to implement PMM to a large scale.

Challenges and gaps include;

a) PPM TB guidelines were last reviewed in 2016 and the existing PPM TB framework is limited to private practitioners only hence outdated.
b) The review team also noted, sequencing mismatch between the PPM framework development and commencement of MAF TB assessment process resulting in delay of the operationalization of the TB PPM Framework.
c) The national Stop TB partnership is only at national level and has not been decentralized to province level limiting opportunities for coordinated engagement of all actors and oversight
d) The TB survivor network has been decentralized to province level however, inadequate technical and financial capacity prevents their visibility and meaningful engagements in decision making process and service deliveries efforts.
e) Limited engagement and capacity of the private sector in TB response such as other line ministries, line departments, CSOs and business sectors was noted
f) Where the private sector is available and engaged they are not well coordinated, save for those under the Private companies occupational nurses with clinics in their companies.
g) Limited engagement of the national TB Caucus (politicians) to meaningfully advocate on behalf of the NTLP
h) Lack of capacity of the Caucus members on TB to fully engage and push motions in parliament

2.10 Monitoring &Evaluation & Research

2.10.1 Achievements

a) TB data is entered in the DHIS2 platform quarterly from district level.
b) The programme is using standardized data collection tools. (registers and forms)
c) A significant number of Health Care Workers are trained in quality data collection, data analysis and utilization at local level, through partner support i.e. KNTB & Africa University,
d) The programme conducts data driven support and supervision visits to sub-national Level
e) The programme conducts data driven review meetings
f) The programme has developed Routine Data Quality Assessment to improve data verification, validation, analysis and utilization through partner support Africa University,
g) The programme is using GIS platform to identify TB hotspot and spatial distribution
h) M&E TWG established and functional (TB research agenda, strengthening the TB surveillance system)

2.10.2 Challenges and Gaps

a) Stock out and outdated tools: The review team observed some challenges with recording and reporting tools in some facilities. First, there was stock out of some recording and reporting tools in some facilities, resulting in users reverting to older versions/ photocopying. Second, some tools were outdated, e.g., DR-TB registers (and this has no section to capture treatment regimen) and health facility tools did not bear the latest risk group categories. Third, in all provinces, there is limited use of presumptive TB registers, and if used, its not used in multiple care points. Related to tools, in Harare, it was noted that DR-TB patients keep their booklets, making the assessment of the quality of care difficult.
b) Limited use of eLMIS: Only 260 out of a target of 900 facilities have eLIMS. This could compromise the supply chain system as relying on the paper base system could lead to errors in ordering and supply. Related to the supply chain, it was also noted that there is limited reporting of the aDSM.
c) Inadequate staff: The review team observed that the M&E unit at the NTLP was understaffed, understanding the role the programme must play in supporting all provinces' functions. Similarly, at the sub-national level, there are few cadres trained in TB data and DHIS2, and the situation is worsened by attrition.
d) Subnational data quality and use: There is also little evidence of data use, especially at the facility level. In Masvingo province, for example, the review noted that M&E tools were available, but poor documentation practice resulted in poor data quality. There was no evidence of a training plan at the provincial/district/facility level to build capacity on R&R/use of TB data.
e) Data timeliness: Much as the DHIS2 platform offers an appropriate transition to electronic data, reports are only available quarterly and by end of reporting timeliness, only about 95-97% of the data will be submitted. HIOs are overwhelmed by data entry from different programs for all health facilities. This raise concerns over the timeliness of data, since if there is a problem raised from data an intervention could only be taken after three months, which would be late.
f) Missing indicators: The review team also noted that indicators, such as TPT and ADR, are missing in the National M&E plan including DR-TB treatment outcomes by regimen. Furthermore, there were no targets for TPT; therefore, the intervention's performance could not be measured.
g) Locking data sets: There is no system to lock data sets once complete and accurate after the submission timelines. This gives room to perpetual changes that does away with the consistency of data as a data quality attribute.

Table 1: Programmatic Gap Analysis

Programme Area		Key gaps	Identified root cause
Health system support	Human resource for health	High staff attrition (up to 50%) resulting in loss of institutional memory	The HCWs are leaving for higher pay in the diaspora
	Health Financing,	42% of the NSP budget is unfunded	Competing national priorities
	Financial and social support	80% of patients experience catastrophic cost	Longer distances between TB diagnostic facilities
		High cost of CXR thereby limiting access	The current system does not exempt TB presumptive clients, however, does exempt CXR for known TB patients
	·Partnerships and multi-sectoral engagement	MAF yet to be rolled and implemented to full scale	MAF F guidelines not yet rolled out
	Pharmaceutical and other medical supplies	Sub optimal utilization of the eLMIS	
Programme Coordination of the NTLP	Organisation of the NTLP	Lack of M&E Officers attached to the TB programme at subnational level	
		Coordination meetings and joint support and supervision on TB/ HIV collaborative activities were not regularly conducted at subnational level particularly at the district level	Limited financial support for conducting TB/HIV meetings
	TB Case finding	Low treatment coverage, in 2021 the treatment coverage was 2021	Constricted diagnostic network
	TB treatment and care	Persistently low treatment success rate (88% in 2021) against target (90%)	High rates of loss to follow-up due to deficits in case holding
		Late TB detection	Low coverage of rapid and molecular TB diagnostic tools.
	TB/HIV	Higher-level facilities (e.g., provincial hospitals) were not fully implementing the One Stop Shop TB/HIV care Model	Limited funding towards holding provincial TB/HIV collaborative meeting
	TB Prevention	Only 42% of Under 5 children were commenced on TPT in 2020	Low confidence levels by HCWs in prescribing TPT in under 5 children
	Screening for comorbidities	suboptimal coverage for TB/DM bidirectional screening	Limited resources for consumables such glucosticks
	TB in Vulnerable population	Low proportion of notifications contributed by children (6% against a target of 12%)	Low index of suspicion for Childhood TB

3. Strategic framework for TB control 2024-2026 with sub-activities

3.1 Vision

A Zimbabwe free of TB

3.2 Goals

By 2026 to have reduced the incidence of all forms of TB by 80% from 242/100,000 in 2015 to 48/100,000
By 2026 to have reduced mortality of all forms of TB by 80% from 40/100,000 in 2015 to 8/100,000.

3.3 Strategic Objective 1

To increase the treatment coverage of drug susceptible TB from 83% in 2018 to 90% by 2026

Strategic Interventions1.1: Improve case detection by expanding case finding to all clinical service areas/points

Activity 1.1.1: Develop TB case finding training material adapted from the WHO and national guidelines

Sub-activity 1.1.1.1: Hold a workshop of 30 staff to develop the TB case finding training materials.
Sub-activity 1.1.1.2: Print and disseminate the training materials
Sub-activity 1.1.1.3: Hold 10 Provincial trainings of 30 people for trainers of trainers
Sub-activity 1.1.1.4: Hold 20 cascade trainings of 30 people in each sitting at provincial/district level
sub-activity 1.1.1.5: Procure a consultant to Develop integrated comprehensive TB Training materials including slides for DS-TB, DR-TB diagnosis and treatment, TB prevention, Childhood TB, TB integration (TB/HIV/DM and PPM),

Strategic invention 1.2: Expand geographic coverage of highly sensitive diagnostic tools, this includes Xpert MTB/Rif/Truenat for early diagnosis of TB including universal drug-susceptibility testing and use of digital radiology as a more sensitive screening tool.

Activity 1.2.1: Expand access to highly sensitive, rapid and molecular diagnostic tools

Sub-activity 1.2.1.1: Procure 40 Genexpert machines
Sub-activity 1.2.1.2: Procure 60 Truenat machines
Sub-activity 1.2.1.3: Procure 300,000 GeneXpert cartridges per year
Sub-activity 1.2.1.4: Procure 60,000 reagents for Truenat
Sub-activity 1.2.1.5: Procure service level agreement for GeneXpert machines
Sub-activity 1.2.1.6: Installation and Training of laboratory scientists in the operations of GeneXpert and Truenat machines in the 4 and 60 sites respectively
Sub-activity 1.2.1.7: Procure 40 digital CXR machines equipped with CAD4TB
Sub-activity 1.2.1.8: Scale up laboratory Information Management System to all diagnostic sites to improve data analysis and aid data driven decision making
Sub-activity 1.2.1.9: Support lab to implement microscopy, Xpert and Truenat PT with consumables to use and funds for supervision of labs with high failure rates
Sub-activity 1.2.1.10: Conduct onsite LQMS mentorship by SRL
sub-activity 1.2.1.11: Procure 26,000 XDR Cartridges per year
sub-activity 1.2.1.12: Maintain Aspect connectivity for 157 Xpert machines and 80 Truenat platforms per year

Sub-activity 1.2.1.13: Conduct field visits to non-connected sites (Xpert & TrueNat) in the country yearly

sub-activity 1.2.1.14: Train 30 HCWs on Aspect connectivity per year Sub-activity 1.2.1.15: Hold a meeting of 30 people to update the integrated national specimen transportation plan/system to incorporate the needs of the TB programme

Suba-activity 1.2.1.16: Hold meetings at Provincial level for 15 people in each meeting for 5 days to plan for the sub-national specimen transportation network.

Sub-activity 1.2.1.17: Procure/develop a digital sample tracking system.

Sub-activity 1.2.1.18: Update the diagnostic algorithm to emphasise the collection of sputum for GeneXpert in patients diagnosed using LF-LAM

Sub-activity 1.2.1.19: Conduct internal and external quarterly assurance to all TB diagnostic facilities for both microscope and GeneXpert

Sub-activity 1.2.1.20: Hold a meeting of 20 people for 5 days to develop on job training and mentoring programs for laboratory personnel.

Sub-activity 1.2.1.21: Conduct a national wide evaluation of the sample transportation system to identify areas for improvement

Strategic intervention 1.3: Expand on active and intensified TB case finding approaches

Activity 1.3.1.: The national level to strengthen approaches to systematic TB screening

Sub-activity 1.3.1.1: The NTLP to hold a meeting for 30 people to develop and TB case finding plan for ACF/ICF detailing the structure and approaches to ACF/ICF at all levels of care, this will include templates for micro plans to be used by districts in their planning

Sub-activity 1.3.1.2: Provinces and districts to conduct workshops for at least 30 people to develop micro-plans using the template developed by the national level NTLP

Sub-activity 1.3.1.3: The National Level to Provide TSS in the execution of the micro-plans

Sub-activity 1.3.1.4: Recruit/support a clinician at national level as a coordinator of TB case finding (Tas4TB, PPM, Urban TB)

Sub-activity 1.3.1.5: The Provinces to provide TSS to the districts in the execution of micro-plans

Sub-activity 1.3.1.6: National Level to hold a workshop of 30 people to develop quality improvement Guidelines

Sub-activity 1.3.1.7: Conducting monthly facility site/community data driven review action planning meetings to review level of site implementation of decentralized case finding

Sub-activity 1.3.1.8: Procure ICF Stamps and Stamp ink for all pending 41 districts and stamp ink for the 26 districts already implementing the strategy

Sub-activity 1.3.1.9: Provincial team to conduct on-site Health Care Worker sensitization on TB screening, to all 1st ,2nd and 3rd level hospitals to raise index of suspicion for TB

Sub-activity 1.3.1.10: Onsite Orientation of frontline health care workers in TB diagnostic site in the clinical presentation and work out of patients with extrapulmonary TB

Sub-activity 1.3.1.11: Integration of TB case finding in all service units/points (MCH, IMCI, surgery, OBGY, ophthalmology, ART, and all in-patients' facilities

Sub-activity 1.3.1.12: Scaling up of TB/Covid, TB/DM, and occupational TB screening in all districts

Sub-activity 1.3.1.13: Hold a meeting of 30 people for 5 days Updating of TB screening algorithms to include all risk populations and newer tools

Sub-activity 1.3.1.14: Print and distribute TB screening algorithms

Sub-activity 1.3.1.15: Introduce facility-based contact tracing to complement community-based TB contact tracing.

Sub-activity 1.3.1.164: Recruit, train and retain 40 microscopists
sub-activity 1.3.1.17: Conduct Biosafety and Biosecurity training for laboratory staff twice a year for 80 people.
Sub activity 1.3.1.18: Procure microscopy reagents (120 GDF kits), 300 000 sputum cups for 230 sites per year
Sub-activity 1.3.1.19: Conduct a Mapping of the private health care provider and profile them into TB screening facilities, TB diagnostic and treatment facilities and TB treatment facilities
Sub-activity 1.3.1.20: Develop an implementation plan for PPM detailing the schedule for the absorption of private facilities as providers of TB services
Sub-activity 1.3.1.21: To operationalisation the PPM action plan, the NTLP through the Provincial Health and District offices to establish the memorandum of understanding
Sub-activity 1.3.1.22: Provide targeted TSS to private health facilities identified in the plan

Strategic intervention 1.4: Strengthen mechanisms for delivering integrated TB and HIV services

Activity 1.4.1: Hold TB/HIV collaborative meetings

Sub-activity 1.4.1.1: Hold combined TB and HIV TSS to the provinces and districts
Sub-activity 1.4.1.2: Hold combined TB/HIV data review meetings
Sub-activity 1.4.1.3: Train HIV officers in systematic TB screening
Sub-activity 1.4.1.4: Procure X number of urine LAM strips
Sub-activity 1.4.1.5: Provincial/District teams to conduct sensitization meetings to increase uptake of urine LAM in PLHIV who meet the national criteria.
Sub-activity 1.4.1.5 Support site-level attachments of 15 HCWs for 10 days at Centres of Excellence per quarter per provincial to build capacity for TB/HIV collaboration/One Stop Shop/TPT, IPC, AHD, pediatric diagnosis and care and CI

Strategic intervention 1.5: Improve childhood TB case detection

Activity 1.5.1: Build capacity in Childhood TB Screening

Sub-activity 1.5.1.1: Update the childhood TB guidelines
Sub-activity 1.5.1.2: Hold a national trainers of trainers training of staff
Sub-activity 1.5.1.3: Train laboratory staff in processing stool for TB diagnosis
Sub-activity 1.5.1.4: Train clinicians in reading and interpreting CXRs in children
Sub-activity 1.5.1.5: Train staff in conducting nasopharyngeal and gastric aspirates. and stool for TB diagnosis
Sub-activity 1.5.1.6: Strengthen TB screening in children living with HIV and those with malnutrition
Sub-activity 1.5.1.7: Conduct comprehensive contact investigations in children who are contacts of TB patients guided by cascade analysis/data
Sub-activity 1.5.1.8: Hold bi-monthly provincial quality improvement mentorship sessions to strengthen capacity of the teams at the existing Diagnostic and treatment units (DTUs)
Sub-activity 1.5.1.8: Procure and distribute stool collection containers and lab weighing machines
Sub-activity 1.5.1.9: Train 30 staff in each province in childhood TB to include diagnostic tools, child friendly medicines, reporting tools, to decentralize childhood TB diagnosis further to PHC facilities and clinics (using The Union's DETECT TB approach (targeting more nurses and Cos)
Sub-activity 1.5.1.10: Strengthen linkages with other programs that deal with child health such as RCH clinics, MNCH, HIV, Nutrition, EPI among others to increase screening and surveillance of TB among children by placing SOPS, presumptive TB registers in all the child health service points.

Sub-activity 1.5.1.11: Hold quarterly coordination meetings for 10 HCWs working in each of the 65 districts working in MCH

Strategic intervention 1.6: Promote TB service delivery in prisons and penitentiary institutions

Activity 1.6.1: Establish systematic TB screening in correctional facilities

Sub-activity 1.6.1.1: Develop SOPs for integrated TB/HIV/Nutrition screening in correctional facilities

Sub-activity 1.6.1.2: Print the SOPS for integrated TB/HIV/Nutrition screening in prisons

Sub-activity 1.6.1.3: Conduct bi-annual integrated TB/HIV/Nutrition mass screening in all correctional facilities

Sub-activity 1.6.1.4: Conduct on entry integrated TB/HIV/Nutrition screening in all correctional facilities

Strategic intervention 1.7: Strengthen access to TB services amongst migrant populations and artisanal miners

Activity 1.7.1: Develop approaches to TB screening for migrant populations and artisanal miners and the peri-mining communities and TB hotspots.

Sub-activity 1.7.1.1: Conduct mass TB screening campaigns in artisanal mining zones atleast once every quarter

Sub-activity1.7.1.2: Hold coordination meeting with IOM on TB services regarding TB screening among, miners, cross border and migratory communities

Sub-activity 1.7.1.3: Hold annual collaborative meetings with IOM and correctional service commission

Sub-activity 1.7.1.4: Hold a meeting to develop the schedule for the mobile TB vans and review quality of service under the mobile TB trucks

Sub-activity 1.7.1.5: Conduct targeted TB mass TB screening using x-ray trucks especially in hot spot areas/slums/correctional facilities

Strategic intervention 1.8: Strengthen TB/DM/Covid-19 bidirectional screening

Activity 1.8.1: Develop SOP for TB bi-directional screening in DM and in Covid-19 patients

Sub-activity 1.8.1.1: Train front line health care workers working in OPD/Diabetics in TB screening

Sub-activity 1.8.1.2: Conduct mass awareness campaigns on DM/TB and TB and Covid-19

Sub-activity 1.8.1.3: Hold a meeting of 20 staff to Develop, and Disseminate Integrated TB/HIV/NCD (DM, mental health and other NCDs) guidelines/SOPs

Strategic 1.9: Promote TB screening amongst HCWs

Activity 1.9.1: Strengthen TB screening among HCWs

Sub-activity 1.9.1.1: Conduct annual mass TB screening for TB in HCWs

Sub-activity 1.9.1.2: Conduct capacity building in TB screening for wellness clinics

Strategic initiative 1.10: Improve data handling and use for or decision making and action

Activity 1.10.1: Strengthen TB data management

Sub-activity 1.10.1.1: Conduct a TB inventory study

Sub-activity 1.10.1.2: Hold quarterly data review meetings

Sub-activity 1.10.1.3: Establish an online monthly TB data review platform

Sub-activity1.10.1.4 Hold a meeting to develop patient level data base for TB surveillance

Strategic intervention 1.11: Improve case detection by expanding case finding at community level and involvement of the private sector

Activity1.11.1: Support CSOs to conduct outreach interventions for priority key populations

Sub-activity: 1.11.1.1: Provide stipend to CHWs of 10 USD per month to conduct TBCI at community level and TB screening in per-mining communities (targeting artisanal miners)

Sub-activity 1.11.1.2: Hold meetings of 30 people to develop community led monitoring (CLM)

Sub-activity 1.11.1.3: Hold trainings for CSOs in CLM

Sub-activity 1.11.1.4: Train 10 clinicians and 10 nurses working private health facilities per province in TB diagnosis and management

Sub-activity 1.11.1.5: Hold half day meeting with private health facilities per province to review TB implantation including data review

Strategic intervention 1.12: Improve TB control in urban areas through introduction of differentiated service delivery through Urban Model in Harare and Bulawayo cities

Activity 1.12.1.1: Establishment and operationalisation of an Urban Area TB Task Force (a coordination mechanism) by bringing together all the stakeholders (50 people, per quarter)

Activity 1.12.1.2: Provide quarterly onsite mentorships using the continuous quality improvement (CQI) approach to private and public facilities.

Activity 1.12.1.3: Strengthening the capacity of the teams at the existing Diagnostic and treatment units (DTUs) through bi-monthly quality improvement mentorship sessions.

Activity 1.12.1.4: Strengthening laboratory capacity through monthly support supervision and conduction of external quality assurance (EQA), improving sputum sample referral and turnaround time of results as well as improving utilization of GeneXpert services including utilization of GxAlert data.

Activity 1.12.1.5: Strengthening monitoring and evaluation for the TB program in the urban area through support to health facility by District/province/ city/municipality/MoHCC/NTP teams to make timely, complete and accurate records for monthly reporting and quarterly performance reviews.

Activity 1.12.1.6: Identification of TB hotspots through use of GIS technology and mapping Hot spots out through targeted TB screening using a combined symptom/CXR approach.

Activity 1.12.1.7: Conducting monthly site data driven review meetings including cohort reviews and action planning.

Activity 1.12.1.8: Conducting quarterly partner data driven coordination meetings and action planning for 30 people for 5 days

Activity 1.12.1.9: At district level hold a 1 day end of month community team review meeting and action planning for 15 people

Strategic Intervention 1.13: Scale up TB Laboratory quality management system

Activity 1.13.1: Develop and implement laboratory quality improvement plan

Sub-activity 1.13.1.1: Form a quality project or quality management team

Sub-activity 1.13.1.2: Support the position of quality officer at the NTRL

Sub-activity 1.13.1.3: Hold a meeting for 20 people for 5 days to update the quality management manual/tool kit

Sub-activity 1.13.1.4: Hold onsite meetings to upgrade background knowledge of quality management amongst staff and management in all TB laboratories by the quality management team

Sub-activity 1.13.1.5: Establish a laboratory adequate stock and ordering system in which incoming supplies are checked for compliance with quality requirements

Sub-activity 1.13.1.6: Establish control system and information management system to create traceability of laboratory information.
Sub-activity 1.13.1.7: Hold a meeting for 30 people for 5 days to establish standard Operating Procedures for all processes performed in the laboratory and Development of Standard Operating Procedures for laboratory tests and equipment to assure that testing is performed in a standardized way, according to a defined methodology and with adequate adherence to safety rules
Sub-activity 1.13.1.8: Hold a meeting for 20 people to develop an equipment maintenance system
Sub-activity 1.13.1.9: Hold a meeting to upgrade laboratory biosafety.
Sub-activity 1.13.1.10: Renovate the NTRL infrastructure and bring it to the required standards
1ub-activity 1.13.1.11: Conduct a diagnostic network assessment to update the occurring situation with regard to TB laboratory diagnostics.
Sub-activity 1.13.1.12: Conduct a mapping of rapid molecular tools and identify the gaps to inform scale up and inform the setup of specimen courier system.
Sub-activity 1.13.1.13: Develop standard operating procedures (SOPs),
Sub-activity 1.13.1.14: Print and orient all laboratory personnel SOP.
Sub-activity 1.13.1.15: Develop an electronic stock management system (Stock-outs and use of expired reagents)
Sub-activity 1.13.1.16: Develop an equipment maintenance plan

3.4 Strategic Objective 2:

To increase the treatment success rate of patients with drug susceptible TB from 83% in 2017 to 90% by 2026

Strategic interventions: 2.1: Improve case holding

Activity 2.1.1: Develop SOPs for community health care workers
Sub-activity 2.1.1.1: Recruit/retain 2000 TB community volunteers
Sub-activity 2.1.1.2: Provide 10 USD stipend per month to 2000 community TB volunteers
Sub-activity 2.1.1.3: Provide the community volunteers with enablers, procure motor cycles, and bicycles
Sub-activity 2.1.1.4: Maintenance of motor bikes and bicycles

Strategic intervention 2.2: Reduce TB related mortality

Activity 2.2.1: Build clinical skill in TB management
Sub-activity 2.2.1.1: Train HCWs in TB management and clerkship
Sub-activity 2.2.1.2: Build capacity in management of Childhood TB and roll-out shorter treatment regimen for children
Sub-activity 2.2.1.3: Raise TB awareness through billboards and the media,
Sub-activity 2.2.1.4: Conduct TB mortality study to understand the drivers of TB mortality
Sub-activity 2.2.1.5: Print death audit forms for routine surveillance
Sub-activity 2.2.1.6: Hold TB mortality review and action planning meetings at facility and district levels
Sub-activity 2.2.1.7: Hold trainings on how to conduct TB mortality audit and an orientation on death audit forms
Sub-activity 2.2.1.8: Hold a meeting for 20 people to update guidelines to take on the new WHO recommendations for non-severe TB (4 months regimen).

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3.5 Strategic Objective 3:

To achieve universal HIV testing and ART coverage for TB cases by 2021 and sustain coverage through to 2026

Strategic Interventions 3.1: Strengthen mechanisms for delivering integrated TB and HIV services

Activity 3.1.1: Strengthen TB/HIV collaboration at all levels

Sub-activity 3.1.1.1: Hold TB/HIV collaborative meetings for 100 people for 3 days

Sub-activity 3.1.1.2: Sustain a stable supply of HIV test kits

Sub-activity 3.1.1.3: Intensify HIV testing in presumptive and confirmed TB patients and offer high-quality patient-centered HIV care for HIV co-infected TB patients.

Sub-activity 3.1.1.4: Train TB HCWs in HIV and ART management refresher in TB/HIV

Sub-activity 3.1.1.5: Conduct national facility assessments, including assessment of level of TB/HIV care service integration: 10 teams of 5 people from national level (4 national and 1 provincial) x 6 days per quarter (65 districts) annually

Sub-activity 3.1.1.6: Conduct quarterly national TB/HIV TWG review and action planning meeting for 20 people for 1/2 a day annually

Sub-activity 3.1.1.7: Conduct monthly district (DHE) coordination meetings (2024 - 2026) meetings for 10 people for 1 day x 65 districts

Sub-activity 3.1.1.8: Conduct monthly district TB/HIV coordination meetings for 10 people for 1 day x 65 districts

Strategic Intervention 3.2: Build clinical and programmatic competencies in TB/HIV management

Activity 3.2.1: Update TB/HIV guidelines and

Sub-activity 3.2.1.1: Hold a meeting to review and update the TB/HIV guidelines

Sub-activity 3.2.1.2: Conduct TB/HIV trainings

Sub-activity 3.2.1.3: Develop a TB/HIV ECHO curriculum, including the revision of blended learning curriculum for 30 people x 3 days conferencing

Sub-activity 3.2.1.4: Procure ECHO platform for facilities that currently do not have

Sub-activity 3.2.1.5: Procure internet bundles for district coordinators

Sub-activity 3.2.1.6: Hold weekly TB/HIV didactic session

Sub-activity 3.2.1.7: Support site -level attachments of 15 HCWs for 10 days at Centres of Excellence per quarter (Provincial level) to build capacity for TB/HIV collaboration/One Stop Shop/TPT, IPC, AHD, (3 provinces in Q1; 3 provinces Q2; 2 provinces Q3 & 2 provinces Q4 annually)

Strategic intervention3.3: Improve the coverage of TPT towards saturation

Activity 3.3.1: Scale Up TPT

Sub-activity 3.3.1.1: Hold a meeting to develop a TPT scale up plan

Sub-activity 3.3.1.2: Hold quarterly meetings to review the performance of the TPT scale up

Sub-activity 3.3.1.3: Procure shorter TPT regimens (IHP,3HP, 3RH) for both adults and children respectively

Sub-activity 3.3.1.4: Procure and print TPT registers

Sub-activity 3.3.1.5: Conduct two Regional TOT on TPT for 35 participants for two and a half days x 2 trainings

Sub-activity 3.3.1.7: Hold a 5-day meeting to develop, SOPs and job aides that include shorter TPT regimens for HCWs and Recipients of Care

Sub-activity 3.3.1.8: Print and distribute IEC materials for TPT to all districts and facilities
Sub-activity 3.3.1.9: Cluster orientation of Community Health Workers, CARG leaders and Expert Clients on TPT including SOPs, tools and guidelines distribution to be done by facility health workers at monthly meetings with VHWs
Sub-activity3.3.1.10: Mass awareness raising on TPT to create demand, taking on board the TPT/TB champions and celebrities.
Sub-activity 3.3.1.11: Hold TPT trainings and re-orientation for front line HCW to help create demand and improve quality of service provision in TPT

3.6 Strategic Objective 4:

To cumulatively detect 2,680 patients with RR/MDR TB between 2021 and 2026

Strategic interventions:4.1: Improve case detection by expanding access to rapid WHO approved molecular diagnostic tools

Activity 4.1.1: Expand coverage of molecular diagnostic tools
Sub-activity 4.1.1.1: Procure 40 GeneXpert machines with 10 color modules
Sub-activity 4.1.1.2: Procure 60 Truenat machines
Sub-activity 4.1.1.3: Procure two whole Genome sequencing equipment for the two reference labs
Sub-activity 4.1.1.4: Procure reagents for culture and DST including for new drug molecules
Sub-activity 4.1.1.5: Conduct quarterly external quality assessment to all GeneXpert sites
Sub-activity 4.1.1.6 Support International advanced trainings and conferences for laboratory staff (QMS and advanced molecular diagnostics; training 2 safety and 2 quality officers from NTRLs every 2 years at the Uganda SRL for accreditation).
Sub-activity 4.1.1.7 Revise Quality Handbook, TB Microscopy ,Truenat & Xpert MTB/Rif SOPs
Sub-activity 4.1.1.8 Print and distribute 500 copies each of Quality handbook, Microscopy, Truenat and Xpert MTB/Rif SOPs
Sub-activity 4.1.1.9 Conduct TB QMS training for TB laboratory supervisors for 2 provincial laboratory scientists per province, and 3 facilitators
Sub-activity 4.1.1.10 Develop the TB Laboratory bio-safety &biosecurity manual for use at sub-national level for 2 participants per province and 2 participants per reference Lab and 2 from the NTP and 4 from partners
Sub-activity 4.1.1.11 Conduct refresher training on Microscopy ,Truenat and Xpert MTB/Rif (Ultra) for Microscopists from all levels (1microscopist/technician per diagnosing centre and 4 facilitators)
Sub-activity 4.1.1.12 Stationery and computer consumables for NRLs for QMS Implementation and maintenance
Sub-activity 4.1.1.13 Enroll in an external QMS accreditation assessment for the NTBRL (e.g., SANAS, or SADCAS) and Management Review meetings
Sub-activity 4.1.1.14 Conduct quarterly TB QMS/EQA mentorship visits provincial to district levels for 9 teams each composed of 2 provincial scientists and a driver
Sub-activity 4.1.1.15 Enroll in an external QMS accreditation assessment for the NMRL (e.g., SANAS, or SADCAS) Initial and Annual Assessment; Airfare, Visa and DSA
Sub-activity 4.1.1.16 Conduct quarterly TB QMS/EQA mentorship visits from national to provincial levels for 2 teams of 2 NRL officers and a driver
Sub-activity 4.1.1.17 Conduct support visits for Aspect for 80 sites that have connected Coverage by 2 teams of 3 people each

Sub-activity 4.1.1.18 Procure Aspect equipment for additional 80 sites
Sub-activity 4.1.1.19 Pay connectivity fees for Aspect services for 205 sites (to increase coverage to 100%)
Sub-activity 4.1.1.20 Maintenance and service contracts (3 Hain equipment ,4 MGIT,130, 2 generators AUTOCLAVES,250 Microscopes, 2 containerized labs,2 level 3 lab and 140 level 1 bscs,)
Sub-activity 4.1.1.21: Procure service contract for auxillary equipment

Strategic intervention 4.2: Build capacity in DR TB

Activity 4.2.1: Develop a training plan for DR TB

Sub-activity 4.2.1.1: Hold a meeting to review and finalise DR TB guidelines
Sub-activity 4.2.1.2: Hold provincial trainings in DR TB
Sub-activity 4.2.1.3: Hold DR-TB Concilium meeting at all sites to review all DR-TB patients enrolled on DR TB treatment (irrespective of being complex/complicated or not)
Sub-activity 4.2.1.4: Raise public awareness of DR TB
Sub-activity 4.2.1.5: Conduct contact tracing for all index DR TB patients

3.7 Strategic Objective 5:

Increase the treatment success rate of patients with RR/MDR TB from 57% (2016) to 75% by 2026

Strategic intervention 5.1: Introduce new and shorter and patient friendly DR TB regimens

Activity 5.1.1: Hold a 5-day consultative meeting on DR TB for 30 members of consilium/clinical expert committee

Sub-activity 5.1.1.1: Hold a meeting to review and finalisePMDT guidelines to include newer regimens (BPaL/BPaLM)
Sub-activity 5.1.1.2: Print and disseminate DR TB guidelines
Sub-activity 5.1.1.3: Procure and distribute second line TB drugs including DR-TB child friendly formulations (450 –500 DR-TB cases per year)
Sub-activity 5.1.1.4: Support site-level attachments of 15 HCWs for 10 days at Centres of Excellence per quarter per provincial to build capacity in DR TB
Sub-activity 5.1.1.5: Train 15 EHTs per province in DR TB to support contact tracing, and DOT
Sub-activity 5.1.1.6: Hold a Training of PMDT HCW care team in 60 PMDT sites (Clinicians, nurses, lab techs, Radiologists/radiographers, nutritionists, pharmacists) on DR-TB Diagnosis, and management, follow up care, aDSM and R&R including eHR, BPaL/BPaLM the new shorter regimen
Sub-activity 5.1.1.7: Conduct a meeting to Review and finalize aDSM Module in eHR including development of aDSM indicators/variables for the DHIS 2 Dashboard
Sub-activity 5.1.1.8: Procure and distribute ancillary medicines to DR-TB sites to manage severe adverse reactions
Sub-activity 5.1.1.9: Conduct Annual Green Light Committee TA mission
Sub-activity 5.1.1.10: Conduct annual Global Drug Facility (GDF) TA mission
Sub-activity 5.1.1.11: Introduce fixed monthly clinical review days to enable patients to be seen by Medical Officer trained in DR-TB case management
Sub-activity 5.1.1.12: Conduct ENHANCED DR-TB Cohort reviews/analysis for both interim (6 and 12 months) and final Outcomes at 24 months and further disaggregate the data by age, sex, , site, HIV status, NCD, treatment initiation delay beyond 7 days – to identify outcome drivers for both favourable and unfavourable outcomes)

Sub-activity 5.1.1.13: Development and Dissemination of a 3-year standardized DR-TB cohort schedule to standardize cohort analysis and reporting.

Strategic interventions 5.2: Improve case holding by extending DOT and treatment support to community level through the use of CHWs

Activity 5.2.1: Build capacity in CHWs on DR TB interventions

Sub-activity 5.2.1.1: Train 500 CHWs in DR-TB

Sub-activity 5.2.1.2: Hold a meeting to develop a DR TB linkage to care system

Sub-activity 5.2.1.3: Conduct monthly home visits by a nurse and clinicians

Sub-activity 5.2.1.4: CHWs to provide psychosocial support

Sub-activity 5,2,1,5: Conduct Mortality audits to identify drivers of DR-TB mortality and take appropriate actions

Sub-activity 5.2.1.6: Map out and profile DR-TB sites with both clinical and lab capacity (at least 1 per district) (fixed treatment initiation facilities)

Sub-activity 5.2.1.7: Develop and implement a standardized minimum package of care interventions to be offered at all treatment initiation sites

Sub-activity 5.2.1.8: Introducing Quarterly District DR-TB performance and action planning meetings at provincial level (40 participants, quarterly) x 10 provinces

Strategic intervention 5.3: Improve the coverage of nutritional support provided to DR TB patients

Activity 5.3.1: Develop a standard nutritional plan and package for DR-TB patients

Sub-activity 5.3.1.1: Procure food hampers for 894 patients per year at USD 100 per months x 6 – 12 months and provide transport at USD 50 per month x 6-12 month

Sub-activity 5.3.1.2: Provide monthly transport refund to all DR TB patients

Strategic intervention 5.4: Strengthen aDSM monitoring

Activity 5.4.1: Upscale the implementation of aDSM

Sub-activity5.4.1.1: Conduct a meeting to Review and finalize aDSM Module in eHR including development of aDSM indicators/variables for the DHIS 2 Dashboard

Sub-activity 5.4.1.2: Procure X portable ECG machines, and printing paper to all DR-TB sites

Sub-activity 5.4.1.3: Conduct training in aDSM for 300 nurses, and 30 clinicians per province

Sub-activity 5.4.1.4: Procure and distribute ancillary medicines to DR-TB sites to manage severe adverse reactions

Sub-activity 5.4.1.5: Procure and distribute Ishihara and Snellen's charts

Sub-activity 5.4.1.6: Procure services for Biochemistry and Haematology tests for DR patients (for safety labs)

Sub-activity 5.4.1.7: Strengthen the linkage of aDSM reporting with the pharmacovigilance committee of Zimbabwe

3.8 Strategic Objective 6:

Decrease the proportion of households facing catastrophic costs due to TB from 80% in 2019 to 50% by 2026

Strategic intervention 6.1: Scale up advocacy for increased funding of TB intervention and social protection for TB patients

Activity 6.1.1: Engage other organizations/departments that provide social protection to include TB patients among target beneficiaries (e.g., Ministry of Social welfare, World Food Programme, Food and Agricultural Organization, UNICEF).

Sub-activity 6.1.1.1: Hold a meeting with the strategic organization to lobby for inclusion of TB patients in social security support.

Activity 6.1.2: Provide psychosocial and palliative care support for TB patients and their households.

Activity 6.1.3: Develop and implement a financial risk protection policy for TB patients and their households.

Activity 6.1.4: Conduct a follow-on TB Patient Cost survey

Activity 6.1.5: Improving linkages with the private sectors and

Activity 6.1.6: Establishing linkages with income generating activities

Activity 6.1.7: Advocate for cost waiver for CXR for TB presumptive TB patients and provision of transport refunds presenting for their clinical reviews/visits (revive transport coupons)

3.9 Strategic Objective 7:

Scale up leprosy prevention alongside integrated active case detection

Strategic interventions 7.1: Promoting partnerships with Leprosy stakeholders

Activity 7.1.1: Hold collaborative meetings

Sub-activity 7.1.1.1: Hold quarterly partners meeting on Leprosy

Sub-activity 7.1.1.2: Hold resource mobilization meetings and advocate for Leprosy

Strategic intervention 7.2: Strengthen clinical capacity to improve case detection

Activity 7.2.1: Build capacity in the diagnosis and management of Leprosy

Sub-activity 7.2.1.1: Hold meetings to review and update Leprosy guidelines

Sub-activity 7.2.1.2: Print and distribute Leprosy guidelines

Sub-activity 7.2.1.3: Train 30 trainers of trainers

Strategic intervention 7.3: Strengthen surveillance and information systems for Leprosy

Activity 7.3.1: Build capacity in Leprosy surveillance

Sub-activity 7.3.1.1: Hold training for HCW in Leprosy surveillance

Sub-activity 7.3.1.2: Print and distribute X registers for Leprosy

3.10 Strategic Objective 8:

Strengthen Programme coordination and management and enhance accountability

Strategic intervention 8.1 Strengthen coordination between the NTLP and implementing and cooperating partners and the private players.

Activity 8.1.1: Enhance coordination between the NTLP and collaborating partners through joint planning, implementation monitoring and evaluation

Sub-activity 8.1.1.1: Hold meetings of 20 people to revise the current CTBC & ACSM guidelines in line with the Costed TB CRG Action Plan and Patient charter.

Sub-activity 8.1.1.2: Hold a meeting of 30 people to Develop and disseminate a capacity building toolkit for the revised PPM and CTBC guidelines.

Sub-activity 8.1.1.3: Hold a meeting annually to validate the final CRG assessment draft report, develop and implement a Costed TB CRG Action Plan.

Sub-activity 8.1.1.4: Hold a meeting to develop community led monitoring framework and link it to the national community health information management system.

Sub-activity 8.1.1.5: Roll out a digital community led monitoring digital App and create linkages with the new community health electronic platform.

Strategic intervention 8.2: Enhance community TB response

Activity: 8.2.1: Community-led research and advocacy

Sub-activity 8.2.1.1: conduct a study to explore needs, barriers, and opportunities for improvements in services and programs, including research on stigma, discrimination, and legal and gender-related issues, and research about revenue and funding allocations and expenditures in efforts against TB, and its comorbidities.

Sub-activity 8.2.1.2: Hold meetings to disseminate findings of community-led research.

Sub-activity 8.2.1.3: Hold meetings with decision makers on finding from the research and to communicate recommendations, co-create shared solutions for improved health services.

Sub-activity 8.2.1.4: Conduct CRG assessment to identify the specific human rights, gender, and community factors hindering the TB response.

Sub-activity 8.2.1.5: Conduct quarterly client satisfaction survey in all provinces

Sub-activity 8.2.1.5: Conduct the TB stigma assessment to understand the levels of TB stigma

Activity 8.2.2 Capacity and leadership development

Sub-activity 8.2.2.1 Hold Trainings, mentorship and sustained support to help community-led and -based organizations to integrate TB within their interventions, functional governance, and participate and contribute to strategic plans.

Activity 8.2.2: Community engagement, linkages and coordination

Sub-activity 8.2.2.1: Hold coordination meetings with community players

Sub-activity 8.2.2.2: Conduct a mapping exercise of all community organisation engaged in TB

Sub-activity 8.2.2.3: Conduct sensitization programs about TB targeting key and vulnerable populations.

Sub-activity 8.2.2.4: Hold a meeting with key stakeholders to review, and harmonize CHW incentive scheme

Sub-activity 8.2.2.5: Hold meeting to engage traditional and religious leaders on TB

Strategic intervention: 8.3 Enhance accountability in the TB response

Activity 8.3.1: Implement Multisectoral accountability framework for TB(MAF-TB)

Sub-activity 8.3.1.1: Hold meetings to disseminate the framework of MAF-TB

Sub-activity 8.3.1.2: Hold quarterly meetings with all stakeholders to review the implementations of MAF-TB

Sub-activity: 8.3.1.3: Conduct MAF-TB Baseline assessment

Sub-activity 8.3.1.4: Hold a 5 day meeting to engage all relevant line ministries, CSOs and stakeholders to draw sector MAF-TB action plans

Sub-activity 8.3.1.5: Conduct semi-annual MAF-TB coordination, performance reviews, and action planning meetings in respect to MAF-TB set targets (250 delegates – fuel, allowances, conferencing

Sub-activity 8.3.1.6: Roll-out OneImpact mobile app in all provinces

Sub-activity 8.3.1.7: Coordinate efforts through ACSM to place TB higher on the political agenda.

Sub-activity 8.3.1.8: Mobilise stakeholder to raise resources for TB.

Sub-activity 8.3.1.9: Engage gatekeeper to Combat stigma and discrimination of TB patients and their families

Sub-activity 8.3.1.10: Empowering people affected by TB to help reduce the inequalities

Sub-activity 8.3.1.11: Print and distribute brochures to all centres for TB patients

Sub-activity 8.3.1.12: Run mass TB sensitisation using the print, radio and television media to inform the public about TB

Strategic interventions 8.4: Improve monitoring and evaluation for TB and Leprosy

Activity 8.4.1: Enhance quality of data

Sub-activity 8.4.1.1: Conduct quarterly data quality assessments supportive supervisons.

Sub-activity 8.4.1.2: Hold trainings on data analysis and use

Sub-activity 8.4.1.3: Roll-out electronic health records for TB to all TB notification sites

Sub-activity 8.4.14: Recruit M&E officers for TB at subnational level

Sub-activity 8.4.1.5: Develop, print, and distribution an integrated and comprehensive support supervision checklist covering all TB program areas for provinces (TB-PMO and PTLCs) and Districts (DHT and DTLC)

Sub-activity 8.4.1.6: Conduct GIS mapping of Hot spots annually to guide targeted TB screening

Sub-activity 8.4.1.7: Conduct quarterly data driven coordination and action planning meetings lead by the City Task force with NTP technical support

Sub-activity 8.4.1.8: Develop and disseminate TB/Leprosy Annual Report

Sub-activity 8.4.1.9: Hold a workshop to develop subnational TB burden estimates and targets

Sub-activity 8.4.1.10: Procure TA to develop subnational TB burden estimates and targets

Sub-activity 8.4.1.11: Facilitate DTLCs and District HMIS officers (Fuel, allowances, and airtime) to capture, collate, clean and promptly enter facility data in DHIS 2 monthly to ensure timeliness, completeness, and accuracy of data within set timelines (Fuel, allowances, and airtime for 2 (DTLC and HMIS) monthly x 12 months x 67 Districts)

Sub-activity 8.4.1.12: Fast track the development and completion of TB module in herEHR including the DHIS2 tracker and a case-based surveillance, for both DS TB and DR TB

Sub-activity8.4.1.13: Establishing a practice of locking data sets once 100% reporting and accuracy is attained to prevent changes in annual aggregates for each indicator over time

Sub-activity 8.4.1.14: Procure tablets for TB data management

Sub-activity 8.4.1.15: Procure TA to develop a self-assessment for TB

Sub-activity 8.4.1.16: Roll-out the self-assessment starting with a pilot in a few districts

Strategic intervention: 8.5 Strengthen TB Research to guide the TB response

Activity 8.5.1: Implement Operational research and Surveys

Sub-activity 8.5.1.1: Conduct the DRS survey

Sub-activity 8.5.1.2: Conduct the Population based National TB prevalence survey

Sub-activity 8.5.1.3: Patient cost survey

Sub-activity 8.5.1.4: Conduct patient Pathway Analysis Study

Table 2: Strategic Plan matrix

Strategic invention1.2 Expand geographic coverage of highly sensitive diagnostic tools, this Xpert MTB/Rif/Truenat for early diagnosis of TB including universal drug-susceptibility testing and use of digital radiology as a more sensitive screening tool.

STRATEGIC INTERVENTION 1.2	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Expand geographic coverage of highly sensitive diagnostic tools, this Xpert MTB/Rif/Truenat for early diagnosis of TB including universal drug-susceptibility testing and use of digital radiology as a more sensitive screening tool.	1.2.1.1	Procure 40 GeneXpert machines with ten-colour modules	764,560	1	764,560	814,256	0	0	867,183	0	0	1	764,560	X			MoHCC-NTP National Level
	1.2.1.2	Procure 60 Truenat machines	364,320	1	364,320	388,001	0	0	413,221	0	0	1	364,320	X			MoHCC-NTP National Level
	1.2.1.3	Procure 300,000 and 4000 GeneXpert 10 color cartridges per year	3,810,768	1	3,810,768	4,058,468	0	0	4,322,268	0	0	1	3,810,768	X			MoHCC-NTP National Level
	1.2.1.4	Procure 60,000 reagents for Truenat	732,000	1	732,000	779,580	1	779,580	830,253	1	830,253	3	2,341,833	X	X	X	MoHCC-NTP National Level
	1.2.1.5	Procure service level agreement for GeneX-pert machines	380,000	1	380,000	404,700	1	404,700	431,006	1	431,006	3	1,215,706	X	X	X	MoHCC-NTP National Level
	1.2.1.6	Installation and Training of laboratory scientists in the operations of GeneXpert and Truenat machines in the 40 and 60 sites respectively	60,400	10	604,000	64,326	0	0	68,507	0	0	10	604,000	X			MoHCC-NTP National Level
	1.2.1.7	Procure 40 digital CXR machines equipped with CAD4TB	3,200,000	1	3,200,000	3,408,000	0	0	3,629,520	0	0	1	3,200,000	X			MoHCC-NTP National Level

	1.2.1.8	Scale up laboratory Information Management System to all diagnostic sites to improve data analysis and aid data driven decision making	13,900	28.33333333	393,833	14,804	28.33333333	419,433	15,766	28.33333333	446,696	85	1,259,961	X	X	X	MoHCC-NTP National Level
	1.2.1.9	Support lab to implement microscopy, Xpert and Truenat PT with consumables to use and funds for supervision of labs with high failure rates	34,200	1	34,200	36,423	1	36,423	38,790	1	38,790	3	109,413	X	X	X	MoHCC-NTP National Level
	1.2.1.10	Conduct onsite LQMS mentorship by SRL	140,000	20	2,800,000	149,100	20	2,982,000	158,792	20	3,175,830	60	8,957,830	X	X	X	MoHCC-NTP National Level
	1.2.1.11	Procure 26,000 XDR Cartridges per year	171,600	1	171,600	182,754	1	182,754	194,633	1	194,633	3	548,987	X	X	X	MoHCC-NTP National Level
	1.2.1.12	Maintain Aspect connectivity for 164 Xpert machines and 80 Truenat platforms per year	264,960	2	529,920	282,182	2	564,365	300,524	2	601,049	6	1,695,333	X	X	X	MoHCC-NTP National Level
	1.2.1.14	Train 30 HCWs on Aspect connectivity per year	4,150	1	4,150	4,420	1	4,420	4,707	1	4,707	3	13,277	X	X	X	MoHCC-NTP National Level
	1.2.1.15	Hold a meeting of 30 people to update the integrated national specimen transportation plan/system to incorporate the needs of the TB programme	10,400	1	10,400	11,076		0	11,796		0	1	10,400	X			MoHCC-NTP National Level
	1.2.1.16	Hold meetings at Provincial level for 15 people in each meeting for 5 days to plan for the sub-national specimen transportation network.	10,500	10	105,000	(11,183)		0	11,909		0	10	105,000	X			MoHCC-NTP National Level
	1.2.1.17	Procure/develop a digital sample tracking system	106,500	1	106,500	113,423		0	120,795		0	1	106,500	X			MoHCC-NTP National Level

	1.2.1.18	Update the diagnostic algorithm to emphasise the collection of sputum for GeneXpert in patients diagnosed using LF-LAM	4,950	1	4,950	5,272		0	5,614		0	1	4,950	X			MoHCC-NTP National Level
	1.2.1.19	Conduct internal and external quarterly assurance to all TB diagnostic facilities for both microscope and GeneXpert			0			0			0	0	0				MoHCC-NTP National Level
	1.2.1.20	Hold a meeting of 20 people for 5 days to develop on job training and mentoring programs for laboratory personnel.	15,200	1	15,200	16,188		0	17,240		0	1	15,200	X			MoHCC-NTP National Level
	1.2.1.21	Conduct a national wide evaluation of the sample transportation system to identify areas for improvement	9,250	1	9,250	9,851	1	9,851	10,492	1	10,492	3	29,593	X	X	X	MoHCC-NTP National Level
Strategic Intervention 1.2: Sub Total					**14,040,651**			**5,383,525**			**5,733,454**		**25,157,631**				

Strategic intervention 1.3: Expand on active and intensified TB case finding approaches

STRATEGIC INTERVENTION 1.3	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Expand on active and intensified TB case finding approaches	1.3.1.1	The NTLP to hold a meeting for 30 people to develop a TB case finding plan for ACF/ICF detailing the structure and approaches to ACF/ICF at all levels of care, this will include templates for micro plans to be used by districts in their planning	11,100	1	11,100	11,822		0	12,590		0	1	11,100	X			MoHCC-NTP Provincial / District Level
	1.3.1.2	Provinces and districts to conduct workshops for at least 30 people to develop micro-plans using the template developed by the national level NTLP	6,600	95	627,000	7,029	95	667,755	7,486	95	711,159	285	2,005,914	X	X	X	MoHCC-NTP Provincial / District Level

	1.3.1.3	The National Level to Provide TSS in the execution of the micro-plans	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	1.3.1.4	Recruit/support a clinician at national level as a coordinator of TB case finding (Tas4TB, PPM, Urban TB)	18,000	1	18,000	19,170	1	19,170	20,416	1	20,416	3	57,586	X	X	X	MoHCC-NTP National Level
	1.3.1.5	The Provinces to provide TSS to the districts in the execution of micro-plans	1,250	44.66666667	55,833	1,331	44.66666667	59,463	1,418	44.66666667	63,328	134	178,623	X	X	X	MoHCC-NTP Provincial / District Level
	1.3.1.6	National Level to hold a workshop of 30 people to develop quality improvement Guidelines	10,750	1	10,750	11,449	1	11,449	12,193	1	12,193	3	34,392	X	X	X	MoHCC-NTP National Level
	1.3.1.7	Conducting monthly facility site/community data driven review action planning meetings to review level of site implementation of decentralized case finding	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	1.3.1.8	Procure ICF Stamps and Stamp ink for all pending 41 districts and stamp ink for the 26 districts already implementing the strategy	27,250	1	27,250	29,021	1	29,021	30,908	1	30,908	3	87,179	X	X	X	MoHCC-NTP Provincial / District Level
	1.3.1.9	Provincial team to conduct on-site Health Care Worker sensitization on TB screening, to all 1st ,2nd and 3rd level hospitals	1,250	40	50,000	0	40	0	0	40	0	120	50,000	X	X	X	MoHCC-NTP National Level
	1.3.1.10	Onsite Orientation of frontline health care workers in TB diagnostic site in the clinical presentation and work out of patients with extrapulmonary TB	1,250	10	12,500	1,331	10	13,313	1,418	10	14,178	30	39,990	X	X	X	MoHCC-NTP National Level
	1.3.1.11	Integration of TB case finding in all service units/points (MCH, IMCI, surgery, OBGY, ophthalmology, ART, and all in-patients' facilities	15,040	1	15,040	16,018	1	16,018	17,059	1	17,059	3	48,116	X	X	X	MoHCC-NTP National Level

	1.3.1.12	Scaling up of TB/Covid, TB/DM, and occupational TB screening in all districts	115,040	1	115,040	122,518	1	122,518	130,481	1	130,481	3	368,039	X	X	X	MoHCC-NTP National Level
	1.3.1.13	Hold a meeting of 30 people for 5 days Updating of TB screening algorithms to include all risk populations and newer tools	10,200	1	10,200	10,863		0	11,569		0	1	10,200	X			MoHCC-NTP National Level
	1.3.1.14	Print and distribute TB screening algorithms	40,838	1	40,838	43,492		0	46,319		0	1	40,838	X			MoHCC-NTP National Level
	1.3.1.15	Introduce facility-based contact tracing to complement community-based TB contact tracing.	281,900	1	281,900	300,224		0	319,738		0	1	281,900	X			MoHCC-NTP National Level
	1.3.1.16	Recruit, train and retain 40 Microscopists	145,440	1	145,440	154,894	1	154,894	164,962	1	164,962	3	465,295	X	X	X	MoHCC-NTP National Level
	1.3.1.17	Conduct Biosafety and Biosecurity training for laboratory staff twice a year for 80 people.	29,200	2	58,400	31,098	2	62,196	33,119	2	66,239	6	186,835	X	X	X	MoHCC-NTP National Level
	1.3.1.18	Procure microscopy reagents (120 GDF kits), 300 000 sputum cups for 230 sites per year	30,988	1	30,988	33,002	1	33,002	35,147	1	35,147	3	99,136	X	X	X	MoHCC-NTP National Level
	1.3.1.19	Conduct a Mapping of the private health care provider and profile them into TB screening facilities, TB diagnostic and treatment facilities and TB treatment facilities	23,520	1	23,520	25,049		0	26,677		0	1	23,520	X			MoHCC-NTP National Level
	1.3.1.20	Develop an implementation plan for PPM detailing the schedule for the absorption of private facilities as providers of TB services	4,950	1	4,950	5,272		0	5,614		0	1	4,950	X			MoHCC-NTP National Level

	1.3.1.21	To operationalisation the PPM action plan, the NTLP through the Provincial Health and District offices to establish the memorandum of understanding			0			0			0	0	0				MoHCC-NTP National Level
	1.3.1.22	Provide targeted TSS to private health facilities identified in the plan	1,250	100	125,000	1,331	100	133,125	1,418	100	141,778	300	399,903	X	X	X	MoHCC-NTP National Level
Strategic Intervention 1.3: Sub Total					**1,663,748**			**1,321,922**			**1,407,846**		**4,393,517**				

Strategic intervention 1.4: Strengthen mechanisms for delivering integrated TB and HIV services

STRATEGIC INTERVENTION 1.4	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strengthen mechanisms for delivering integrated TB and HIV services	1.4.1.1	Hold combined TB and HIV TSS to the provinces and districts	36,925	2	73,850	39,325	2	78,650	41,881	2	83,763	6	236,263	X	X	X	MoHCC-NTP National Level
	1.4.1.2	Hold combined TB/HIV data review meetings	14,800	2	29,600	15,762	2	31,524	16,787	2	33,573	6	94,697	X	X	X	MoHCC-NTP National Level
	1.4.1.3	Train HIV officers in systematic TB screening	14,800	2	29,600	15,762	2	31,524	16,787	2	33,573	6	94,697	X	X	X	MoHCC-NTP National Level
	1.4.1.4	Procure X number of urine LAM strips per year	67,618	1	67,618	72,013	1	72,013	76,693	1	76,693	3	216,324	X	X	X	MoHCC-NTP National Level
	1.4.1.5	Provincial/District teams to conduct sensitization meetings to increase uptake of urine LAM in PLHIV who meet the national criteria.	12,900	2	25,800	13,739	2	27,477	14,632	2	29,263	6	82,540	X	X	X	MoHCC-NTP Provincial / District Level

	1.4.1.5	Support site-level attachments of 15 HCWs for 10 days at Centres of Excellence per quarter per provincial to build capacity for TB/HIV collaboration/One Stop Shop/TPT, IPC, AHD, pediatric diagnosis and care and CI	2,250	40	90,000	2,396	40	95,850	2,552	40	102,080	120	287,930	X	X	X	MoHCC-NTP Provincial / District Level
Strategic Intervention 1.4: Sub Total					**316,468**			**337,038**			**358,945**		**1,012,451**				

Strategic intervention 1.5: Improve childhood TB case detection

STRATEGIC INTERVENTION 1.5	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Improve childhood TB case detection	1.5.1.1	Update the childhood TB guidelines	13,640	1	13,640	14,527	1	14,527	15,471	1	15,471	3	43,637	X	X	X	MoHCC-NTP National Level
	1.5.1.2	Hold a national trainers of trainers training of staff	25,800	1	25,800	27,477		0	29,263		0	1	25,800	X			MoHCC-NTP National Level
	1.5.1.3	Train laboratory staff in processing stool for TB diagnosis	13,400	10	134,000	14,271		0	15,199		0	10	134,000	X			MoHCC-NTP National Level
	1.5.1.4	Train clinicians in reading and interpreting CXRs in children	14,200	2	28,400	15,123	2	30,246	16,106	2	32,212	6	90,858	X	X	X	MoHCC-NTP National Level
	1.5.1.5	Train staff in conducting nasopharyngeal and gastric aspirates, and stool for TB diagnosis to include diagnostic tools, child friendly medicines, reporting tools, to decentralize childhood TB diagnosis further to PHC facilities and clinics (using The Union's DETECT TB approach (targeting more nurses and Cos)	8,800	65	572,000	9,372	65	609,180	9,981	65	648,777	195	1,829,957	X	X	X	MoHCC-NTP National Level

	1.5.1.6	Strengthen TB screening in children living with HIV and those with malnutrition	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	1.5.1.7	Conduct comprehensive contact investigations in children who are contacts of TB patients guided by cascade analysis/data	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	1.5.1.8	Hold bi-annual provincial quality improvement mentorship sessions to strengthen capacity of the teams at the existing Diagnostic and treatment units (DTUs)	11,000	10	110,000	11,715	10	117,150	12,476	10	124,765	30	351,915	X	X	X	MoHCC-NTP National Level
	1.5.1.8	Procure and distribute 53,000 of stool collection containers and lab weighing machines	328,600	1	328,600	349,959	0	0	372,706	0	0	1	328,600	X			MoHCC-NTP National Level
	1.5.1.9	Train 30 staff in each province in childhood TB to include diagnostic tools, child friendly medicines, reporting tools, to decentralize childhood TB diagnosis further to PHC facilities and clinics (using The Union's DETECT TB approach (targeting more nurses and Cos)															MoHCC-NTP National Level
	1.5.1.10	Strengthen linkages with other programs that deal with child health such as RCH clinics, MNCH, HIV, Nutrition, EPI among others to increase screening and surveillance of TB among children by placing SOPS, presumptive TB registers in all the child health service points.	1,750	2	3,500	1,864	2	3,728	1,985	2	3,970	6	11,197	X	X	X	MoHCC-NTP National Level

	1.5.1.11	Hold quarterly coordination meetings for 10 HCWs working in each of the 65 districts working in MCH	1,950	65	126,750	2,077	65	134,989	2,212	65	143,763	195	405,502	X	X	X	MoHCC-NTP National Level
Strategic Intervention 1.5: Sub Total					**1,342,690**			**909,819**			**968,957**		**3,221,466**				

Strategic intervention 1.6: Promote TB service delivery in prisons and penitentiary institutions

STRATEGIC INTERVENTION 1.6	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Promote TB service delivery in prisons and penitentiary institutions	1.6.1.1	Develop SOPs for integrated TB/HIV/Nutrition screening in correctional facilities	2,450	1	2,450	2,609	0	0	2,779	0	0	1	2,450	X			MoHCC-NTP National Level
	1.6.1.2	Print the SOPS for integrated TB/HIV/Nutrition screening in prisons	13,613	1	13,613	14,497	0	0	15,440	0	0	1	13,613	X			MoHCC-NTP National Level
	1.6.1.3	Conduct bi-annual integrated screening in all correctional facilities	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	1.6.1.4	Conduct on entry integrated TB/HIV/ Nutrition screening in all correctional facilities	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
Strategic Intervention 1.6: Sub Total					**16,063**			**0**			**0**		**16,063**				

Strategic intervention 1.7: Strengthen access to TB services amongst migrant populations and artisanal miners

STRATEGIC INTERVENTION 1.7	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strengthen access to TB services amongst migrant populations and artisanal miners	1.7.1.1	Conduct mass TB screening campaigns in artisanal mining zones atleast once every quarter	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	1.7.1.2	Hold coordination meeting with IOM on TB services regarding TB screening among, miners, cross border and migratory communities	2,800	4	11,200	2,982	4	11,928	3,176	4	12,703	12	35,831	X	X	X	MoHCC-NTP National Level

	1.7.1.3	Hold annual collaborative meetings with IOM and Zimbabwe Prisons and Correctional Service	1,750	1	1,750	1,864	1	1,864	1,985	1	1,985	3	5,599	X	X	X	MoHCC-NTP National Level
	1.7.1.4	Hold a meeting to develop the schedule for the mobile TB vans and review quality of service under the mobile TB trucks	12,050	1	12,050	12,833	1	12,833	13,667	1	13,667	3	38,551	X	X	X	MoHCC-NTP National Level
	1.7.1.5	Conduct targeted TB screening using x-ray trucks especially in hot spot areas/slums/correctional facilities	34,950	12	419,400	37,222	12	446,661	39,641	12	475,694	36	1,341,755	X	X	X	MoHCC-NTP National Level
Strategic Intervention 1.7: Sub Total					**444,400**			**473,286**			**504,050**		**1,421,736**				

Strategic intervention 1.8: Strengthen TB/DM/Covid-19 bidirectional screening

STRATEGIC INTERVENTION 1.8	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strengthen TB/DM/Covid-19 bidirectional screening	1.8.1.1	Train front line health care workers working in OPD/Diabetics in TB screening	395,800	1	395,800	421,527	1	421,527	448,926	1	448,926	3	1,266,253	X	X	X	MoHCC-NTP National Level
	1.8.1.2	Conduct mass awareness campaigns on DM/TB and TB and Covid-19	1,200	12	14,400	1,278	12	15,336	1,361	12	16,333	36	46,069	X	X	X	MoHCC-NTP National Level
	1.8.1.3	Hold a meeting of 20 staff to Develop, and Disseminate Integrated TB/HIV/NCD (DM, mental health and other NCDs) guidelines/SOPs	600	1	600	639	1	639	681	1	681	3	1,920	X	X	X	MoHCC-NTP National Level
Strategic Intervention 18: Sub Total					**410,800**			**437,502**			**465,940**		**1,314,242**				

Strategic 1.9: Promote TB screening amongst HCWs

STRATEGIC INTERVENTION 1.9	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Promote TB screening amongst HCWs	1.9.1.1	Conduct annual mass TB screening for TB in HCWs	1,475	20	29,500	1,571	20	31,418	1,673	20	33,460	60	94,377	X	X	X	MoHCC-NTP National Level

	1.9.1.2	Conduct capacity building in TB screening for wellness clinics	18,750	1	18,750	19,969	1	19,969	21,267	1	21,267	3	59,985	X	X	X	MoHCC-NTP National Level
Strategic Intervention 1.9: Sub Total					**48,250**			**51,386**			**54,726**		**154,363**				

Strategic initiative 1.10: Improve data handling and use for or decision making and action

STRATEGIC INTERVENTION 1.10	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Improve data handling and use for or decision making and action	1.10.1.1	Conduct a TB inventory study	100,000	1	100,000	106,500		0	113,423		0	1	100,000	X			MoHCC-NTP National Level
	1.10.1.2	Hold quarterly data review meetings	25,000	4	100,000	26,625	4	106,500	28,356	4	113,423	12	319,923	X	X	X	MoHCC-NTP National Level
	1.10.1.3	Establish an online monthly TB data review platform	11,760	1	11,760	12,524	0	0	13,338	0	0	1	11,760	X			MoHCC-NTP National Level
	1.10.1.4	Hold a meeting to develop patient level data base for TB surveillance	29,370	1	29,370	31,279	0	0	33,312	0	0	1	29,370	X			MoHCC-NTP National Level
Strategic Intervention 1.10: Sub Total					**241,130**			**106,500**			**113,423**		**461,053**				

Strategic intervention 1.11: Improve case detection by expanding case finding at community level and involvement of the private sector

Strategic intervention 1.11	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Improve case detection by expanding case finding at community level and involvement of the private sector	1.11.1.1	Provide stipend to CHWs of 15 USD per month to conduct TBCI at community level and TB screening in peri-urban mining communities (targeting artisanal miners)	54,000	2	108,000	57,510	2	115,020	61,248	2	122,496	6	345,516	X	X	X	MoHCC-NTP National Level
	1.11.1.2	Hold meetings of 30 people to develop community led monitoring (CLM)	11,350	1	11,350	12,088	1	12,088	12,873	1	12,873	3	36,311	X	X	X	MoHCC-NTP National Level

	1.11.1.3	Hold trainings for CSOs in CLM	18,575	2	37,150	19,782	2	39,565	21,068	2	42,136	6	118,851	X	X	X	MoHCC-NTP National Level
	1.11.1.4	Train 10 clinicians and 10 nurses working private health facilities per province in TB diagnosis and management	8,500	10	85,000	9,053	10	90,525	9,641	10	96,409	30	271,934	X	X	X	MoHCC-NTP National Level
	1.11.1.5	Hold half day meeting with private health facilities per province to review TB implantation including data review	850	20	17,000	905	20	18,105	964	20	19,282	60	54,387	X	X	X	MoHCC-NTP National Level
Strategic Intervention 1.11: Sub Total					**258,500**			**275,303**			**293,197**		**827,000**				

Strategic intervention 1.12: Improve TB control in urban areas through introduction of differentiated service delivery through Urban Model in Harare and Bulawayo cities

Strategic intervention 1.12	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Improve TB control in urban areas through introduction of differentiated service delivery through Urban Model in Harare and Bulawayo cities	1.12.1.1	Establishment and operationalisation of an Urban Area TB Task Force (a coordination mechanism) by bringing together all the stakeholders (50 people, per quarter)	750	4	3,000	799	4	3,195	851	4	3,403	12	9,598	X	X	X	MoHCC-NTP National Level
	1.12.1.2	Provide quarterly onsite mentorships using the continuous quality improvement (CQI) approach to private and public facilities.	6,025	4	24,100	6,417	4	25,667	6,834	4	27,335	12	77,101	X	X	X	MoHCC-NTP National Level
	1.12.1.3	Strengthening the capacity of the teams at the existing Diagnostic and treatment units (DTUs) through bi-monthly quality improvement mentorship sessions.	750	24	18,000	799	24	19,170	851	24	20,416	72	57,586	X	X	X	MoHCC-NTP National Level

	1.12.1.4	Strengthening laboratory capacity through monthly support supervision and conduction of external quality assurance (EQA), improving sputum sample referral and turnaround time of results as well as improving utilization of GeneXpert services including utilization of GxAlert data.	6,025	4	24,100	6,417	4	25,667	6,834	4	27,335	12	77,101	X	X	X	MoHCC-NTP National Level
	1.12.1.5	Strengthening monitoring and evaluation for the TB program in the urban area through support to health facility by District/province/ city/ municipality/MoHCC/ NTP teams to make timely, complete and accurate records for monthly reporting and quarterly performance reviews.	8,100	4	32,400	8,627	4	34,506	9,187	4	36,749	12	103,655	X	X	X	MoHCC-NTP National Level
	1.12.1.6	Identification of TB hotspots through use of GIS technology and mapping Hot spots out through targeted TB screening using a combined symptom/ CXR approach.	57,620	1	57,620	61,365	1	61,365	65,354	1	65,354	3	184,339	X	X	X	MoHCC-NTP National Level
	1.12.1.7	Conducting monthly site data driven review meetings including cohort reviews and action planning.	8,100	12	97,200	8,627	12	103,518	9,187	12	110,247	36	310,965	X	X	X	MoHCC-NTP National Level
	1.12.1.8	Conducting quarterly partner data driven coordination meetings and action planning for 30 people for 5 days	22,800	4	91,200	24,282	4	97,128	25,860	4	103,441	12	291,769	X	X	X	MoHCC-NTP National Level
	1.12.1.9	At district level hold a 1-day end of month community team review meeting and action planning for 15 people	525	12	6,300	559	12	6,710	595	12	7,146	36	20,155	X	X	X	MoHCC-NTP National Level
Strategic Intervention 1.12: Sub Total					**353,920**			**376,925**			**401,425**		**1,132,270**				

Strategic Intevention 1.13 Scale up TB Laboratory quality management system

Strategic intervention 1.13	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
	1.13.1	Develop and implement laboratory quality improvement plan	30,150	1	30,150	32,110	1	32,110	34,197	1	34,197	3	96,457	X	X	X	MoHCC-NTP National Level
	1.13.1.1	Form a quality project or quality management team			0			0			0	0	0				MoHCC-NTP National Level
	1.13.1.2	Support the position of quality officer at the NTRL	24,673	1	24,673	26,277	1	26,277	27,985	1	27,985	3	78,935	X	X	X	MoHCC-NTP National Level
	1.13.1.3	Hold a meeting for 20 people for 5 days to update the quality management manual/ tool kit	15,200	1	15,200	16,188		0	17,240		0	1	15,200	X			MoHCC-NTP National Level
	1.13.1.4	Hold onsite meetings to upgrade background knowledge of quality management amongst staff and management in all TB laboratories by the quality management team	1,500	40	60,000	1,598	40	63,900	1,701	40	68,054	120	191,954	X	X	X	MoHCC-NTP National Level
	1.13.1.5	Establish a laboratory adequate stock and ordering system in which incoming supplies are checked for compliance with quality requirements	23,520	1	23,520	25,049		0	26,677		0	1	23,520	X			MoHCC-NTP National Level
	1.13.1.6	Establish control system and information management system to create traceability of laboratory information.	23,520	1	23,520	25,049		0	26,677		0	1	23,520	X			MoHCC-NTP National Level

	1.13.1.7	Hold a meeting for 30 people for 5 days to establish standard Operating Procedures for all processes performed in the laboratory and Development of Standard Operating Procedures for laboratory tests and equipment to assure that testing is performed in a standardized way, according to a defined methodology and with adequate adherence to safety rules	17,900	1	17,900	19,064		0	20,303		0	1	17,900	X	X	X	MoHCC-NTP National Level
	1.13.1.8	Hold a meeting for 20 people to develop an equipment maintenance system	7,400	1	7,400	7,881		0	8,393		0	1	7,400	X			MoHCC-NTP National Level
	1.13.1.9	Hold a meeting to upgrade laboratory biosafety.	15,200	1	15,200	16,188		0	17,240		0	1	15,200	X			MoHCC-NTP National Level
	1.13.1.10	Renovate the NTRL infrastructure and bring it to the required standards	2,300,000	1	2,300,000	2,449,500		0	2,608,718		0	1	2,300,000	X			MoHCC-NTP National Level
	1.13.1.11	Conduct a diagnostic network assessment to update the occurring situation with regard to TB laboratory diagnostics.	23,520	1	23,520	25,049		0	26,677		0	1	23,520	X			MoHCC-NTP National Level
	1.13.1.12	Conduct a mapping of rapid molecular tools and identify the gaps to inform scale up and inform the setup of specimen courier system.	1,725	140	241,500	1,837	140	257,198	1,957	140	273,915	420	772,613	X	X	X	MoHCC-NTP National Level
	1.13.1.13	Develop standard operating procedures (SOPs),	22,800	1	22,800	24,282		0	25,860		0	1	22,800	X			MoHCC-NTP National Level
	1.13.1.14	Print and orient all laboratory personnel SOP.	272,250	1	272,250	289,946		0	308,793		0	1	272,250	X			MoHCC-NTP National Level

	1.13.1.15	Develop an electronic stock management system (Stock-outs and use of expired reagents)	23,520	1	23,520	25,049		0	26,677		0	1	23,520	X			MoHCC-NTP National Level
Strategic Intervention 1.12: Sub Total					**3,101,153**			**379,484**			**404,151**		**3,884,788**				

Strategic Objective 2: To increase the treatment success rate of patients with drug susceptible TB from 83% in 2017 to 90% by 2026

Strategic interventions: 2.1: Improve case holding

STRATEGIC INTERVENTION 2.1	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Improve case holding	2.1.1.1	Recruit/retain 2000 TB community volunteers									0	0	0				MoHCC-NTP National Level
	2.1.1.2	Provide USD stipend per month to 100 community TB volunteers	12,000	12	144,000	12,780	12	153,360	13,611	12	163,328	36	460,688	X	X	X	MoHCC-NTP National Level
	2.1.1.3	Provide the EHTs with enablers, procure 764 motor cycles, and 50 bicycles per district for community volunteers	3,467,100	1	3,467,100	3,692,462	0	0	3,932,471	0	0	1	3,467,100	X			MoHCC-NTP National Level
	2.1.1.4	Maintaince of 764 motor bikes	620,900	1	620,900	661,259	1	661,259	704,240	1	704,240	3	1,986,399	X	X	X	MoHCC-NTP National Level
Strategic Intervention 2.1: Sub Total					**4,232,000**			**814,619**			**867,569**		**5,914,187**				

Strategic intervention 2.2: Reduce TB related mortality

STRATEGIC INTERVENTION 2.2	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strategic intervention 2.2: Reduce TB related mortality	2.2.1.1	Train HCWs in TB management and clerkship	18,600	20	372,000	19,809	20	396,180	21,097	20	421,932	60	1,190,112	X	X	X	MoHCC-NTP National Level
	2.2.1.2	Build capacity in management of Childhood TB and Roll-out shorter treatment regimen for children	12,740	1	12,740	13,568	0	0	14,450	0	0	1	12,740	X			MoHCC-NTP National Level

	2.2.1.3	Raise TB awareness through billboards and the media,	81,600	1	81,600	88,373	1	88,373	95,708	1	95,708	3	265,681	X	X	X	MoHCC-NTP National Level
	2.2.1.4	Conduct TB mortality study to understand the drivers of TB mortality	23,020	1	23,020	24,516	1	24,516	26,110	1	26,110	3	73,646	X	X	X	MoHCC-NTP National Level
	2.2.1.5	Print death audit forms for routine surveillance	408,375	1	408,375	434,919	1	434,919	463,189	1	463,189	3	1,306,484	X	X	X	MoHCC-NTP National Level
	2.2.1.6	Hold TB mortality review and action planning meetings at facility and district levels	14,070	260	3,658,200	14,985	260	3,895,983	15,959	260	4,149,222	780	11,703,405	X	X	X	MoHCC-NTP National Level
	2.2.1.7	Hold trainings on how to conduct TB mortality audit and an orientation on death audit forms	8,800	1	8,800	9,372		0	9,981		0	1	8,800	X	X	X	MoHCC-NTP National Level
	2.2.1.8	Hold a meeting for 20 people to update guide-lines to take on the new WHO recommendations for non-severe TB (4 months regimen).	29,141	1	29,141	31,035		0	33,053		0	1	29,141	X			MoHCC-NTP National Level
Strategic Intervention 2.2: Sub Total					**4,593,876**			**4,839,971**			**5,156,160**		**14,590,008**				

Strategic objective 3: To achieve universal HIV testing and ART coverage for TB cases by 2021 and sustain coverage through to 2026

Strategic Interventions 3.1: Strengthen mechanisms for delivering integrated TB and HIV services

STRATEGIC INTERVENTION 3.1	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strengthen mechanisms for delivering integrated TB and HIV services	3.1.1.1	Hold TB/HIV collaborative meetings for 100 people for 3 days	32,500	4	130,000	34,613	4	138,450	36,862	4	147,449	12	415,899	X	X	X	MoHCC-NTP National Level
	3.1.1.2	Sustain a stable supply of HIV test kits	909,548	1	909,548	968,668	1	968,668	1,031,632	1	1,031,632	3	2,909,848	X	X	X	MoHCC-NTP National Level

	3.1.1.3	Intensify HIV testing in presumptive and confirmed TB patients and offer high-quality patient-centered HIV care for HIV co-infected TB patients.	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	3.1.1.4	Train TB HCWs in HIV and ART management refresher in TB/HIV	438,025	1	438,025	466,497	1	466,497	496,819	1	496,819	3	1,401,341	X	X	X	MoHCC-NTP National Level
	3.1.1.5	Conduct national facility assessments, including assessment of level of TB/HIV care service integration	7,900	89.33333333	705,733	8,414	89.33333333	751,606	8,960	89.33333333	800,460	268	2,257,800	X	X	X	MoHCC-NTP National Level
	3.1.1.6	Conduct quarterly national TB/HIV TWG review and action planning meeting	1,000	4	4,000	1,065	4	4,260	1,134	4	4,537	12	12,797	X	X	X	MoHCC-NTP National Level
	3.1.1.7	Conduct monthly district (DHE) coordination meetings	0	0	0	0	0	0	0	0	0	0	0	X	X	X	MoHCC-NTP National Level
	3.1.1.8	Conduct monthly district TB/HIV coordination meetings	500	260	130,000	533	260	138,450	567	260	147,449	780	415,899	X	X	X	MoHCC-NTP National Level
Strategic Intervention 3.1: Sub Total					**2,317,306**			**2,467,931**			**2,628,347**		**7,413,584**				

Strategic Intervention 3.2: Build clinical and programmatic competencies in TB/HIV management

STRATEGIC INTERVENTION 3.2	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Build clinical and programmatic competencies in TB/HIV management	3.2.1.1	Hold a meeting to review and update the TB/HIV guidelines	15,567	1	15,567	16,579	0	0	17,657	0	0	1	15,567	X			MoHCC-NTP National Level
	3.2.1.2	Conduct TB/HIV trainings	508,375	2	1,016,750	541,419	2	1,082,839	576,612	0	0	4	2,099,589	X	X	X	MoHCC-NTP National Level
	3.2.1.3	Develop a TB/HIV ECHO curriculum, including the revision of blended learning curriculum	14,075	1	14,075	14,990	1	14,990	15,964	1	15,964	3	45,029	X	X	X	MoHCC-NTP National Level

	3.2.1.4	Procure ECHO platform for facilities that currently do not have	3,581	1	3,581	3,814	0	0	4,062	0	0	1	3,581	X			MoHCC-NTP National Level
	3.2.1.5	Procure internet bundles for district coordinators	27,110	4	108,440	28,872	4	115,489	30,749	4	122,995	12	346,924	X	X	X	MoHCC-NTP National Level
	3.2.1.6	Hold weekly TB/HIV didactic session	450	52	23,400	479	52	24,921	510	52	26,541	156	74,862	X	X	X	MoHCC-NTP National Level
	3.2.1.7	Support site -level attachments of 15 HCWs for 10 days at Centres of Excellence per quarter (Provincial level) to build capacity for TB/HIV collaboration/One Stop Shop/TPT, IPC, AHD	18,350	10	183,500	19,543	10	195,428	20,813	10	208,130	30	587,058	X	X	X	MoHCC-NTP National Level
Strategic Intervention 3.2: Sub Total					**1,365,313**			**1,433,666**			**373,631**		**3,172,610**				

Strategic intervention3.3: Improve the coverage of TPT towards saturation

STRATEGIC INTERVENTION 3.3	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Improve the coverage of TPT towards saturation	3.3.1.1	Hold a meeting to develop a TPT scale up plan	950	1	950	1,012	1	1,012	1,078	1	1,078	3	3,039	X	X	X	MoHCC-NTP National Level
	3.3.1.2	Hold quarterly meetings to review the performance of the TPT scale up	950	4	3,800	1,012	4	4,047	1,078	4	4,310	12	12,157	X	X	X	MoHCC-NTP National Level
	3.3.1.3	Procure shorter TPT regimens (IHP,3HP, 3RH and other emerging therapies) for both adults and children respectively	16,483,064	1	16,483,064	17,554,463	0	0	18,695,503	0	0	1	16,483,064	X			MoHCC-NTP National Level
	3.3.1.4	Procure and print TPT registers	899,250	1	899,250	957,701	0	0	1,019,952	1	1,019,952	2	1,919,202	X		X	MoHCC-NTP National Level

	3.3.1.5	Conduct two Regional TOT on TPT	17,178	2	34,355	18,294	2	36,588	19,483	2	38,966	6	109,909	X	X	X	MoHCC-NTP National Level
	3.3.1.7	Hold a 5-day meeting to develop, SOPs and job aides that include shorter TPT regimens for HCWs and Recipi-ents of Care	26,600	1	26,600	28,329	0	0	30,170	0	0	1	26,600	X			MoHCC-NTP National Level
	3.3.1.8	Print and distribute IEC materials for TPT to all districts and facilities	904,613	1	904,613	963,412	0	0	1,026,034	1	1,026,034	2	1,930,647	X	X	X	MoHCC-NTP National Level
	3.3.1.9	Cluster orientation of Community Health Workers, CARG leaders and Expert Clients on TPT including SOPs, tools and guidelines distribution to be done by facility health workers at monthly meetings with VHWs	4,400	4	17,600	4,686	4	18,744	4,991	4	19,962	12	56,306	X	X	X	MoHCC-NTP National Level
	3.3.1.10	Mass awareness raising on TPT to create de-mand, taking on board the TPT/TB champions and celebrities.	160,300	1	160,300	173,605	1	173,605	188,014	1	188,014	3	521,919	X	X	X	MoHCC-NTP National Level
	3.3.1.11	Hold TPT trainings and re-orientation for front line HCW to help create demand and improve quality of service provi-sion in TPT	40,991	1	40,991	43,655	1	43,655	46,493	1	46,493	3	131,138	X	X	X	MoHCC-NTP National Level
Strategic Intervention 3.3: Sub Total					**18,571,522**			**277,651**			**2,344,809**		**21,193,982**				

Strategic objective 4:To cumulatively detect 2,680 patients with RR/MDR TB between 2021 and 2026

Strategic interventions:4.1: Improve case detection by expanding access to rapid WHO approved molecular diagnostic tools

STRATEGIC INTERVENTION 4.1	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Improve case detection by expanding access to rapid WHO approved molecular diagnostic tools	4.1.1.1	Procure two whole Genome sequencing equipment for the two reference labs	500,000	1	500,000	532,500	1	532,500	567,113	1	567,113	3	1,599,613	X			MoHCC-NTP National Level
	4.1.1.2	Procure reagents for culture and DST including for new drug molecules	1,619,908	1	1,619,908	1,725,202	1	1,725,202	1,837,340	1	1,837,340	3	5,182,449	X			MoHCC-NTP National Level
	4.1.1.3	Conduct quarterly external quality assessment to all GeneXpert sites	11,030	4	44,120	11,747	4	46,988	12,511	4	50,042	12	141,150	X	X	X	MoHCC-NTP National Level
	4.1.1.4	Support International advanced trainings and conferences for laboratory staff (QMS and advanced molecular diagnostics; training 2 safety and 2 quality officers from NTRLs every 2 years at the Uganda SRL for accreditation).	3,259,816	1	3,259,816	3,471,704	0	0	3,697,364	0	0	1	3,259,816	X			MoHCC-NTP National Level
	4.1.1.7	Revise Quality Handbook ,TB Microscopy ,Truenat & Xpert MTB/Rif SOPs	39,660	1	39,660	42,238	0	0	44,983	0	0	1	39,660	X			MoHCC-NTP National Level
	4.1.1.8	Print and distribute 500 copies each of Quality handbook, Microscopy ,truenat and Xpert MTB/Rif SOPs	13,613	1	13,613	14,497	0.25	3,624	15,440	0.25	3,860	2	21,097	X	X	X	MoHCC-NTP National Level
	4.1.1.9	Conduct TB QMS training for TB laboratory supervisors for 2 provincial laboratory scientists per province, and 3 facilitators	8,360	3.333333333	27,867	8,903	3.333333333	29,678	9,482	3.333333333	31,607	10	89,152	X	X	X	MoHCC-NTP National Level

	4.1.1.10	Develop the TB Laboratory bio-safety & biosecurity manual for use at sub-national level	11,840	1	11,840	12,610	0	0	13,429	0	0	1	11,840	X			MoHCC-NTP National Level
	4.1.1.11	Conduct refresher training on Microscopy ,Truenat and Xpert MTB/Rif (Ultra) for Microscopists from all levels	14,800	2	29,600	15,762	2	31,524	16,787	2	33,573	6	94,697	X	X	X	MoHCC-NTP National Level
	4.1.1.12	Stationery and computer consumables for NRLs for QMS Implementation and maintenance	1,500	4	6,000	1,598	4	6,390	1,701	4	6,805	12	19,195	X	X	X	MoHCC-NTP National Level
	4.1.1.13	Enroll in an external QMS accreditation assessment for the NTBRL (e.g., SANAS, or SADCAS) and Management Review meetings	23,380	1	23,380	24,900	1	24,900	26,518	1	26,518	3	74,798	X	X	X	MoHCC-NTP National Level
	4.1.1.14	Conduct quarterly TB QMS/EQA mentorship visits from provincial to district levels	15,350	4	61,400	16,348	4	65,391	17,410	4	69,641	12	196,432	X	X	X	MoHCC-NTP National Level
	4.1.1.15	Enroll in an external QMS accreditation assessment for the NMRL (e.g., SANAS, or SADCAS) Initial and Annual Assessment; Airfare, Visa and DSA	930	1	930	990	1	990	1,055	1	1,055	3	2,975	X	X	X	MoHCC-NTP National Level
	4.1.1.16	Conduct quarterly TB QMS/EQA mentorship visits from national to provincial levels for 2 teams of 2 NRL officers and a driver	15,666	4	62,664	16,684	4	66,737	17,769	4	71,075	12	200,476	X	X	X	MoHCC-NTP National Level
	4.1.1.18	Procure Aspect equipment for additional 80 sites	230,400	1	230,400	245,376		0	261,325		0	1	230,400	X			MoHCC-NTP National Level
	4.1.1.20	Maintenace and service contracts	34,560	1	34,560	321,081	1	321,081	39,199	1	39,199	3	394,840	X	X	X	MoHCC-NTP National Level
	4.1.1.21	Procure service contract for auxillary equipment	301,485	1	301,485	321,081	1	321,081	341,951	1	341,951	3	964,517	X	X	X	MoHCC-NTP National Level
Strategic Intervention 4.1: Sub Total					**6,267,241**			**3,176,086**			**3,079,779**		**12,523,107**				

Strategic intervention 4.2: Build capacity in DR TB

STRATEGIC INTERVENTION 4.2	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Build capacity in DR TB	4.2.1.1	Hold a meeting to review and finalize DR TB guidelines	14,800	1	14,800	15,762	1	15,762	16,787	1	16,787	3	47,349	X	X	X	MoHCC-NTP National Level
	4.2.1.2	Hold provincial trainings in DR TB	13,600	10	136,000	14,484	10	144,840	15,425	10	154,255	30	435,095	X	X	X	MoHCC-NTP National Level
	4.2.1.3	Hold DR-TB Concilium meeting at all sites to review all DR-TB patients enrolled on DR TB treatment (irrespective of being complex/ complicated or not)	14,800	2	29,600	15,762	2	31,524	16,787	2	33,573	6	94,697	X	X	X	MoHCC-NTP National Level
	4.2.1.4	Raise public awareness of DR TB	160,300	1	160,300	173,605	1	173,605	188,014	1	188,014	3	521,919	X	X	X	MoHCC-NTP National Level
	4.2.1.5	Conduct contact tracing for all index DR TB patients	780	1	780	845	1	845	915	1	915	3	2,540	X	X	X	MoHCC-NTP National Level
Strategic Intervention 4.2: Sub Total					**341,480**			**366,576**			**393,543**		**1,101,599**				

Strategic Objective 5: Increase the treatment success rate of patients with RR/MDR TB from 57% (2016) to 75% by 2026

Strategic intervention 5.1: Introduce new and shorter and patient friendly DR TB regimens

Strategic intervention 5.1	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strategic intervention 5.1: Introduce new and shorter and patient friendly DR TB regimens	5.1.1.1	Hold a meeting to review and finalize PMDT guidelines to include newer regimens (BPaL/ BPaLM)	11,100	2	22,200	11,822	2	23,643	12,590	2	25,180	6	71,023	X	X	X	MoHCC-NTP National Level
	5.1.1.2	Print and disseminate DR TB guidelines	40,838	1	40,838	43,492	1	43,492	46,319	1	46,319	3	130,648	X	X	X	MoHCC-NTP National Level

	5.1.1.3	Procure and distribute second line TB drugs including DR-TB child friendly formulations (450 –500 DR-TB cases per year)	1,345,636	1	1,345,636	1,433,102	0	0	1,526,254	0	0	1	1,345,636				MoHCC-NTP National Level
	5.1.1.4	Support site-level attachments of 15 HCWs for 10 days at Centres of Excellence per quarter per provincial to build capacity in DR TB	2,250	40	90,000	2,396	40	95,850	2,552	40	102,080	120	287,930	X	X	X	MoHCC-NTP National Level
	5.1.1.5	Train 15 EHTs per province in DR TB to support contact tracing, and DOT	5,100	40	204,000	5,432	40	217,260	5,785	40	231,382	120	652,642	X	X	X	MoHCC-NTP National Level
	5.1.1.6	Hold a Training of PMDT HCW care team in 60 PMDT sites (Clinicians, nurses, lab techs, Radiologists/ radiographers, nutritionists, pharmacists) on DR-TB Diagnosis, and management, follow up care, aDSM and R&R including eHR, BPaL/ BPaLM the new shorter regimen	5,550	60	333,000	5,911	60	354,645	6,295	60	377,697	180	1,065,342	X	X	X	MoHCC-NTP National Level
	5.1.1.7	Conduct a meeting to review and finalize aDSM Module in eHR including development of aDSM indicators/ variables for the DHIS 2 Dashboard	8,800	1	8,800	9,372	0	0	9,981	1	9,981	2	18,781	X		X	MoHCC-NTP National Level

	5.1.1.8	Procure and distribute ancillary medicines to DR-TB sites to manage severe adverse reac-tions	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	5.1.1.9	Conduct Annual Green Light Committee TA mission	19,320	1	19,320	20,576	1	20,576	21,913	1	21,913	3	61,809	X	X	X	MoHCC-NTP National Level
	5.1.1.10	Conduct annual Global Drug Facility (GDF) TA mission	19,320	1	19,320	20,576	1	20,576	21,913	1	21,913	3	61,809	X	X	X	MoHCC-NTP National Level
	5.1.1.11	Introduce fixed monthly clinical review days to enable patients to be seen by Medical Officer trained in DR-TB case management	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	5.1.1.12	Conduct ENHANCED DR-TB Cohort reviews/ analysis for both interim (6 and 12 months) and final Outcomes at 24 months and further disaggregate the data by age, sex, , site, HIV status, NCD, treatment initiation delay beyond 7 days – to identify outcome drivers for both favourable and unfa-vourable outcomes)	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	5.1.1.13	Development and Dis-semination of a 3-year standardized DR-TB cohort schedule to stan-dardize cohort analysis and reporting.	8,800	1	8,800	9,372	1	9,372	9,981	1	9,981	3	28,153	X	X	X	MoHCC-NTP National Level
Strategic Intervention 5.1: Sub Total					**2,091,913**			**785,414**			**846,447**		**3,723,774**				

Strategic interventions 5.2: Improve case holding by extending DOT and treatment support to community level through the use of CHWs

STRATEGIC INTERVENTION 5.2	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strategic interventions 5.2: Improve case holding by extending DOT and treatment support to community level through the use of CHWs	5.2.1.1:	Train 500 CHWs in DR-TB	20,900	1	20,900	22,259	1	22,259	23,705	1	23,705	3	66,864	X	X	X	MoHCC-NTP National Level
	5.2.1.2	Hold a meeting to develop a DR TB linkage to care system	8,800	1	8,800	9,372	0	0	9,981	0	0	1	8,800	X			MoHCC-NTP National Level
	5.2.1.3	Conduct monthly home visits by a nurse and clinicians	20	443	8,860	21	431	9,180	23	413	9,369	1,287	27,409	X	X	X	MoHCC-NTP National Level
	5.2.1.4	CHWs to provide psychosocial support	15	443	6,645	16	431	6,885	17	413	7,027	1,287	20,557	X	X	X	MoHCC-NTP National Level
	5.2.1.5	Conduct Mortality audits to identify drivers of DR-TB mortality and take appropriate actions	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	5.2.1.6	Map out and profile DR-TB sites with both clinical and lab capacity (at least 1 per district) (fixed treatment initiation facilities)	27,500	1	27,500	29,288	1	29,288	31,191	1	31,191	3	87,979	X	X	X	MoHCC-NTP National Level
	5.2.1.7	Develop and implement a standardized minimum package of care interventions to be offered at all treatment initiation sites	8,800	100	880,000	9,372	0	0	9,981	1	9,981	101	889,981	X		X	MoHCC-NTP National Level
	5.2.1.8	Introducing Quarterly District DR-TB performance and action planning meetings at provincial level	8,200	10	82,000	8,733	10	87,330	9,301	10	93,006	30	262,336	X	X	X	MoHCC-NTP National Level
Strategic Intervention 5.2: Sub Total					**1,034,705**			**154,942**			**174,279**		**1,363,926**				

Strategic intervention 5.3: Improve the coverage of nutritional support provided to DR TB patients

STRATEGIC INTERVENTION 5.3	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Improve the coverage of nutritional support provided to DR TB patients	5.3.1.1	Procure food hampers for 894 patients per year	89,400	1	89,400	95,211	1	95,211	101,400	1	101,400	3	286,011	X	X	X	MoHCC-NTP National Level
	5.3.1.2	Provide monthly transport refund to all DR TB patients	44,700	12	536,400	47,606	12	571,266	50,700	12	608,398	36	1,716,064	X	X	X	MoHCC-NTP National Level
Strategic Intervention 5.3: Sub Total					**625,800**			**666,477**			**709,798**						

Strategic intervention 5.4: Strengthen aDSM monitoring

Strategic intervention 5.4	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strengthen aDSM monitoring	5.4.1.1	Conduct a meeting to Review and finalize aDSM Module in eHR including development of aDSM indicators/ variables for the DHIS 2 Dashboard	7,300	1	7,300	7,775	0	0	8,280	0	0	1	7,300	X			MoHCC-NTP National Level
	5.4.1.2	Procure X portable ECG machines, and printing paper to all DR-TB sites	103,696	1	103,696	110,436	0	0	117,615	0	0	1	103,696	X			MoHCC-NTP National Level
	5.4.1.3	Conduct training in aDSM for 300 nurses, and 30 clinicians per province	17,000	22	374,000	18,105	22	398,310	19,282	22	424,200	66	1,196,510	X	X	X	MoHCC-NTP National Level
	5.4.1.4	Procure and distribute ancillary medicines to DR-TB sites to manage severe adverse reactions	5,030,902	1	5,030,902	5,357,910	0	0	5,706,175	0	0	1	5,030,902	X			MoHCC-NTP National Level
	5.4.1.5	Procure and distribute Ishihara and Snellen's charts	32,700	1	32,700	34,826	0	0	37,089	1	37,089	2	69,789	X		X	MoHCC-NTP National Level

	5.4.1.6	Procure services for Biochemistry and Haematology tests for DR patients (for safety labs)	22,500	1	22,500	24,368	1	24,368	26,390	1	26,390	3	73,258	X	X	X	MoHCC-NTP National Level
	5.4.1.7	Strengthen the linkage of aDSM reporting with the pharmacovigillance committee of Zimbabwe	9,500	1	9,500	10,118	1	10,118	10,775	1	10,775	3	30,393	X	X	X	MoHCC-NTP National Level
Strategic Intervention 5.4: Sub Total					**5,580,598**			**432,795**			**498,454**						

Strategic objective 6: Decrease the proportion of households facing catastrophic costs due to TB from 80% in 2019 to 50% by 2026

Strategic intervention 6.1: Scale up advocacy for increased funding of TB intervention and social protection for TB patients

STRATEGIC INTERVENTION 10	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Scale up advocacy for increased funding of TB intervention and social protection for TB patients	6.1.1.1	Hold a meeting with the strategic organization to lobby for inclusion of TB patients in social security support.	3,500	1	3,500	3,728	0	0	3,970	0	0	1	3,500	X			MoHCC-NTP National Level
	6.1.2	Provide psychosocial and palliative care support for TB patients and their households.	60	443	26,580	64	431	27,541	68	413	28,106	1,287	82,227	X	X	X	MoHCC-NTP National Level
	6.1.3	Develop and implement a financial risk protection policy for TB patients and their households.	22,500	1	22,500	24,368	0	0	26,390	0	0	1	22,500	X			MoHCC-NTP National Level
	6.1.4	Conduct a follow-on TB Patient Cost survey	12,500	1	12,500	13,313	1	13,313	14,178	1	14,178	3	39,990	X	X	X	MoHCC-NTP National Level
	6.1.5	Improving linkages with the private sectors	3,000	2	6,000	3,195	2	6,390	3,403	2	6,805	6	19,195	X	X	X	MoHCC-NTP National Level
	6.1.6	Establishing linkages with income generating activities	4,000	2	8,000	4,260	2	8,520	4,537	2	9,074	6	25,594	X	X	X	MoHCC-NTP National Level

	6.1.7	Advocate for cost waiver for CXR for TB presumptive TB patients and provision of transport refunds presenting for their clinical reviews/ visits (revive transport coupons)	2,800	1	2,800	2,982	1	2,982	3,176	1	3,176	3	8,958	X	X	X	MoHCC-NTP National Level
Strategic Intervention: Sub Total					**81,880**			**58,745**			**61,339**		**201,964**				

Strategic Objective 7: Scale up leprosy prevention alongside integrated active case detection

Strategic interventions 7.1: Promoting partnerships with Leprosy stakeholders

STRATEGIC INTERVENTION 7.1	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Promoting partnerships with Leprosy stakeholders	7.1.1.1	Hold quarterly partners meeting on Leprosy	1,750	4	7,000	1,864	4	7,455	1,985	4	7,940	12	22,395	X	X	X	MoHCC-NTP National Level
	7.1.1.2	Hold resource mobilization meetings and advocate for Leprosy	1,750	2	3,500	1,864	2	3,728	1,985	2	3,970	6	11,197	X	X	X	MoHCC-NTP National Level
Strategic Intervention 7.1: Sub Total					**10,500**			**11,183**			**11,909**		**33,592**				

Strategic intervention 7.2: Strengthen clinical capacity to improve case detection

STRATEGIC INTERVENTION 7.2	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strategic intervention 7.2: Strengthen clinical capacity to improve case detection	7.2.1.1	Hold training for HCW in Leprosy surveillance	9,500	1	9,500	10,118	1	10,118	10,775	1	10,775	3	30,393	X	X	X	MoHCC-NTP National Level
	7.2.1.2	Print and distribute Leprosy guidelines	40,838	1	40,838	43,492	0.5	21,746	46,319	0.5	23,159	2	85,743	X	X	X	MoHCC-NTP National Level
	7.2.1.3	Train 30 trainers of trainers	11,100	1	11,100	11,822	1	11,822	12,590	1	12,590	3	35,511	X	X	X	MoHCC-NTP National Level
Strategic Intervention 7.2: Sub Total					**61,438**			**43,685**			**46,524**		**151,647**				

Strategic intervention 7.3: Strengthen surveillance and information systems for Leprosy

STRATEGIC INTERVENTION 7.3	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strengthen surveillance and information systems for Leprosy	7.3.1.1	Hold training for HCW in Leprosy surveillance	4,200	1	4,200	4,473	1	4,473	4,764	1	4,764	3	13,437	X	X	X	MoHCC-NTP National Level
	7.3.1.2	Print and distribute X registers for Leprosy	8,250	1	8,250	8,786	0.5	4,393	9,357	0.5	4,679	2	17,322	X	X	X	MoHCC-NTP National Level
Strategic Objective 7.3: Sub Total					**12,450**			**8,866**			**9,442**		**30,759**				

Strategic objective 8: Strengthen Programme coordination and management and enhance accountability

Strategic intervention 8.1 Strengthen coordination between the NTLP and implementing and cooperating partners and the private players.

STRATEGIC INTERVENTION 8.1	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strengthen coordination between the NTLP and implementing and cooperating partners and the private players.	8.1.1.1	Hold meetings of 20 people to revise the current CTBC & ACSM guidelines in line with the Costed TB CRG Action Plan and Patient charter.	4,800	1	4,800	5,112	1	5,112	5,444	1	5,444	3	15,356	X	X	X	MoHCC-NTP National Level
	8.1.1.2	Hold a meeting to develop and disseminate a capacity building toolkit for the revised PPM and CTBC guidelines.	33,750	1	33,750	35,944	0	0	38,280	0	0	1	33,750	X			MoHCC-NTP National Level
	8.1.1.3	Hold a meeting annually to validate the final CRG assessment draft report, develop and implement a Costed TB CRG Action Plan.	10,950	1	10,950	11,662	1	11,662	12,420	1	12,420	3	35,032	X	X	X	MoHCC-NTP National Level

	8.1.1.4	Hold a meeting to develop community led monitoring framework and link it to the national community health information management system.	10,950	1	10,950	11,662	0	0	12,420	0	0	1	10,950	X			MoHCC-NTP National Level
	8.1.1.5	Roll out a digital community led monitoring digital App and create linkages with the new community health electronic platform.	10,950	1	10,950	11,662	1	11,662	12,420	1	12,420	3	35,032	X	X	X	MoHCC-NTP National Level
Strategic Intervention 8.1: Sub Total					**71,400**			**28,436**			**30,284**		**130,119**				

Strategic intervention 8.2: Enhance community TB response

STRATEGIC INTERVENTION 8.2	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Enhance community TB response	8.2.1.1	Conduct a study to explore needs, barriers, and opportunities for improvements in services and programs, including research on stigma, discrimination, and legal and gender-related issues, and research about revenue and funding allocations and expenditures in efforts against TB, and its comorbidities	15,950	30	478,500	16,987	30	509,603	18,091	30	542,727	90	1,530,829	X	X	X	MoHCC-NTP National Level
	8.2.1.2	Hold meetings to disseminate findings of community-led research	1,450	1	1,450	1,544	1	1,544	1,645	1	1,645	3	4,639	X	X	X	MoHCC-NTP National Level
	8.2.1.3	Hold meetings with decision makers on finding from the research and to communicate recommendations, co-create shared solutions for improved health services	6,300	1	6,300	6,710	1	6,710	7,146	1	7,146	3	20,155	X	X	X	MoHCC-NTP National Level

	8.2.1.4	Conduct CRG assessment to identify the specific human rights, gender, and community factors hindering the TB response	23,520	1	23,520	25,049	0	0	26,677	0	0	1	23,520	X			MoHCC-NTP National Level
	8.2.1.5	Conduct quarterly client satisfaction survey in all provinces	30,000	1	30,000	31,950	1	31,950	34,027	1	34,027	3	95,977	X	X	X	MoHCC-NTP National Level
	8.2.1.6	Conduct the TB stigma assessment to understand the levels of TB stigma	50,000	1	50,000	53,250	1	53,250	56,711	1	56,711	3	159,961	X	X	X	MoHCC-NTP National Level
	8.2.2.1	Hold Trainings, mentorship and sustained support to help community-led and -based organizations to integrate TB within their interventions, functional governance, and participate and contribute to strategic plans.	30,525	2	61,050	32,509	2	65,018	34,622	2	69,244	6	195,313	X	X	X	MoHCC-NTP National Level
	8.2.2.1	Hold coordination meetings with community players	2,250	2	4,500	2,396	2	4,793	2,552	2	5,104	6	14,397	X	X	X	MoHCC-NTP National Level
	8.2.2.2	Conduct a mapping exercise of all community organisation engaged in TB	27,110	1	27,110	28,872	0	0	30,749	0	0	1	27,110	X			MoHCC-NTP National Level
	8.2.2.3	Conduct sensitization programs about TB targeting key and vulnerable populations.	8,900	2	17,800	9,479	2	18,957	10,095	2	20,189	6	56,946	X	X	X	MoHCC-NTP National Level
	8.2.2.4	Hold a meeting with key stakeholders to review, and harmonize CHW incentive scheme	5,850	2	11,700	6,230	2	12,461	6,635	2	13,270	6	37,431	X	X	X	MoHCC-NTP National Level
	8.2.2.5	Hold meeting to engage traditional and religious leaders on TB	16,500	2	33,000	17,573	2	35,145	18,715	2	37,429	6	105,574	X	X	X	MoHCC-NTP National Level
Strategic Intervention 8.2: Sub Total					**744,930**			**739,430**			**787,492**		**2,271,852**				

Strategic intervention: 8.3 Enhance accountability in the TB response

STRATEGIC INTERVENTION 8.3	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Enhance accountability in the TB response	8.3.1.1	Hold meetings to disseminate the framework of MAF-TB	5,850	1	5,850	6,230	0	0	6,635	0	0	1	5,850	X			MoHCC-NTP National Level
	8.3.1.2	Hold quarterly meetings with all stakeholders to review the implementations of MAF-TB	5,850	4	23,400	6,230	4	24,921	6,635	4	26,541	12	74,862	X	X	X	MoHCC-NTP National Level
	8.3.1.3	Conduct MAF-TB Baseline assessment	11,760	1	11,760	12,524	0	0	13,338	0	0	1	11,760	X			MoHCC-NTP National Level
	8.3.1.4	Hold a 5 day meeting to engage all relevant line ministries, CSOs and stakeholders to draw sector MAF-TB action plans	20,450	2	40,900	21,779	2	43,559	23,195	2	46,390	6	130,848	X	X	X	MoHCC-NTP National Level
	8.3.1.5	Conduct semi-annual MAF-TB coordination, performance reviews, and action planning meetings in respect to MAF-TB set targets (250 delegates – fuel, allowances, conferencing	9,500	2	19,000	10,118	2	20,235	10,775	2	21,550	6	60,785	X	X	X	MoHCC-NTP National Level
	8.3.1.6	Roll-out OneImpact mobile app in all provinces	19,200	1	19,200	20,448	1	20,448	21,777	1	21,777	3	61,425	X	X	X	MoHCC-NTP National Level
	8.3.1.7	Coordinate efforts through ACSM to place TB higher on the political agenda.	81,600	1	81,600	88,373	1	88,373	95,708	1	95,708	3	265,681	1	X	X	MoHCC-NTP National Level
	8.3.1.8	Mobilise stakeholder to raise resources for TB.			0			0			0	0	0				MoHCC-NTP National Level
	8.3.1.9	Engage gatekeeper to Combat stigma and discrimination of TB patients and their families	40,125	1	40,125	42,733	1	42,733	45,511	1	45,511	3	128,369	X	X	X	MoHCC-NTP National Level

	8.3.1.10	Empowering people affected by TB to help reduce the inequalities	2,002,560	1	2,002,560	2,132,726	1	2,132,726	2,271,354	1	2,271,354	3	6,406,640	X	X	X	MoHCC-NTP National Level
	8.3.1.11	Print and distribute brochures to all centres for TB patients	20,625	1	20,625	21,966		0	23,393		0	1	20,625	X			MoHCC-NTP National Level
	8.3.1.12	Run mass TB sensitisation using the print, radio and television media to inform the public about TB	81,600	1	81,600	88,373	1	88,373	95,708	1	95,708	3	265,681	X	X	X	MoHCC-NTP National Level
Strategic Intervention 8.3: Sub Total					**2,346,620**			**2,461,368**			**2,624,538**		**7,432,526**				

Strategic interventions 8.4: Improve monitoring and evaluation for TB and Leprosy

STRATEGIC INTERVENTION 8.4	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Improve monitoring and evaluation for TB and Leprosy	8.4.1.1	Conduct quarterly data quality assessments	29,125	4	116,500	31,018	4	124,073	33,034	4	132,137	12	372,710	X	X	X	MoHCC-NTP National Level
	8.4.1.2	Hold trainings on data analysis and use	18,000	2	36,000	19,170	2	38,340	20,416	2	40,832	6	115,172	X	X	X	MoHCC-NTP National Level
	8.4.1.3	Roll-out electronic health records for TB to all TB notification sites	89,825	1	89,825	95,664	1	95,664	101,882	1	101,882	3	287,370	X	X	X	MoHCC-NTP National Level
	8.4.14	Recruit M&E officers for TB at subnational level	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level
	8.4.1.5	Develop, print, and distribution an integrated and comprehensive support supervision checklist covering all TB program areas for provinces (TB-PMO and PTLCs) and Districts (DHT and DTLC)	8,638	1	8,638	9,199	1	9,199	9,797	1	9,797	3	27,633	X	X	X	MoHCC-NTP National Level

	8.4.1.6	Conduct GIS mapping of Hot spots annually to guide targeted TB screening	27,110	1	27,110	28,872	1	28,872	30,749	1	30,749	3	86,731	X	X	X	MoHCC-NTP National Level
	8.4.1.7	Conduct quarterly data driven coordination and action planning meetings lead by the City Task force with NTP technical support	3,200	4	12,800	3,408	4	13,632	3,630	4	14,518	12	40,950	X	X	X	MoHCC-NTP National Level
	8.4.1.8	Develop and dissemi-nate TB/Leprosy Annual Report	22,500	1	22,500	24,368	1	24,368	26,390	1	26,390	3	73,258	X	X	X	MoHCC-NTP National Level
	8.4.1.9	Hold a workshop to develop subnational TB burden estimates and targets	8,900	1	8,900	9,479	1	9,479	10,095	1	10,095	3	28,473	X	X	X	MoHCC-NTP National Level
	8.4.1.10	Procure TA to develop subnational TB burden estimates and targets	23,520	1	23,520	25,049	1	25,049	26,677	1	26,677	3	75,246	X	X	X	MoHCC-NTP National Level
	8.4.1.11	Facilitate DTLCs and District HMIS officers (Fuel, allowances, and airtime) to capture, collate, clean and promptly enter facility data in DHIS 2 monthly to ensure timeliness, completeness, and accuracy of data within set timelines (Fuel, allowances, and airtime for 2 (DTLC and HMIS) monthly x 12 months x 67 Districts)	22,110	1	22,110	23,547	1	23,547	25,078	1	25,078	3	70,735	X	X	X	MoHCC-NTP National Level
	8.8.1.12	Fast track the develop-ment and completion of TB module in her includ-ing the DHIS2 tracker and a case-based surveillance, for both DS TB and DR TB	0	0	0	0	0	0	0	0	0	0	0				MoHCC-NTP National Level

	8.8.1.13	Establishing a practice of locking data sets once 100% reporting and accuracy is attained to prevent changes in annual aggregates for each indicator over time	3,200	1	3,200	3,408	1	3,408	3,630	1	3,630	3	10,238	X	X	X	MoHCC-NTP National Level
	8.8.1.14	Procure tablets for TB data management	13,500	1	13,500	14,621		0	15,834		0	1	13,500	X			MoHCC-NTP National Level
	8.8.1.15	Procure TA to develop a self-assessment for TB	23,520	1	23,520	25,049		0	26,677		0	1	23,520	X			MoHCC-NTP National Level
	8.8.1.16	Roll-out the self-assessment starting with a pilot in a few districts	59,800	1	59,800	64,763	1	64,763	70,139	1	70,139	3	194,702	X	X	X	MoHCC-NTP National Level
Strategic Intervention 8.4: Sub Total					**467,923**			**460,393**			**491,922**		**1,420,237**				

Strategic intervention: 8.4 Strengthen TB Research to guide the TB response

STRATEGIC INTERVENTION 8.4	No.	Activity	"Unit Cost 2024 (USD) Yr 1"	Total Qty 2024	Total Amount 2024	"Unit Cost 2025 (USD) Yr 2"	Total Qty 2025	Total Amount 2025	"Unit Cost 2026 (USD) Yr 3"	Total Qty 2026	Total Amount 2026	Total Quantity for 3 Years: 2024 - 2026	Total Amount for 3 Years: 2024 - 2026	Implementation Timeframe			Responsible Unit
														2024	2025	2026	
Strengthen TB Research to guide the TB response	8.4.1.1	Conduct the DRS survey	150,000	1	150,000	159,750	0	0	170,134	0	0	1	150,000	X			MoHCC-NTP National Level
	8.4.1.2	Conduct the Population based National TB prevalence survey	200,000	1	200,000	213,000	0	0	226,845	0	0	1	200,000	X			MoHCC-NTP National Level
	8.4.1.3	Patient cost survey	200,000	1	200,000	213,000	0	0	226,845	0	0	1	200,000	X			MoHCC-NTP National Level
	8.4.1.4	Conduct Sigma Index Study-	200,000	1	200,000	213,000	0	0	226,845	0	0	1	200,000	X			MoHCC-NTP National Level
	8.4.1.5	Conduct patient Pathway Analysis	200,000	1	200,000	213,000	0	0	226,845	0	0	1	200,000	X			MoHCC-NTP National Level
Strategic Intervention 8.4: Sub Total					**950,000**			**0**			**0**		**950,000**				

Table 3: Summary Budget by Intervention

Summary Budget by Intervention	Year 1 - 2024 (USD)	Year 2 - 2025 (USD)	Year 3 - 2026 (USD)	3 Year Total - 2024 - 2026 (USD)
Strategic Intervention 1				
Strategic Interventions1.1: Improve case detection by expanding case finding to all clinical service areas/points	191,848	171,036	182,154	545,038
Strategic invention1.2 Expand geographic coverage of highly sensitive diagnostic tools, this Xpert MTB/Rif/Truenat for early diagnosis of TB including universal drug-susceptibility testing and use of digital radiology as a more sensitive screening tool.	14,040,651	5,383,525	5,733,454	25,157,631
Strategic intervention 1.3: Expand on active and intensified TB case finding approaches	1,663,748	1,321,922	1,407,846	4,393,517
Strategic intervention 1.4: Strengthen mechanisms for delivering integrated TB and HIV services	316,468	337,038	358,945	1,012,451
Strategic intervention 1.5: Improve childhood TB case detection	1,342,690	909,819	968,957	3,221,466
Strategic intervention 1.6: Promote TB service delivery in prisons and penitentiary institutions	16,063	0	0	16,063
Strategic intervention 1.7: Strengthen access to TB services amongst migrant populations and artisanal miners	444,400	473,286	504,050	1,421,736
Strategic intervention 1.8: Strengthen TB/DM/Covid-19 bidirectional screening	410,800	437,502	465,940	1,314,242
Strategic 1.9: Promote TB screening amongst HCWs	48,250	51,386	54,726	154,363
Strategic initiative 1.10: Improve data handling and use for or decision making and action	241,130	106,500	113,423	461,053
Strategic intervention 1.11: Improve case detection by expanding case finding at community level and involvement of the private sector	258,500	275,303	293,197	827,000
Strategic intervention 1.12: Improve TB control in urban areas through introduction of differentiated service delivery through Urban Model in Harare and Bulawayo cities	353,920	376,925	401,425	1,132,270
Strategic Intevention 1.13 Scale up TB Laboratory quality management system	3,101,153	379,484	404,151	3,884,788
Strategic Intervention 2				
Strategic interventions: 2.1: Improve case holding	4,232,000	814,619	867,569	5,914,187
Strategic intervention 2.2: Reduce TB related mortality	4,593,876	4,839,971	5,156,160	14,590,008
Strategic Intervention 3				
Strategic Interventions 3.1: Strengthen mechanisms for delivering integrated TB and HIV services	2,317,306	2,467,931	2,628,347	7,413,584
Strategic Intervention 3.2: Build clinical and programmatic competencies in TB/HIV management	1,365,313	1,433,666	373,631	3,172,610
Strategic intervention3.3: Improve the coverage of TPT towards saturation	18,571,522	277,651	2,344,809	21,193,982
Strategic Intervention 4				
Strategic interventions:4.1: Improve case detection by expanding access to rapid WHO approved molecular diagnostic tools	6,267,241	3,176,086	3,079,779	12,523,107
Strategic intervention 4.2: Build capacity in DR TB	341,480	366,576	393,543	1,101,599

Summary Budget by Intervention	Year 1 - 2024 (USD)	Year 2 - 2025 (USD)	Year 3 - 2026 (USD)	3 Year Total - 2024 - 2026 (USD)
Strategic Intervention 5				
Strategic intervention 5.1: Introduce new and shorter and patient friendly DR TB regimens	2,091,913	785,414	846,447	3,723,774
Strategic interventions 5.2: Improve case holding by extending DOT and treatment support to community level through the use of CHWs	1,034,705	154,942	174,279	1,363,926
Strategic intervention 5.3: Improve the coverage of nutritional support provided to DR TB patients	625,800	666,477	709,798	2,002,075
Strategic intervention 5.4: Strengthen aDSM monitoring	5,580,598	432,795	498,454	6,511,847
Strategic Intervention 6				
Strategic intervention 6.1: Scale up advocacy for increased funding of TB intervention and social protection for TB patients	81,880	58,745	61,339	201,964
Strategic Intervention 7				
Strategic interventions 7.1: Promoting partnerships with Leprosy stakeholders	10,500	11,183	11,909	33,592
Strategic intervention 7.2: Strengthen clinical capacity to improve case detection	61,438	43,685	46,524	151,647
Strategic intervention 7.3: Strengthen surveillance and information systems for Leprosy	12,450	8,866	9,442	30,759
Strategic Intervention 8				
Strategic intervention 8.1 Strengthen coordination between the NTLP and implementing and cooperating partners and the private players.	71,400	28,436	30,284	130,119
Strategic intervention 8.2: Enhance community TB response	744,930	739,430	787,492	2,271,852
Strategic intervention: 8.3 Enhance accountability in the TB response	2,346,620	2,461,368	2,624,538	7,432,526
Strategic interventions 8.4: Improve monitoring and evaluation for TB and Leprosy	467,923	460,393	491,922	1,420,237
Strategic intervention: 8.4 Strengthen TB Research to guide the TB response	950,000	0	0	950,000
TOTAL	**74,198,515**	**29,451,956**	**32,024,536**	**135,675,008**

Table 4: Update Technical Assistance Plan

Sub-activity #	Sub-activity	Profile of the expert	Implementer	Timeframe	Estimated cost	Source of funding
1.1.1.6	Procure 2 consultants to develop an active TB case finding plan	External/Local	NTLP	2024		GF
1.1.1.7	Procure a consultant to Develop integrated comprehensive TB Training materials including slides for DS-TB, DR-TB diagnosis and treatment, TB prevention, Childhood TB, TB integration (TB/HIV/DM and PPM), M&E.	External	NTLP	2024		TBA
1.10.1.1:	Procure TA to conduct an Inventory study	External/Local	NTLP	2024		TBA
2.2.1.4:	Procure TA to support the TB mortality study	External/Local	NTLP	2024		GF
8.4.1.10	Procure TA to develop subnational TB burden estimates and targets	External	NTLP	2024		GF
1.3.1.8	Develop contact tracing framework	External/Internal	NTLP	2024		TBA
1.3.1.4	Develop QI and PI manual to guide implementation of TB services at community level					
		NTLP	2025		TBA	
5.1.1.9	Conduct Annual Green Light Committee TA mission	External	NTLP	Yearly		GF
5.1.1.10	Conduct annual Global Drug Facility (GDF) TA mission					
		NTLP	Yearly		GF	
8.1.1.7	Conduct an End of term review	External/Local	NTLP	2026		GF
	Procure consultancy to develop new NSP 2027-2031	External/Local	NTLP	2026		GF
8.4.1.1	Procure TA to support the DRS	External/Local	NTLP	2024		GF
8.4.1.2	Procure TA to conduct population-based TB prevalence survey	External/Local	NTLP	2025		TBA
	Routine GF Country Team STTA support	External	NTLP	annually		GF
	WHO/GF TPT surge SI	External	NTLP			GF
8.4.1.3	Procure TA to conduct Patient cost survey	External	NTLP			GF
	Procure TA to support Implementation of Digital technologies: WHO Prevent TB App, OneImpact, TB surveillance and M&E Dashboard, e-learning Module	Externa;	NTLP			GF
	Procure TA to support operationalizing Whole Genome Sequencing introduction	External	NTLP			GF
8.4.1.4	Procure TA to support conducting, Stigma Index Study	Local	NTLP			GF
8.4.1.5	Conduct the Patient pathway analtsis	Local	NTLP			

4. Contingency Plan

The TB Programmes across the globe were negatively by the Covid-19 pandemic, which resulted in reduced TB detection and an increase in the burden of TB and TB mortality. An estimated 10.6 million people fell ill with tuberculosis (TB) in 2021, an increase of 4.5% from 2020, and 1.6 million people died from TB (including 187 000 PLHIV), according to the World Health Organization's 2022 Global TB report. The burden of drug-resistant TB (DR-TB) also increased by 3% between 2020 and 2021, with 450 000 new cases of rifampicin-resistant TB (RR-TB) in 2021. This is the first time in many years an increase has been reported in the number of people falling ill with TB and drug-resistant TB. TB services are among many others disrupted by the COVID-19 pandemic in 2021, but its impact on the TB response has been particularly severe. In the case of Zimbabwe, TB case finding did decline severely, widening the gap between estimated incidence and TB notifications.

Besides Covid-19 there are other public health emergencies that may emerge or natural catastrophes that may be fueled by climate change.

Proposed mitigation measures/interventions in case of Natural Catastrophes/Disease outbreaks/Peaks of Covid-19.

4.1 Proposed interventions in context of covid-19 emergencies.

4.1.1 Capacity building

Updating TB guidelines and training material to re-adapt the management of TB;

4.1.2 Case finding and diagnostics

COVID-19 screening and testing of all HIV, TB, MDR-TB and other patients with chronic disease;
Multiplexing COVID 19; viral load and TB testing on the Xpert platform, while ensuring infection prevention through appropriate scheduling of testing

4.2 Case management

a) Differentiated dispensing of anti-TB medication; synchronized of ART refills to reduce frequency of non-essential contact with health facilities.
b) Considerations should be made to extend weekly supplies during intensive phase of TB treatment with monthly supplies, and up to 3-month supplies for the continuation phase of treatment. This will help to limit the need for frequent travel to health facilities.
c) Remote adherence support, therapy through video DOT, telephone calls
d) Integrated contact investigation for both COVID 19 and TB.
e) Roll out of integrated mHealth platforms for both communication and treatment.
f) Provide DR-TB treatment refills to align with a health facility visit schedule for clinical assessment at 2 weeks, 4 weeks, 8 weeks and 2 monthly thereafter.
g) ECG and Hb should be assessed at each clinical visit together with other monitoring parameters set out in the DR TB guidelines. The 2nd, 4th and 6-month clinical consultations are particularly important

to assess treatment effectiveness, follow up on sputum culture results, make treatment modifications and monitor ECGs for patients receiving QT-prolonging drugs.

h) Children with TB will require regular dose adjustment due the rapid weight gains when on treatment. In this regard we will maintain monthly clinical visits for the purpose of adjusting the dose. Where weight monitoring is assured from home, above guidance shall apply

4.3 Infection prevention

a) If people with a cough do appear in outpatient departments, attention should be given to intensified triaging.
b) Patients with a cough to be provided a surgical mask.
c) Health care workers to wear N-95 masks.