

ZIMBABWE MINISTRY OF HEALTH AND CHILD WELFARE



NATIONAL TUBERCULOSIS CONTROL PROGRAMME FIVE YEAR STRATEGIC PLAN 2009 - 2013

June 2009

FOREWORD

This five year strategic plan (2009 – 2013) was produced as a result of wide consultation with various players involved prevention, care and treatment of TB. This involved various activities which included, review of key documents, meetings and interviews with stakeholders and key informants. Additionally country-wide visits to provinces, districts and other health related institutions and partners were conducted to assess and review progress on the key strategic issues for inclusion in this strategic plan.

The plan takes into account the global strategic framework and targets for effective TB control, health and human development as outlined in the WHO Global TB strategy and the UN MDGS.

The Ministry of Health and Child Welfare acknowledges that the investment in tuberculosis control is one of the most cost-effective investments in the health sector and this is as well acknowledged by the World Bank.

It is along these lines that the Ministry of Health and Child Welfare is highly committed to sustain and increase its commitment to support to the National Tuberculosis Control Programme (NTP), within the context of its National priorities.

The way in which TB control is implemented in Zimbabwe may change with health sector reform, however, during the next five years good quality TB control will of necessity have to be delivered through a strong and effective National Programme. The National programme will work closely with all provinces to assist in strengthening their systems so that ultimately they can plan and implement provincial TB control activities themselves.

The Ministry of health and Child Welfare working together with various partners in health will continue to offer assistance and supportive supervision to provinces, including private sector and peripheral health unit in order to effectively monitor TB control activities. It is hoped that his 5 year strategic plan will be an excellent and effective policy guide in winning the fight against tuberculosis in Zimbabwe

Honourable Dr Henry Madzorera

MINISTER OF HEALTH AND CHILD WELFARE

ACKNOWLEDGEMENTS

Special thanks to go to the following individuals under the leadership of Dr. C. Sandy (AIDS/TB Programme) without whose effort this 5 year strategic plan would not have been produced:-

1. ST Zizhou
2. SK Gorogodo
3. C.A Matiringe
4. TD Gowa
5. M Jonasi
6. P Dhliwayo
7. T Amouh
8. C ielo Rios
9. Jonathan Whande
10. Freddie M Mutsvairo
11. Barbra Murwira
12. Godfrey Mutetse
13. Martha Tholana
14. Misheck Nhlovhu
15. Stanley Mungofa
16. Tonderayi Murimwa
17. Tsitsi Appollo
18. Peter Shiri
19. Barnet Nyathi
20. Dimitri Peffer
21. Adonija Muzondiona
22. Mhaka Tendayi Florence
23. Solomon Mukunugwa
24. E Chisakaitwa
25. N Siziba
26. C Chakanyuka
27. Patricia Mwangambako

The MOHCW is also heavily indebted to USAID through TBCAP for the financial assistance provided to develop the plan. We thank KNCV (Prof. Felix Salaniponi) and WHO (Dr. Sam Ogiri) for providing the direct Technical Assistance to compile the plan.

Brigadier- General (Dr) Gerald Gwinji

Permanent Secretary

MINISTRY OF HEALTH AND CHILD WELFARE

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CHAPTER ONE: BACKGROUND INFORMATION

GENERAL ASPECTS

Zimbabwe is a landlocked country situated in Southern Africa, covering 390,759 square km and is divided into 10 administrative provinces including Harare and Bulawayo Metropolitan provinces. The 8 rural provinces are made up from 63 districts. In 2006, the population was estimated at 12 103 950 (52% females, 48 males). Zimbabwe has over the last 10 years witnessed a decline in most health indicators and the status of some key health indicators following the Zimbabwe Demographic Health Survey (ZDHS) 2005-2006 is shown in table

DEMOGRAPHY

The population projection of 2006 by Zimbabwe Central Statistics Office estimated Zimbabwe's population at 12 103 949 of which women made up 52% and men 48%. During the 30-year period between the 1962 and 1992 censuses, the population more than doubled. Between 1983 and 1992 the population grew 40% from 7 million to 10.4 million. At this average rate of 3.14% a year, the population would double in 23 years. As a result of the high rate of population growth, 48.6% of the population is below the age of 15 years (ZDHS). With such a young population age structure it is likely that population growth will continue for decades to come, even if fertility rates decline.

The proportion of the population under one year remained stable at around 3.3% in 2006, while the proportion of 1-4 year olds dropped from 13.9% on 1982 to 8.8% in 1992 and increased again to 15.4% in 2006. The proportion of 5-24 year olds remained stable at around 29.9%. The proportion of those above 65 dropped slightly to 2.49 in 2006. The elderly continue to represent a small proportion of the total population, but their need for assistance should be considered in the context of the gradual expansion of geriatric services.

The male / female ratio has shown a drop from 0.95 in 1992 (that is, 95 men to every 100 women), to 0.92 in 1997 and has gone back to 0.95 in 2006... This is probably due to the initial external migration of males, and latter on to the stabilization into the same number probably due to the repatriation from other countries.

Because of the large proportion of young people in the population, Zimbabwe's dependency ratio is high. The 2002 Census gives a dependency ratio of 0.94 for the country as a whole, down from the 1982 figure of 1.3. In 1997, the ratio stood at 0.87 and in 2006 it stood at 0.82. This means that for every 100 adults in the age group 15 – 64, there are 82 children and elderly people who should be looked after.

This dependency ratio has obviously increased as AIDS takes its toll on Zimbabwe's adult population and as the number of orphans increases.

The in-migration to Zimbabwe from Mozambique that was an important factor of the population change during the early 1980s has ended. With the advent of peace, refugees have been repatriated and today this migration is local, seasonal and almost irrelevant. The migration of young people to South Africa and Botswana for employment is, by contrast, significant.

Internal migration statistics show that the urban population at the time of the 2002 Census was about 26%, rising to 31% in 2006. Urbanization appears to be moderate Zimbabwe did not experience the dramatic movement from commercial and communal lands towards cities that occurred in other southern African countries. On the other hand, the rise urbanization of 5% over 5 years could be an underestimate for two reasons. First, not all seasonal and temporary lodgers who live most of the year in cities are recorded during the census exercise. Secondly, the classification of urban areas used during the 2002 Census was more restrictive than the one adopted in 1982.

The impact of HIV/ AIDS related diseases on the population pyramid is not totally clear, but it is anticipated that more orphans will result as young parents succumb to the epidemic. The population pyramid in the 25 – 45 year age group has narrowed. The impact of AIDS on population development is the subject of many and varied projections.

MORTALITY

Mortality indicators are key to assessing quality of life. They show a trend than can be confirmed by other important indicators. Within a decade after independence, Zimbabwe made impressive progress in improving the health status of its population. This is evident in the improved indicators for infant mortality, child mortality, and life expectancy at birth, prevalence of malnutrition and access to health services. The general Life expectancy for Zimbabwe has dropped from 57 in 1978 to 45 in 2006, with males having dropped to 43, whilst females to 46 in the same years.

CRUDE DEATH RATE

The CDR in Zimbabwe has dropped from 10.8 in 1982 to 6.1 in 1987, but rose to 9.49 in 1992 and 12.2 in 1997. It is evident that HIV/AIDS epidemic is affecting the national CDR. This has shown to rise as the age specific death rate among 15 – 45 olds and in the under- five age group increases due to HIV/AIDS. The

major causes of deaths in hospitals for all ages, according to the 1996 National Health Profile, are tuberculosis, malaria, respiratory infections, perinatal conditions and nutritional deficiencies.

GENERAL HEALTH ISSUES

BURDEN OF DISEASE

Communicable diseases account for more than half of all visits to Zimbabwe health facilities. Among them, respiratory infections are the leading cause of OPD first visits, accounting for a quarter of all new cases. Malaria and skin diseases follow at second and third respectively, with injuries and STIs ranked fifth and sixth respectively. In 2006, the top five commonest causes of deaths in order of ranking were as follows:

- Pulmonary TB
- ARI (lower tract)
- Other viral diseases
- Malaria
- Intestinal infections

Tuberculosis (TB) is the commonest cause of death, particularly in age groups with high HIV prevalence (15 – 49) years. The estimated adult HIV seroprevalence rate in 2006 was 18%. Young adults are most commonly affected. Among adolescents, female outnumber males by a ratio of over 5:1 and about 70% of deaths among children under 5 years are attributed to HIV. Patients with HIV/AIDS – related conditions occupy up to 70% of all hospital beds, and constitute the majority of hospital deaths

Zimbabwe's health status is currently facing several significant challenges. These include the HIV/AIDS epidemic, decreased access to health services by the population, poor availability of essential drugs, reduced quality of care at health facilities and inadequate human resources; associated with the deterioration of the country's economic situation.

HEALTH POLICY AND STRATEGY

The Primary Health Care (PHC) approach was adopted at Independence in 1980 as government's strategy for achieving the Health-For –All targets by 2000. In the early 1990s, the MOHCW embarked on

a Health Sector Reform programme, which includes decentralization, health financing, regulation of the private sector, management strengthening and contracting out practices of non-essential services. In 1997, the Ministry launched National Health strategy for Zimbabwe: “Working for Quality and Equity in Health”, covering the period 1997 – 2007. Since 2008 The MOHCW has been working on a successor to the 1997-2007 National Health Strategy as well as a National Human Resources for Health Strategy.

ORGANIZATION OF THE HEALTH SYSTEM

Most health services are provided by the public sector, which consists of the MOHCW, the Ministry of Defence, the Ministry of Home Affairs (police), the Ministry of Justice (prison services), local authorities and mission health services. Management and administration of this sector is divided into four functional levels: national, provincial, district and ward.

The national level is responsible for policy formulation, regulation, resource mobilization, disbursement of resources for programme implementation, training, co-ordination of research activities and monitoring and evaluation. The provincial level provides technical and management support to the district level including co-ordination of planning, oversee implementation of national standards and guidelines, training and monitoring and evaluation. The overall responsibility for these activities lies with the Provincial Health Executive (PHE).

The district level supports, supervises and co-ordinates the implementation of primary health care in the district. The overall responsibility for these activities lies with the District Health Executive (DHE).

Many mines, large estates, and industrial complexes run their own health delivery services. There is a well –developed private health sector, comprising mainly of independent medical practitioners and private hospitals, found in almost all towns in the country. Traditional healers have an important role in health delivery. The Zimbabwe National Traditional Healers Association (ZINATHA) was formed to regulate their activities.

The loss of experienced managers at all levels of the health system in the last ten years has reduced management capacity, negatively impacting on basic health care, particularly at the lowest level. This has contributed to the breakdown of the referral chain and to the increasing use of referral hospitals as primary care providers.

HEALTH INFRASTRUCTURE

With the adoption of the goal of health for all by 2000 primary health care expanded tremendously after independence and ambitious targets of health infrastructure development were set:

- One health clinic/centre per 10 000 people
- One district hospital per 140 000 people and
- One provincial hospital per province.

These targets were generally adequate for health services provision but the advent of land reforms which resulted in population dispersion has led to drop in access to health services and hence there is need to develop additional health service points. For instance, in 1997, 85% of the population lived within 8 km of a primary care facility but this figure has significantly fallen over the recent past. Access to primary health care has also declined due to lack of essential drug supplies, staff shortages and poor maintenance of health facilities, while some populations cannot access services because of failure to pay user fees.

Level of care	Central Government	Mission	Rural District Council	Total
Primary Rural Health Centre	301	55	525	881
Rural hospitals	55	61		116
Secondary (District)	50	8	0	58
Tertiary (Provincial)	8	0	0	8
Quaternary (Central/specialist)	7	0	0	7
Grand Total	421	124	525	1 170

Health Facilities by Ownership 1

DRUGS AND MEDICAL SUPPLIES

The MOHCW regularly publishes the Essential Drug List of Zimbabwe (EDLIZ), a guide for standard treatment practice and rational drug use. The national Government Medical Stores was privatized to form the National Pharmaceutical Company of Zimbabwe (NatPharm) in 2002. NatPharm is the major

supplier of drugs and supplies to public health institutions. Recent foreign currency shortages have led to inadequate stocks of essential drugs, vaccines and medical supplies. Drugs purchased from private sources are prohibitively expensive for the majority of the population. TB drugs are part of the Essential Medicines List and their distribution is similar to any other medicine but special requisition forms are used because TB drugs are provided free to all health facilities.

HUMAN RESOURCES FOR HEALTH

Following Independence, Zimbabwe steadily increased the number of health workers trained in the country. However health professionals continue to leave the public sector to move to the private sector and other countries. The vacancy rate for doctors increased from 31% in 1999 to 55% in 2002, while that for nurses increased from 24% to 31.4% during the same period. The loss of health care professionals has accelerated since then with increasing emigration of staff. Low morale and chronic understaffing have significantly hindered the delivery of basic quality health care. Despite a significant increase in the number of training schools and intakes of health cadres since 1999, there are increasing vacancies among all cadres of health professionals, a situation exacerbated by staff misdistribution. According to a 1999 human resource study, only 5% of all MOHCW personnel were employed at health centre level, but more than third were employed at central hospital level.

Staff category	Establishment	Staff-in-post	Vacant posts	Vacancy Rate (%)	Population: Category ratio
Medical Doctors	1562	703	889	57	
Dentists	11 640	6 940	43		
Nurses	19811	12552	7259	37	
Pharmacists	1 624	764	120		
Environmental Health Officers			860		

Health Staff Situation 1 Source: Establishment register

HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS) AND ESSENTIAL NATIONAL RESEARCH

The HMIS was established in the early 1980s to accelerate the implementation and management of PHC programmes. Frequent staff turnover has hampered the effective functioning of the system, hindering the generation, analysis, dissemination and use of information to guide programme planning and performance measurement.

The National Institute for Health Research (NIHR) is the main government health research institution and operates mostly as a bio-medical research institution. Research institutions supporting and or complementing the efforts of the NIHR include the University of Zimbabwe Medical School and the Bio-Medical Research and Training Institute (BRTI). The Medical Research Council is the controlling body for all biomedical research.

HEALTH FINANCING

Health is financed through government funding, private voluntary medical schemes/health insurance and development assistance. The public health budget has increased nominally over the past decade, it has declined in real terms because of high inflation and increased demand for health care services, and it is inadequate to meet the basic and essential health care needs of the population. The raging HIV/AIDS pandemic has markedly increased demand for health care services and has contributed to the problem. Development assistance, which used to augment government health expenditure, has fallen by 90% in recent years, as shown in figure below

CHAPTER TWO: TB CONTROL PROGRAMME IN ZIMBABWE

1) OVERVIEW AND HISTORY OF TB CONTROL PROGRAMME

The NTP was established in the sixties. In 1983 the government developed a policy of integration of all TB activities into the general health services. The NTP officially adopted the Directly Observed treatment Short-course (DOTS) strategy in 1997 and adopted the new Stop TB Control Strategy in 2006. The NTP has three main functional levels: central, provincial and district.

TB EPIDEMIOLOGY IN ZIMBABWE

Tuberculosis is among the top 10 diseases of public health importance in Zimbabwe and it is indeed a leading cause of death among adults. According to the WHO 2009 Global TB report, Zimbabwe is ranked 17th among the 22 high burden TB countries (HBC) in the world.

Incidence	All	In HIV+ People
All forms of TB(thousands of new cases per year)	104	72
All forms of TB(new cases per 100 000 pop/year)	782	539
New ss+ cases (thousands of new cases per year)	40	25
New ss+ cases (per 100 000 pop/year)	298	189
HIV+ incident TB cases (% of all TB cases)	69	

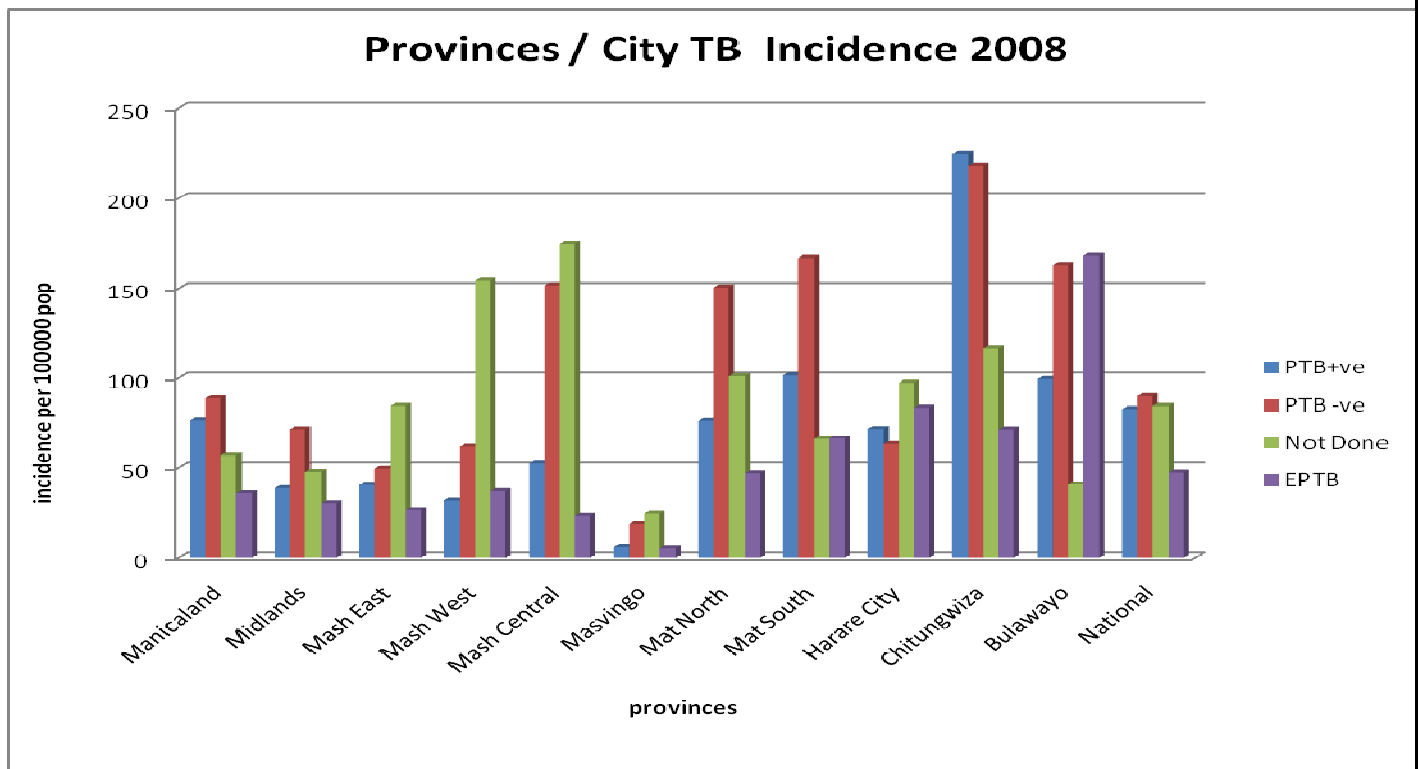
Estimates of TB burden for 2007 (WHO) 1

The report states that the country had an estimated incidence of about 40,000 new smear positive TB cases (incident rate of 298/100,000) and incident of 104,000 of all forms of TB (incident rate of 782/100,000). The burden of all forms of TB disease has increased by over six fold from 121 cases/100,000 population in 1991 to 782 cases/100,000 population in 2007. Correspondingly, the notification of both all forms and new smear positive TB

cases increased steadily between 2000 and 2004. However, from 2005, the notified cases began to decline. For instance, the notified cases of all forms declined from 56,162 in 2004 to 41,387 cases in 2007 (representing a 26.3% decline). Similarly, the notified new smear TB cases in the same period declined by 27.4% (i.e. 14,581 to 10,583).

This observed decline is attributable mainly to operational and systemic issues such as the weakness in the health care delivery system, high turn-over of skilled and experienced health workers and the poor performance of the recording and reporting system. The notified cases at the end of 2007 compared to the estimates for the period shows that only 40% and 26.5% of the expected of all forms of TB and new smear positive cases respectively were notified. It is a deep concern that a high proportion pulmonary TB cases up to 30% are being put on treatment without any smear microscopy performed.

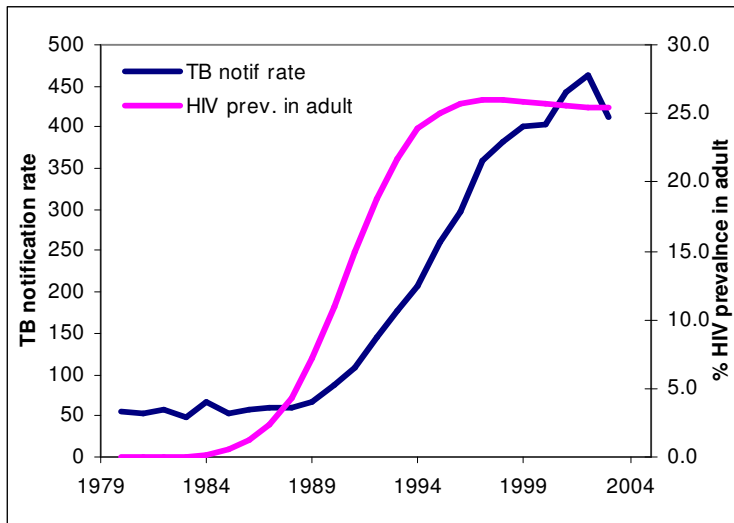
The notification rates and patterns vary greatly by province. The variations are a reflection of the weaknesses of the recording and reporting system. The peak incidence of TB among remains the 25-44 age groups for both sexes.



TB AND HIV/AIDS

The most significant contributing factor to the TB epidemic is the HIV/AIDS epidemic. As shown in figure, the rise in HIV/AIDS cases preceded the rise in TB cases by about 6 years. TB remains the commonest cause of death among people living with HIV/AIDS (PLWHA). Routine testing of HIV among TB patients is being expanded through various strategies including the provider initiated testing and counseling programme. Health facility based data and WHO estimates put the TB/HIV co-infection rate at 72%. However the proportion of TB patients with a recorded HIV result in the TB register is still low and not more than 15%.

Impact of HIV/AIDS epidemic on the TB Burden in Zimbabwe

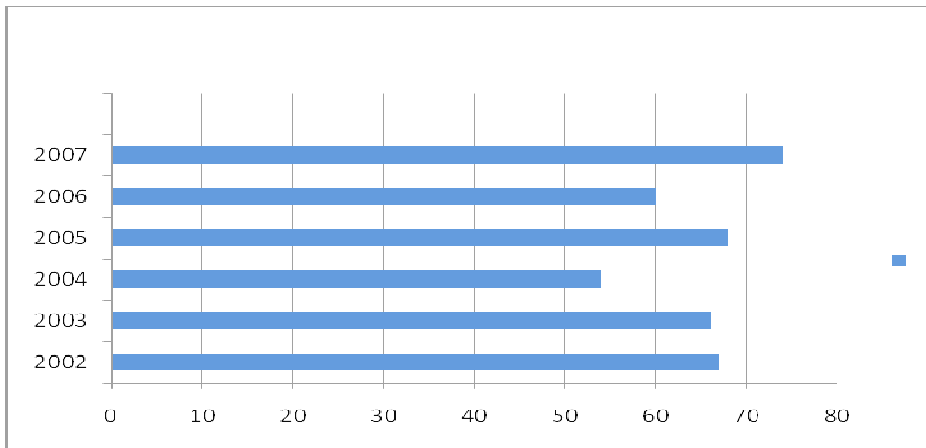


MDR-TB BURDEN

The drug resistance survey performed in 1995 showed a prevalence of less than 3% multi-drug-resistant strains of TB among new cases and less than 6% among patients on re-treatment. There is no systematic monitoring of drug resistance but the 2009 World Health Organization report estimated MDR-TB rates of 1.9% and 8.3% among new and re-treatment TB cases respectively in 2007.

NATIONAL TREATMENT OUTCOME TRENDS 2002 – 2007

Treatment success rates over the past 5 years have generally been showing a decline. However up to 74% of TB patients diagnosed in 2007 were successfully treated, up from 60% in the previous year but still well below the global benchmark target of 85% recommended by WHO. The increase in the treatment success rate is mainly attributable to improvements in the recording and reporting system and intensive follow-ups as a positive result of additional dedicated M/E staff recruited with assistance of Global Fund resources. See figure 2.3.



NATIONAL TUBERCULOSIS POLICY

The three key points of the TB policy are:

- Sputum smear microscopy is the basis for case identification and follow up and is provided free of charge in the public health sector at the point of access;
- All TB cases are provided with a standardized short course of chemotherapy free of charge.
- TB services are available at all levels of the health delivery system, being integrated into the primary health care system to ensure efficient case finding, particularly for smear positive patients.

TB CONTROL INSTITUTIONAL FRAMEWORK: STRUCTURE AND ROLES OF AT VARIOUS LEVEL

CENTRAL LEVEL

The NTP central unit is part of the Directorate of HIV/AIDS/STI and TB which falls under the Division of Preventive Health Services. The central unit of NTP is responsible for National TB policy review, development and formulation; the planning, coordination, monitoring, training and evaluation of programme performance. The unit collaborates with the Directorates of Laboratory and Pharmaceutical Services on the procurement and distribution of anti-TB drugs, laboratory reagents and materials at all levels. Other key responsibilities include organizing National level trainings, TB data compilation and analysis. The unit also collaborates closely with the Environmental Health Department, the National AIDS Council (NAC), NGOs, and private health sector, bi-lateral and multi-lateral organizations. On the current MOHCW structure the Central unit is headed by a deputy director

who is assisted by a National TB Control Manager and a Logistician (see annexe). This current structure is undergoing review so as to strengthen the Central unit and absorb key staff recruited with Global Fund assistance. (see annex)

CENTRAL HOSPITAL LEVEL

These hospitals manage TB patients i.e. diagnosis, treatment, referral of patients to appropriate authorities, and have the responsibility for the management of complicated or severe forms of TB such as TB meningitis or pericardial TB. Clinical management of TB is led by consultant physicians but coordination of patient management and recording and reporting is done by the infection control sister. Central Hospitals refer all diagnosed TB cases to the City Health Department for case notification, treatment continuation and contact tracing.

PROVINCIAL LEVEL AND LOCAL AUTHORITIES

In the NTP this level has several key responsibilities which include are training of staff, supportive supervision of the district, compilation of TB data, analysis of TB data, submission of TB quarterly notification summaries and outcomes to the National level and participation in TB policy formulation. The PMD is overall through the Provincial Epidemiology and Disease Control Officer (PEDCO), a medical officer with public health training. The PEDCO is a member of the Provincial Health Executive (PHE). A Provincial TB coordinator, usually an environmental health technician, supports the PEDCO and reports to both the PEDCO and the Provincial Environmental Health Officer (PEHO).

Four large local authorities, Harare, Bulawayo, Mutare and Gweru, are responsible for TB control in their cities, and operate infectious diseases hospitals. The local authorities adhere to national guidelines, report their activities to the NTP and actively participate in policy development and implementation at national level. The MOHCW is responsible for TB control in the remaining smaller local authorities. Central and general hospitals in the large cities diagnose TB patients and refer them to local authorities for registration and further management.

DISTRICT LEVEL

The District Medical Officer (DMO) has overall responsibility for the organisation and management of TB control activities at district level, with the assistance of a District TB Coordinator, who is often an Environmental Health Technician. The district hospital is the basic management unit in tuberculosis control, and is responsible for the diagnosis, treatment and follow-up of patients and tracing of contacts, and supervises TB control activities at

primary health care facilities. The district office orders drugs, reagents and stationery for all health facilities in that district.

PRIMARY HEALTH CARE LEVEL

These are usually rural health centres or municipal clinics in urban localities, and assist in the identification and referral of TB suspects, supervision of treatment of confirmed cases of TB, supply of drugs and observation of treatment (DOT), tracing of contacts and defaulters. Most facilities maintain facility TB records and registers (e.g., health unit DOTS registers).

COMMUNITY, COMMUNITY BASED ORGANIZATIONS (CBOS) AND NON-GOVERNMENTAL ORGANIZATIONS (NGOS)

These organizations compliment the efforts of the NTP in providing TB services. The range of services provided by such partners include patient support, including direct observation of treatment (DOT), patient, family and community TB related education, supporting case finding activities, and lobbying for greater government support for TB control

PRIVATE PRACTITIONERS AND INSTITUTIONS

Most private medical care is available on a fee for service basis, often with the support of medical insurance companies. The private health sector supports the NTP mainly in the diagnosis of TB and referral of diagnosed cases to government or designated health facilities for notification and treatment. Some large corporations have developed company-based TB control programmes using the DOTS strategy in accordance with the national guidelines.

LABORATORY SERVICES

There is a National Reference Laboratory (NRL) at Mpilo Hospital in Bulawayo, 10 intermediate (province/city) and 96 peripheral level laboratories. All intermediate and peripheral laboratories perform smear microscopy and refer re-treatment and failure cases for culture and drug susceptibility testing to the NRL. The NRL is expected to provide overall technical assistance and external quality assessment (EQA) to all laboratories in the network. There are more than 30 private laboratories that perform smear microscopy for private and public providers but that are not involved in the NRL EQA.

PARTNERSHIPS AND COLLABORATION:

Partnerships are potentially one of the most important elements in combating TB in Zimbabwe. Various partners are supporting the National TB efforts but still more need to be taken on board and better efforts at coordinating the partners are required.

Partners	Scope of Support and Collaboration
The European Union (EU)	<ul style="list-style-type: none"> • Supports the procurement of First Line anti-TB drugs including pediatric preparations; • Support for human resource development.
United State Agency for International Development (USAID)	<ul style="list-style-type: none"> • Provide funds (through TBCAP) to support TB control activities
Centre for Disease Control and Prevention (CDC)	<ul style="list-style-type: none"> • Support for laboratory strengthening activities
The Union	<ul style="list-style-type: none"> • Support for integrated HIV care for PLWHA and TB;
World Health Organization (WHO)	<ul style="list-style-type: none"> • Technical support to NTP in programme development, planning, monitoring and evaluation; • Support for DOTS expansion and enhancement; TB/HIV integration, MDR-TB/XDR-TB surveillance and building capacities of laboratories
The Global Fund	<ul style="list-style-type: none"> • Providing grant support for TB control activities
Zimbabwe Association of Church-Related Hospitals (ZACH)	<ul style="list-style-type: none"> • Principal Recipient of Global Fund Round 5 TB grant • Coordinating mechanism for mission institutions
TBCAP	<ul style="list-style-type: none"> • Leadership and management development • DOTS implementation activities at subnational levels

GAP ANALYSIS OF TB CONTROL ACTIVITIES USING THE STOP TB STRATEGY FRAMEWORK

<p>Political Commitment</p>	<p>Well structured health delivery system;</p> <p>Government of Zimbabwe has virtually funded all NTP activities until recently. Budget line exists for TB programmatic management, National Reference Laboratory and procurement of anti-TB drugs;</p> <p>National TB policy in place and TB management guidelines developed since 1999 – revised in 2001 and 2007</p>	<p>Inadequate funding from the government due to the economic situation in the country;</p> <p>The health delivery system has been weakened overtime because of the economic situation</p>
<p>TB case finding and diagnosis</p>	<p>Case finding is mainly passive</p> <p>Smear microscopy is the cornerstone of TB diagnosis in the country</p> <p>Diagnosis by smear microscopy is free.</p>	<p>The TB prevalence in the country is not known - planning is based on estimates;</p> <p>Contact tracing activities are largely uncoordinated, there is no systematic evaluation to show the added-value of the activity;</p> <p>Reported evidence that 30% of pulmonary TB cases are placed on treatment without smear microscopy clinicians over rely on x-rays for diagnosis.</p> <p>The national case detection rate is still below the global/national targets of 70% - 54% at the end of 2007</p> <p>Recurrent stock outs of laboratory reagents and materials</p>
<p>Laboratory network and External quality Assurance System</p>	<p>Existing TB National Reference Laboratory;</p> <p>Draft National policy on laboratory services;</p> <p>Zimbabwe National Quality Assurance Programme (ZINQAP) runs proficiency testing for laboratories in general;</p>	<p>The National Reference Laboratory currently lack the capacity for TB culture and drug susceptibility test (DST);</p> <p>Inefficient and irregular; External Quality Assurance system;</p> <p>Inequitable distribution of microscopy services;</p> <p>Human resource challenges;</p> <p>Weak supervision of the laboratory network.</p>

<p>Treatment and treatment outcome</p>	<p>Treatment is based on the DOTS strategy since 1997</p> <p>The treatment policy provides for free treatment;</p> <p>Fixed dose combination (FDC) based drug formula adopted in</p> <p>Treatment protocols available in most of the clinics;</p> <p>Weighing scales available but some need calibration;</p> <p>The policy environment allows the stocking of anti-TB drugs only in the public health institutions</p>	<p>The national treatment target is still below the global target of 85%;</p> <p>The combined defaulter & transfer out rates of about 15% is relatively high compared to the regional target of less than 10%</p> <p>DOT is predominantly family member dependant but there is no training for the treatment observer</p> <p>The 3rd edition of the NTP manual is not readily available in the health facilities;</p>
<p>Drug supply and management system</p>	<p>Electronic-based inventory system between NatPharm and the provinces/districts – the system is able to link procurement and finances</p> <p>European Union has been supporting procurement of anti-TB drugs</p> <p>Global Fund Round 8 TB grant will support drug procurement through the Global Drug Facility (GDF) mechanism.</p>	<p>Drug quantification and ordering at the national level is not linked to actual consumption because of incomplete data/information from the peripheral levels;</p> <p>The drug stock management system is still ineffective and inefficient resulting in overstocking; wastage through expiry and ‘artificial’ out of stock syndrome in some districts/health facilities.</p>
<p>Recording and Reporting System</p>	<p>Standardized recording and reporting system in place;</p> <p>Some aspects of TB/HIV information integrated in to the recording and reporting system;</p>	<p>Decline in regularity and timeliness of reporting;</p> <p>Inadequate completeness and quality of reporting in recent times</p> <p>Lack of recording and reporting materials in some facilities;</p> <p>Some recording materials do not capture TB/HIV information/data wholly.</p>
<p>Programme management and supervision</p>	<p>Five additional staff recruited for NTP through the Global Fund Round 5 TB grant;</p> <p>A motor vehicle (4-wheel drive Toyota hilux) and laptop computers available</p>	<p>Management function of NTP still weak because of inadequate human and financial resources;</p> <p>M & E plan not in place;</p> <p>Weak supervision and monitoring system due to lack of funding.</p>

Human Resource Development for TB	Post of Provincial and District TB coordinators created	Staffing level for NTP still inadequate; There is high staff attrition at all levels; No human resource plan for the NTP is in place; No training manual for the programme; Training has not been held for most facility staff in the last 5 years.
TB/HIV Collaboration	There is some ongoing TB/HIV collaborative activities; Many health facility workers trained on counseling and rapid HIV testing;	No guidelines on TB/HIV collaboration; No functional TB/HIV collaborative mechanism (Working Group) at all levels Anecdotally, uptake of HIV screening among TB suspects/patients is still low. However, available evidence shows a very high TB/HIV co-infection rate of more than 70%; Referral network between NTP and HIV/AIDS programme is still not optimal;
MD/XDR-TB control and prevention	3 rd edition of NTP manual addresses basic issues on suspecting MDR-TB, preventing and managing MDR-TB	Currently no national capacity for the diagnosis of M/XDR-TB; No systematic MD/XDR-TB surveillance in place and no survey conducted since 1995; No programmatic management system in place
TB Control and prevention in congregate settings and special high risk groups	NTP manual in principle recognizes the need to provide TB care in the prisons; Functional collaboration and networking between NTP and the armed forces health institutions The International Organization for Migration is collaborating with the Ministry of Health supporting health services for migrants at the borders;	No nationally coordinated mechanism for operationalizing DOTS in the prisons; Further strengthening of collaboration with the armed forces is required; Institutionalize referral mechanism for TB suspects among migrants to access TB care.
TB Infection Control in health	Broadly recognized as a strategy for TB prevention and	No infection control guideline or protocol in place.

care settings	control in the NTP manual.	
Public-Private Mix DOTS initiatives	<p>NTP policy recognizes the potential role of the private health sector in TB control;</p> <p>The private for profit are only involved in the diagnosis and referral of confirmed TB cases for treatment in the public health sector;</p> <p>The faith-based or mission hospitals are integral parts of the public health system and participate actively in TB control</p>	No guidelines on private-private mix DOTS.
Community TB care and ACSM	<p>TB related IEC materials (print and electronic) developed and disseminated;</p> <p>World TB Day observed annually.</p>	<p>No guidelines on community involvement in TB care;</p> <p>No guidelines on ACSM;</p> <p>Low level of TB awareness in the community;</p> <p>Low community involvement and participation in TB control;</p> <p>TB Patient charter yet to be adopted for use.</p>
TB and TB/HIV Related Operational Research		NTP currently has no capacity for operational research activities
Partnership and collaboration	<p>The European Union is supporting NTP in the procurement of anti-TB drugs (200 – December 2008);</p> <p>USAID is supporting NTP with about \$1.5 million annually;</p> <p>WHO, IUATLD and KNVC are providing technical assistance to NTP;</p> <p>Global Fund Round 5 TB grant totaling \$9.2 million.</p>	<p>Non release of Global Fund Round 5 grant since quarter 7 of the grant cycle.</p> <p>Too few partners with the NTP compared to HIV/AIDS</p>

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (SWOT) ANALYSIS OF NTP

STRENGTHS:

- Well structured health care delivery system at all levels
- Evidence of strong Government commitment i.e. funding of NTP over the years with little donor input existence of NTP management guidelines;
- Establishment of the Integrated National TB Programme structured along the existing health care delivery system;
- Attainment of 100% DOTS coverage in the country and free access to both diagnosis (by smear microscopy) and treatment at the point of access
- Existence of an electronic-based soft ware for drug management at the national and provincial levels;
- Existence of a magnificent of National TB Laboratory infrastructure;
- Integrated TB/HIV recording and reporting system

WEAKNESSES:

- Inadequate funding of NTP by the government;
- Weak management capacity of the NTP to provide coherent leadership for effective and efficient programme implementation, supervision, monitoring and evaluation;
- No monitoring and evaluation plan and no human resource development plan;
- Relatively low case detection rate compared to the global/national target of 70%: this is attributable in part to over 30% pulmonary TB cases not being offered smear microscopy and poorly functioning laboratory systems and network;
- Non-functioning TB National Reference Laboratory and collapse of external quality assurance for the network of microscopy centers;
- Relatively low treatment outcome compared to the global/national targets: this is attributable to inadequate DOT, erratic drug supplies; high transfer out rates, weak defaulter retrieval mechanisms, etc;

- Inadequately functioning drug management system resulting in skewed distribution, overstocking, wastage through expiry, and out of stock syndromes;
- Lack of any programmatic interventions (including surveillance) for M/XDR-TB control and prevention;
- Limited access to ARVs by TB/HIV co-infected patients;
- Non-functional mechanisms for effective TB/HIV collaboration at all levels;
- Weak implementation of PPM-DOTS, Community TB Care and TB related operational research activities.

OPPORTUNITIES:

- Support by partners such as WHO, USAID, TBCAP, The European Union;
- Global Fund support;
- Improving political situation in the country;
- The existing Home Based Care structure for HIV/AIDS provides opportunity for the integration of Community TB Care;

THREATS:

- Non conducive political climate with continued poor relationship with the West may result in limitations in the improvement of the macroeconomic environment
- Poor socio-economic situation in the country;
- Continued migration of highly skilled and experienced health and other workers to other countries;
- Prevailing and increasing poverty level, especially among the urban poor and rural areas
-

CHALLENGES/CONTEXTUAL ISSUES

PREVAILING POVERTY:

Zimbabwe is suffering its worst-ever economic crisis, with an estimated 80 percent living below the poverty line. Transport costs could therefore be a barrier to completing treatment and also the likelihood that large numbers of TB cases are going undetected and untreated. The strategic plan assumes that while sector wide approaches are being deployed to address poverty, access to TB services will be made more equitable.

DWINDLING FUNDING ENVIRONMENT

The public health budget has increased nominally over the past decade however it has declined in real terms because of high inflation and increased demand for health care services, and is now inadequate to meet the basic and essential health care needs of the population. The raging HIV/AIDS pandemic has markedly increased demand for health care services and has contributed to the problem. Development assistance, which used to augment government health expenditure, has fallen by 90% in recent years. Moreover, there are too few donors supporting the TB control efforts in the country.

HUMAN RESOURCE CHALLENGES

The overall health care delivery system has been experiencing chronic shortage of qualified staff as a result of high turnover and emigration. Given that the human resource capital is the most critical in the health care delivery system, the human resource challenge has continued to pose serious threat to health care delivery in general and to TB control in particular. The strategic plan assumes that the human resources issues proposed will contribute to health systems strengthening and hence improvement in the implementation of TB control in the country.

HEALTH CARE SYSTEM

The weakness of the health care is a direct consequence of the decline in the economy, inadequate funding and the high turnover of experienced and skilled health workers. As an integral part of the health care system, TB control has equally experienced decline in making progress towards attaining the cases finding and treatment targets. The strategic plan assumes that if adequate resources are made available and the plan is implemented effectively and efficiently, the health care system will also benefit positively.

HIV/AIDS EPIDEMIC

The high HIV disease prevalence is mainly driving the TB epidemic being experienced in Zimbabwe. The strategic plan assumes that TB control cannot be effectively tackled without an effective HIV/AIDS control. Therefore, priority is given to strengthening the implementation of TB/HIV collaborative activities.

M/XDR-TB

Though the true burden of MDR/XDR TB is not known, estimates indicate that the prevalence of MDR-TB in Zimbabwe may still be low. The strategic plan assumes that the reported epidemic of XDR-TB in the neighboring countries could be a threat to effective TB control in the country. As such, the plan equally gives priority to the implementation of M/XDR-TB control and prevention activities.

CONCLUSIONS

Zimbabwe has been experiencing the dual epidemics of TB and HIV/AIDS with the latter being one of the most important driving forces contributing to the TB burden. Similarly, TB is the most common cause of morbidity and mortality among people living with HIV/AIDS. Some modest progress has been made in the control of TB, but programme implementation has been bedeviled by many challenges as mentioned above. The strategic plan is expected therefore to contribute directly to improving TB programme implementation towards attaining especially the global case finding and treatment outcome targets. The plan will also impact positively in strengthening the health care system. It is also assumed that the current international sanctions will be lifted and the economy will improve to open the space for greater resource mobilization for the system in general and TB control in particular.

CHAPTER THREE: STRATEGIC FRAMEWORK FOR TB CONTROL 2009 - 2013

PURPOSE OF THE STRATEGIC PLAN:

The first strategic plan for TB is a critical tool for the delivery of effective TB services. It is envisioned that the strategic plan will contribute immensely towards national health development and improve the socioeconomic status of Zimbabweans directly and indirectly. The SP provides a roadmap for strengthening NTP programme planning, coordination and effective implementation towards attaining the national and global TB targets i.e. serve as a medium term plan for achieving the MDG targets. It will also facilitate the coordination of inputs from various sectors including NGOs and donors, and hence provide a platform for effective coordination of partners by the NTP. It is expected that the SP will contribute to the strengthening of the overall health system and also act as an instrument for resource mobilization.

THE STRATEGIC PLAN DEVELOPMENT PROCESS:

The NTP developed the TORs for the external TA which was engaged to assist and facilitate in the strategic plan formulation. In collaboration with the key partners and stakeholders a work plan for the strategic plan was developed. External TA was provided jointly by WHO and KNCV through funding from TBCAP. The strategic plan was then developed through a variety of activities mainly by the following activities:

- desktop review of existing health policies, guidelines, plans, previous assessments
- stakeholder consultative meeting
- key informant interviews
- rapid situation analysis through field visits

Table 1 Vision Mission Goals Strategic Plan

Vision: A TB-free Zimbabwe
Mission: to develop and implement TB control activities through effective, efficient and evidence-based strategies that contribute to the attainment of national and global TB control targets as well as the Millennium Development Goals
Goal: To dramatically reduce the mortality, morbidity and transmission of tuberculosis in line with the Millennium Development Goals and the Stop TB Partnership targets.

OBJECTIVES

The challenges in the delivery of services in the National TB programme have been highlighted earlier. The following objectives of the SP if met will contribute towards a better national TB situation:

- a. to expand and ensure universal access to high-quality diagnosis and treatment equally for people with all types of TB, in all age, gender and socioeconomic groups*
- b. to reduce the suffering and socioeconomic burden associated with TB*
- c. to protect poor and vulnerable populations from TB, including drug-resistant TB and TB/HIV*
- d. to support the timely and effective introduction of new tools for diagnosis, treatment and prevention of TB*

TARGETS

To dramatically improve and revive TB control in Zimbabwe it is critical that the country aims to perform and achieve results on ambitious targets need. The aims of the NTP strategic plan are to reach by 2014 the following targets:

- i. increase the case detection rate of new infectious (sputum smear-positive) TB cases to at least 70%;*

- ii. **achieve treatment success in at least 85% of detected new infectious TB cases;**
- iii. **provide treatment according to internationally recommended guidelines to 100% of MDR-TB cases (new and previously treated cases);**
- iv. **reduce the prevalence of TB cases (all forms) to per 100 000 population; and**
- v. **Decrease the mortality rate of TB cases (all forms) to per 100 000 population.**

The smear microscopy network will be expanded in terms of access and coverage and new diagnostic tests are expected to be available by 2010 for increased and more efficient detection of MDR-TB cases at the 2 TB Culture referral laboratories.

KEY MILESTONES BY YEAR

The National TB strategy's effectiveness and impact will be assessed annually through achievement on set targets as indicated in table. 2007 was chosen as the baseline year as it has the most recent available complete data. Data for the rest of the years is based on projections from existing trend

Target by year

Indicator	2007 (Baseline)	2008	2009	2010	2011	2012	2013	2014
number of new smear positive cases detected	10583	12388	13365	18307	18075	17986	17908	17896
number of TB cases detected (all forms)	40277	42500	45000	48000	49000	48000	47000	46500
proportion of new smear positive cases detected out of estimated TB burden	27%	40%	42%	56.0%	62%	68%	70%	72%
proportion of new smear positive cases completing treatment successfully	60%	65%	70%	73%	78%	84%	85%	87%
number of TB cases with a recorded HIV test result	5252	12000	15000	26000	31000	38000	42000	46000
number and proportion of MDR cases identified and commenced on recommended treatment regimen	0	5	10	50	150	200	300	400

BROAD STRATEGIC AREAS:

This strategic plan has six key strategic areas of focus for reviving effective TB control in Zimbabwe which are:

- 1) To expand and enhance access to and provision of high-quality DOTS.
- 2) To enhance coordination and implementation of TB/ HIV collaborative activities.
- 3) To contribute towards the strengthening of health systems.
- 4) To effectively prevent, control and manage multi-drug resistant TB.
- 5) To promote partnerships with other care providers and stakeholders at all levels of the health system.
- 6) To empower people with TB and their communities
- 7) To promote operations research.

The strategic areas are further expanded below

STRATEGIC AREA NUMBER 1: TO EXPAND AND ENHANCE PROVISION OF HIGH-QUALITY DOTS

BACKGROUND AND JUSTIFICATION

The NTP has over the years witnessed a decline in the performance as evidenced by the lower performance indicators. Case detection has been continuously declining and has never exceeded 40% and treatment success has stagnated below 70%. The reasons for this situation have been outlined in detail in Chapter 2 but in summary it is the weaknesses in DOTS implementation. Therefore the ***number one priority*** for the NTP is to re-establish the basic DOTS programme urgently.

STRATEGIC OBJECTIVES:

- a. Enhance advocacy efforts for increased political commitment towards increased and sustained financing for the NTP
- b. Expand provision of and access to quality-assured bacteriology
- c. Develop and implement appropriate models of DOT and patient support systems
- d. Provide adequate drug supplies and establish effective drug management systems
- e. Increase performance and capacity for monitoring and evaluation and impact measurement

STRATEGIES

Enhance advocacy efforts for increased political commitment towards increased and sustained financing for the NTP

- i. Organize TB related high level advocacy sessions at least once per year with government and partners
- ii. Organize quarterly briefing TB sessions for top management/executive of MOH & CW
- iii. Organize advocacy sessions at least once per year with international partners
- iv. Establish Zimbabwe Stop TB Partnership
- v. Organize and support annually World TB Day commemoration (both at national and subnational levels)

Expand provision of and access to quality-assured bacteriology

- i. Renovate and expand existing laboratory infrastructure for expansion of smear and culture services
- ii. Establish additional microscopy centres strategically to improve access and availability of smear services
- iii. Establish additional TB culture services within the public health laboratory network
- iv. Recruit, train and retain adequate number of laboratory personnel for all the levels of the laboratory network
- v. Procure, distribute and maintain /repair laboratory equipment
- vi. Establish an effective procurement and distribution system for reagents, materials and other consumables for microscopy and culture
- vii. Develop and implement Laboratory Quality Assurance System for AFB microscopy in the entirety of the laboratory network
- viii. Develop and implement Laboratory Quality Assurance System for TB culture and DST
- ix. Introduce rapid methods for TB diagnosis and culture

Develop and implement appropriate models of DOT and patient support systems

- i. Revise/update, print and disseminate the National TB Treatment guidelines
- ii. Train health facility workers on DOTS
- iii. Actively promote health facility-based direct observation of treatment (DOT) of all patients
- iv. Develop guidelines or policy on TB patient support;
- v. Develop implementation plan/resource requirements at all levels;
- vi. Phased implementation of patient support activities in 10 selected districts;
- vii. Strengthen and provide support for contact tracing of smear positive TB cases.

Provide adequate drug supplies and establish effective drug management systems

- i. Review existing PMS guidelines and develop and adopt a robust and effective drug management system.
- ii. Train health workers on drug management system at all levels;
- iii. Establish and implement a TB drugs LMIS for all levels

Improve Diagnosis and Management of Smear negative PTB, childhood TB and EPTB.

The diagnosis of smear negative TB, childhood TB and EPTB requires high skills, expertise, experience and appropriate tools. This function will therefore be performed mainly by the clinician in the facilities.

- i. Develop national Pediatric TB Diagnosis and Treatment Guidelines and Training materials
- ii. Assess equipment and human resource needs to make diagnosis of childhood TB
- iii. Procure, install and maintain both fixed and mobile x-ray machines
- iv. Train and/ or retrain clinicians on management of childhood TB

Increase performance and capacity for monitoring and evaluation and impact measurement

- i. Train/re-train health workers on the recording and reporting system
- ii. Provide regular feedback on TB data to all levels
- iii. Procure and maintain adequate vehicles and motor cycles for the various levels of the NTP
- iv. Review and update supervision checklists at national, provincial and district levels;
- v. Conduct quarterly planning and coordination meetings at all levels;
- vi. Conduct annual TB and TB/HIV review meetings with partners at all levels;
- vii. Write and disseminate annual report at all levels.
- viii. Conduct mid-term and final evaluation of the 2009-2013 M&E plan
- ix. Procure and maintain appropriate office furnishings and equipment for all levels of the NTP
- x. Develop capacity and proficiency in ICT at all levels
- xi. Develop and implement an electronic TB register

STRATEGIC AREA NUMBER 2: TO ENHANCE COORDINATION AND IMPLEMENTATION OF TB/ HIV COLLABORATIVE ACTIVITIES.

BACKGROUND AND OBJECTIVES

Available evidence shows that HIV/AIDS is the most important factor driving the TB epidemic and conversely, TB is most frequent cause of morbidity and mortality among PLWHA. For over a decade, Zimbabwe has been experiencing the dual epidemic of TB and HIV/AIDS and the TB/HIV co-infection rate is currently estimated at 70%. The implementation of collaboration TB/HIV activities provides synergy in stemming the burden of both diseases. Attainment of this objective requires that there be functional collaboration between the TB and HIV/AIDS programmes and other key stakeholders such as PLWHAs at all levels

STRATEGIC OBJECTIVES

- a) Facilitate and strengthen mechanism for joint TB/HIV coordination and collaboration at all levels in the country
- b) Reduce the burden of TB in people living with HIV and AIDS
- c) Reduce the burden of HIV in TB patients and suspects

STRATEGIES

Facilitate and strengthen mechanism for joint TB/HIV coordination and collaboration at all levels in the country

- i. Establish TB/HIV committees at all levels;
- ii. Develop national guidelines and training materials for collaborative TB/HIV activities;
- iii. Conduct routine surveillance of HIV among TB patients;
- iv. Produce and disseminate appropriate IEC strategies (print and electronic media);
- v. Conduct integrated supervision of TB/HIV activities at all levels.

Reduce the burden of TB in people living with HIV and AIDS

- i. Adapt protocol for screening PLHWA for TB suspects;
- ii. Orient Health Workers at HIV/AIDS clinics, VCT/ART sites on TB;
- iii. Screen all PLHWA for TB at ART clinics, PMTCT, VCT sites and other HIV entry points.
- iv. Introduce in a phased manner Isoniazid Preventive Therapy (IPT) for PLWHAs
- v. Conduct an assessment of national infection control status and needs;
- vi. Review policies/guidelines on infection control at all levels
- vii. Develop & integrate infection control M&E tools into the NTP system;

- viii. Train health facility staff on infection control measures;
- ix. Provide appropriate technologies e.g. UVGI, mechanical ventilation, negative pressure equipment in Reference labs, MDR wards and other places as is necessary
- x. Procure and distribute personal protection equipment (HEPA filters) in infectious disease hospitals/units/TB reference laboratory;
- xi. Institute package of care for HIV positive health care workers;

Reduce the burden of HIV in TB suspects and patients

- i. Ensure universal access for HIV Testing and Counseling (HTC) for all TB suspects and patients
- ii. Advocate for policy change to allow other health workers e.g. nurses, PCs, EHTs to conduct rapid HIV testing;
- iii. Establish effective referral linkage with sites offering HTC;
- iv. Provide to all TB patients appropriate behavior change information and services for the prevention of HIV
- v. Ensure provision of Co-trimoxazole Preventive Therapy (CPT) to HIV positive TB
- vi. Ensure provision of HAART to Eligible HIV positive TB patients.
- vii. Provide targeted nutritional support services;

STRATEGIC AREA NUMBER 3: TO CONTRIBUTE TOWARDS THE STRENGTHENING OF HEALTH SYSTEMS.

JUSTIFICATIONS AND BACKGROUND

The Practical Approach to Lung Health strategy is an integrated approach to manage respiratory conditions with a focus on PHC system. The development and implementation of a comprehensive and systematic approach to manage patients with respiratory symptoms in PHC settings are likely to improve the quality of respiratory care and subsequently, create conditions resulting in increasing TB case detection and increasing the quality of TB diagnosis. The strategic plan will introduce this approach as a deliberate strategy of contributing to health system strengthening and hence improvement in TB case finding.

OBJECTIVES

Introduce the PAL strategy in all districts by the end of 2013

STRATEGIES

- i. Conduct an assessment of PAL needs in the country;
- ii. Establish a national PAL Working Group;
- iii. Adapt/develop and produce PAL guideline
- iv. Develop a national plan for the implementation of PAL;
- v. Train health workers on PAL.

STRATEGIC AREA NUMBER 4: TO EFFECTIVELY PREVENT, CONTROL AND MANAGE MULTI-DRUG RESISTANT TB

JUSTIFICATIONS AND BACKGROUND

Currently there is neither a national surveillance system for drug resistance TB nor a programme for management of drug resistance TB. The reported outbreak of XDR-TB in the neighboring South Africa, coupled with the high level migration of people pose a real threat to the spread of drug resistance TB in the country. The plan therefore intends to guide the establishment and sustenance of M/XDR-TB control and prevention through improved implementation of basic DOTS.

OBJECTIVES

- a) Capacitate The National Reference Laboratories to perform TB culture and DST services by 2010 (Bulawayo and Harare)
- b) Establish a functional M/XDR-TB surveillance system established by the end of 2011
- c) Introduce Programmatic management of MDR-TB patients in place by the end of 2010

STRATEGIES

Capacitate the National Reference Laboratories to perform TB culture and DST services by 2010

- i. Conduct needs assessment of human resource, infrastructural and equipment requirements of NRLs at Bulawayo and Harare;
- ii. Develop a strategic and implementation plan for TB culture and DST
- iii. Facilitate linkage to a Supra-national Reference Laboratory (SRL);

- iv. Enroll the two reference laboratories in EQA programme with a SRL.

Establish a functional M/XDR-TB surveillance system established by the end of 2011

- i. Conduct needs assessment of surveillance requirements.
- ii. Develop guidelines for routine MDR-TB surveillance.
- iii. Establish/strengthen referral network and transport logistics between peripheral health facilities/laboratories and the NRL.
- iv. Integrate recording and reporting system for M/XDR into NTP system and HIMS
- v. Conduct a national M/XDR-TB survey;

Introduce Programmatic management of MDR-TB patients in place by the end of 2010

- i. Develop and/or update guidelines and training materials for the programmatic management of drug resistant TB
- ii. Train medical specialists, nurses, social workers, counselors etc on MDR-TB management setting up 2 hospitals
- iii. Develop a proposal to access quality-assured second line drugs /ancillary medicines through Green Light Committee (GLC) mechanism;

STRATEGIC AREA NUMBER 5: TO PROMOTE PARTNERSHIPS WITH OTHER CARE PROVIDERS AND STAKEHOLDERS AT ALL LEVELS OF THE HEALTH SYSTEM.

JUSTIFICATIONS AND BACKGROUND

The private health sector contributes substantially to the health care delivery system in the country. At the moment, private sector participation in TB control is limited to patient diagnosis and referral to the public health sector for treatment. The strategic plan envisages that widening the scope of participation of the private sector in TB control will enhance progress towards meeting the main programme targets. Congregate settings enhance the transmission of TB. This strategy will therefore address TB control and prevention in congregate settings and explore the added-value of contributing to case detection and treatment success rates.

OBJECTIVES

- a. To engage at least 60 % of all existing relevant care providers in the implementation of DOTS.

- b. To strengthen TB control and prevention activities in uniformed forces' institutions and congregate settings by the end of 2013
- c. Institute TB prevention and control activities at all international borders and refugee camps.

STRATEGIES

To engage at least 60 % of all existing relevant care providers in the implementation of DOTS.

- i. Develop policy, guidelines and training materials on PPM DOTS
- ii. Train health workers in the private sector including and certification of the health facilities;
- iii. Supply of anti-TB drugs or lab reagents (equipment), recording/reporting tools;
- iv. Conduct supportive supervision, monitoring and evaluation of PPM-DOTS implementation.

To strengthen TB control and prevention activities in uniformed forces' institutions and congregate settings by the end of 2013

- i. Establish/strengthen linkage with uniformed forces health institutions in the country.
- ii. Train/re-train health workers on case management
- iii. Regularly supply anti-TB drugs and other essential materials;
- iv. Provide support for supervision and infrastructure
- v. Conduct supportive supervision, monitoring and evaluation by NTP as part of the routine national supportive supervision

Institute TB prevention and control activities at all international borders and refugee camps.

- i. Conduct rapid assessment of TB situation among migrants and refugee camps in the country.
- ii. Establish/strengthen surveillance for TB and other disease among migrants and refugees at international borders of the country;
- iii. Train/re-train health workers at border/refugee health posts/clinics
- iv. Establish referral network with TB diagnostic and treatment centres for migrants/refugees
- v. NTP Central Unit and affected provinces/districts participate in regional/inter-country meetings to streamline TB control activities for this population;

STRATEGIC AREA NUMBER 6: TO EMPOWER PEOPLE WITH TB AND THEIR COMMUNITIES

JUSTIFICATIONS AND BACKGROUND

Community participation in health care delivery is a key component of the PHC system. The involvement of the community should enhance case finding and case holding thereby contributing to improved programme outcomes.

OBJECTIVES

- a) To promote and strengthen community TB DOTS in all districts by end of 2013.
- b) Develop and implement a communication strategy for the NTP.

STRATEGIES

To promote and strengthen community TB DOTS in all districts by end of 2013.

- i. Develop guidelines and training materials on Community DOTS including the **TB** patient charter.
- ii. Train stakeholders on Community DOTS.
- iii. Support phased implementation of Community DOTS.
- iv. Provide supportive supervision and monitoring of community DOTS.

Develop and implement a communication strategy for the NTP.

- i. Conduct a TB/HIV KAP survey;
- ii. Develop an operational plan for ACSM
- iii. Develop communication guidelines and tools;
- iv. Develop training materials for journalists etc;
- v. Train journalists to support information dissemination on TB/HIV;
- vi. Organize bi-monthly press briefing on TB/HIV activities;
- vii. Conduct mass media TB/HIV campaigns on TB/HIV;
- viii. Produce and distribute TB/HIV related IEC materials;
- ix. Conduct Educational programmes for community leaders;
- x. Support the establishment and empowerment of organizations of people affected by TB

- xi. Engage and support civil society to promote TB/HIV peer education.
- xii. Monitor and evaluate communication activities.

STRATEGIC AREA NUMBER 7: TO PROMOTE OPERATIONS RESEARCH

JUSTIFICATIONS AND BACKGROUND

OBJECTIVES

STRATEGIES

STRATEGIC AREA NUMBER 8: TO PROMOTE THE DEVELOPMENT OF ADEQUATE AND SUSTAINABLE HUMAN RESOURCES CAPACITY FOR THE NTP AT THE NATIONAL, PROVINCIAL, DISTRICT AND FACILITY LEVELS BY THE END OF 2013.

JUSTIFICATIONS AND BACKGROUND

Effective implementation of TB programme has been hampered over the years by chronic shortage of health workers because of high turnover of experienced and qualified staff from the public sector into the private sector and emigration to other countries. This observation cuts across the entire national structure up to the facility levels. The strategic plan will reposition the NTP to perform the critical role of programme coordination, development, planning, supervision, monitoring and evaluation through strengthening of its human resource in terms of capacity and competence.

OBJECTIVES

- a) Increase performance of the National TB Control Programme enhance through engagement and retention of adequate and qualified staff by the end of 2010
- b) Develop and sustain technical competence of NTP the end of 2011
- c) Review and revise TB related pre-service and in-service training curricula for all level of health workers by end of 2010

STRATEGIES

Increase performance of the National TB Control Programme enhance through engagement and retention of adequate and qualified staff by the end of 2010

- i. Conduct programme staff audit at all levels
- ii. Appoint qualified staff to fill positions to key TB thematic areas at all levels.
- iii. Advocate for the recruitment of a full time NPO for TB control in WHO to support NTP;
- iv. Strengthen the implementation of a performance management system.

Develop and sustain technical competence of NTP the end of 2011

- i. Nominate for training staff at all levels for relevant international courses and workshops on TB e.g. at Arusha, Sondalo, Japan etc
- ii. Conduct management and leadership training of critical programme staff at NTP Central Unit, Provincial and District levels;
- iii. Train NTP central unit focal persons in relevant thematic areas;
- iv. Develop, train and retain a critical mass of national trainers for the programme;
- v. Train/re-train on Stop TB Strategy and other initiatives for DMOs and DTBCs;
- vi. Conduct regular course for DMOs and DTBCs on TB programme management course (WHO Module)

Review and revise TB related pre-service and in-service training curricula for all level of health workers by end of 2010

- i. Appoint a focal person for training at NTP;
- ii. Develop a TB national training plan
- iii. Develop a Human Resources Development Plan in with the MOHCW HRD Strategic Plan
- iv. Review pre-service curriculum for medical, nursing schools, and other professional institutions;
- v. Develop and/or review NTP training curriculum for in-service training.