COUNTRY PROFILE

Zimbabwe

Overview of TB control system

Primary health care is seen as the route to affordable universal coverage. Health sector reforms undertaken in the 1990s aimed to improve equity and access to essential health services, including TB diagnosis and treatment. At present, treatment is free to TB patients. More recent health reforms facilitated the process of decentralization, stimulated health financing schemes, regulated the private sector, and strengthened management. In the past, up to 80% of the rural population lived within 5km of a health centre, but access is now lower because changes in land ownership have led to resettlement in areas with no clinics.

Surveillance, planning, operations

The notification rate of all TB cases increased 8-fold between 1988 and 2002, driven by the spread of HIV. An estimated two thirds of adult TB cases were infected with HIV in 2002. The age-structure of smear-positive TB cases, showing very high rates among young adults, is typical of populations that have been severely affected by HIV/AIDS. As in some other countries in the region, such as Tanzania, the reported rate of smear-positive disease has remained roughly stable over the past 5 years while the overall case rate has continued to increase. This may reflect the fact that HIV-infected patients are less likely to be smear-positive, or that diagnosis has become less reliable under pressure of a mounting case load. The estimated smear-positive case detection rate by the DOTS programme was 46% in 2002, but the underlying incidence of TB in Zimbabwe is not accurately known. Treatment success in the 2001 cohort was only 71%, principally because 12% of patients died, and 17% either defaulted or were transferred without follow-up.

A draft strategic plan for DOTS expansion now exists but has yet to be approved by the government. An NICC does not yet exist. Decentralization has been accepted in principle, and TB programmes are being run and financed by the provinces, though funding is insufficient. Funding for TB is now a separate line item in the national, regional, and district health budgets, which may help to protect funding in future.

Provincial and district TB coordinators are in place, though there is still no national TB programme coordinator, and there are no central staff to support a national coordinator. There are too few nurses in health centres and too few doctors in hospitals, especially in rural areas. Staff attrition is high because salaries are low. A WHO national programme officer is likely to be appointed during 2004, and further support will be provided through secondments from the Institute of Public Health. An intensive 18-month long training course for public health nurses will increase postings in rural health centres.

Better public information about TB, in the form of radio and TV programmes and IEC materials, is expected to lead to improved case detection in populations living near rural health centres. All 8 provinces and the 3 main cities have held DOTS expansion training workshops, which include training for STI coordinators. Neighbours and relatives of TB patients have been trained as TB treatment observers.

Every district now has a laboratory that is adequately supplied. Some laboratories were refurbished in 2003, laboratory staff were trained, and a system was developed to ensure a consistent supply of reagents. A national workshop was held for top

PROGRESS IN TB CONTROL IN ZIMBABWE

Indicators

Treatment success 2001 cohort	71%
DOTS detection rate, 2002	46%
NTP budget available, 2003	NA
Government contribution to NTP budget, including loans, 2003	NA
Government contribution to total TB control costs, including loans, 2003	NA
Government health spending used for TB, 2003	NA

Major constraints to achieving targets

- Improving, but still weak political commitment to TB control
- Insufficient staffing of central unit
- Low access to treatment due to poor infrastructure in new settlements
- Limited involvement of communities in TB control

Remedial actions needed to overcome constraints

- Failing support from the GFATM and GDF, funds will need to be sought elsewhere
- Strengthen advocacy for TB control, with the particular aim of establishing more managerial and staff positions in the NTP
- Introduce PHC services and subsequently community-based DOTS in new settlements where there is no health infrastructure, and home-based DOTS in large cities where there is weak participation in existing TB control activities

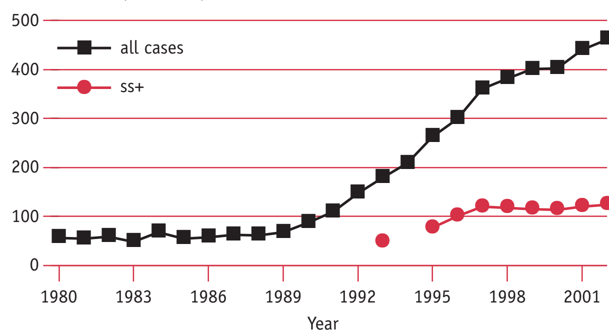
NA indicates not available

ZIMBABWE

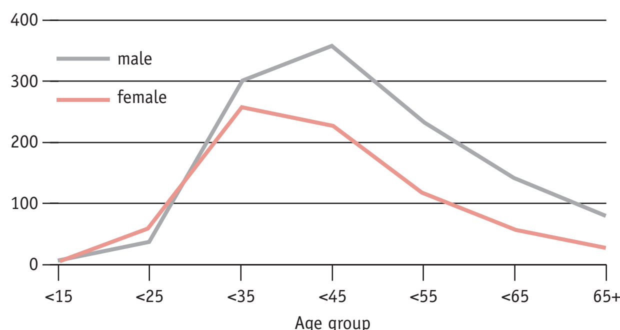
LATEST ESTIMATES[a]		TRENDS	1999	2000	2001	2002
Population	**12 835 125**	DOTS population coverage (%)	12	100	100	100
Global rank (by est. number of cases)	17	Notification rate (all cases/100 000 pop)	401	402	441	461
Incidence (all cases/100 000 pop)	683	Notification rate (new ss+/100 000 pop)	115	114	120	124
Incidence (new ss+/100 000 pop)	271	Detection of all cases (%)	68	65	68	68
Prevalence (ss+/100 000 pop)	309	Detection of new ss+ cases (%)	49	46	47	46
TB mortality per 100 000 pop	150	DOTS detection of new ss+ (%)	49	46	47	46
% of adult (15-49y) TB cases HIV+	75	DOTS detection of new ss+/coverage(%)	423	46	47	46
% of new cases multi-drug resistant	1.9	DOTS treatment success (new ss+, %)	73	69	71	—

Notification rate (per 100 000 pop)

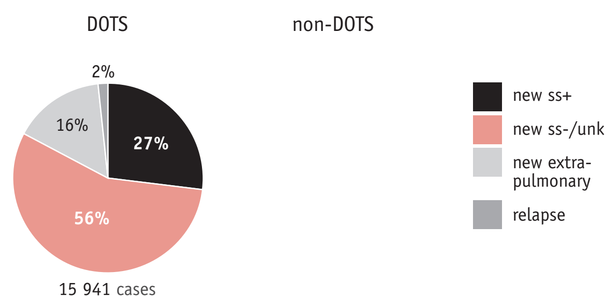
Notification (all cases) = 59 170 in 2002



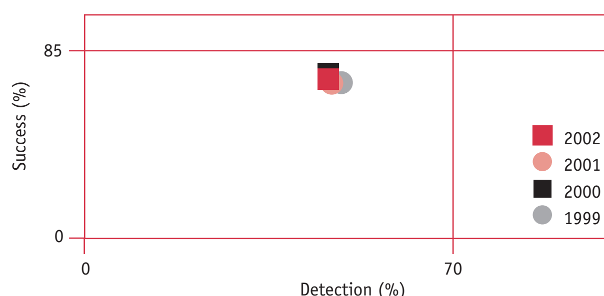
Notification rate by age and sex (new ss+)[b]



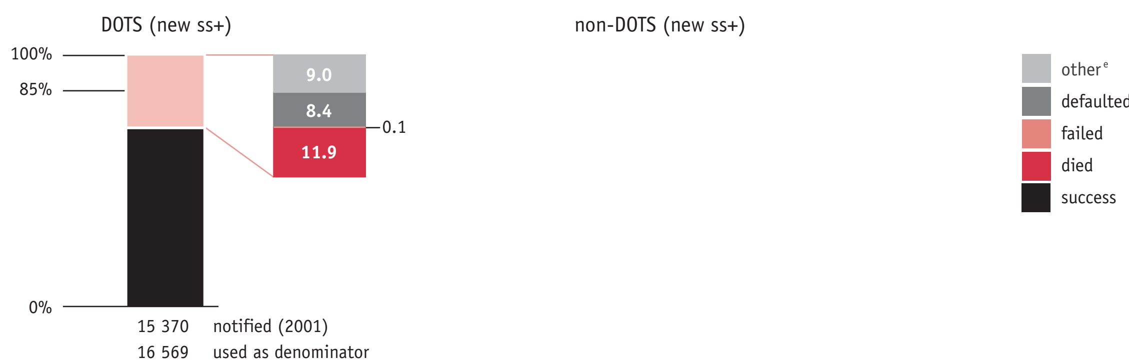
Case types notified[c]



DOTS progress towards targets[d]



Treatment outcomes[c]



Notes

ss+ Indicates smear-positive; ss-, smear-negative; pop, population; unk, unknown.

[a] See Methods for data sources.

[b] The sum of cases notified by age and sex is less than the number of new smear-positive cases notified for some countries.

[c] Non-DOTS is blank for countries which are 100% DOTS, or where no non-DOTS data were reported.

[d] DOTS progress towards targets: DOTS detection rate for given year, DOTS success rate for cohort registered in previous year.

[e] "Other" includes transfer out and not evaluated, still on treatment, and other unknown.

managers from the public and private sectors in order to improve case detection and laboratory efficiency.

Although the NTP has a system for tracking drug stocks and funds, drugs are not always available. However, the EU will provide a grant for drugs over 2.5 years starting in 2003. A liaison is now being developed with the National Pharmacetucial Company (Natpharm) and the national drug coordinator, with formal links to be established. FDCs will be introduced in 2004.

A national DOTS supervision checklist has been developed but remains untested. NTP supervisory visits have been conducted in several provinces and cities, though others have had no supervision because of fuel shortages. TB coordinators meet on a quarterly basis, and quarterly reports for epidemiological surveillance are available from all districts and provinces.

There is no TB/HIV coordinating body, but the CCM (at national level) and AIDS action committees (at provincial and district levels) do play a coordinating role. The MoH has established a special TB/HIV/AIDS/STI unit to jointly develop an awareness campaign. There is no surveillance system for assessing HIV infection among TB patients. The NTP is introducing a comprehensive TB/HIV care package, including ART delivery. Zimbabwe participates in DRS surveys within the framework of the WHO/IUATLD framework.

Partnerships

WHO leads external technical support for the country, and IUATLD may contribute in the future. CDC LIFE is planning to support some activities to control TB. WHO provides technical support, and DANIDA supports laboratories. Because some external partners have withdrawn support, an application to the GFATM was submitted in 2002.

Budgets and expenditures

Zimbabwe did not submit financial information to WHO.