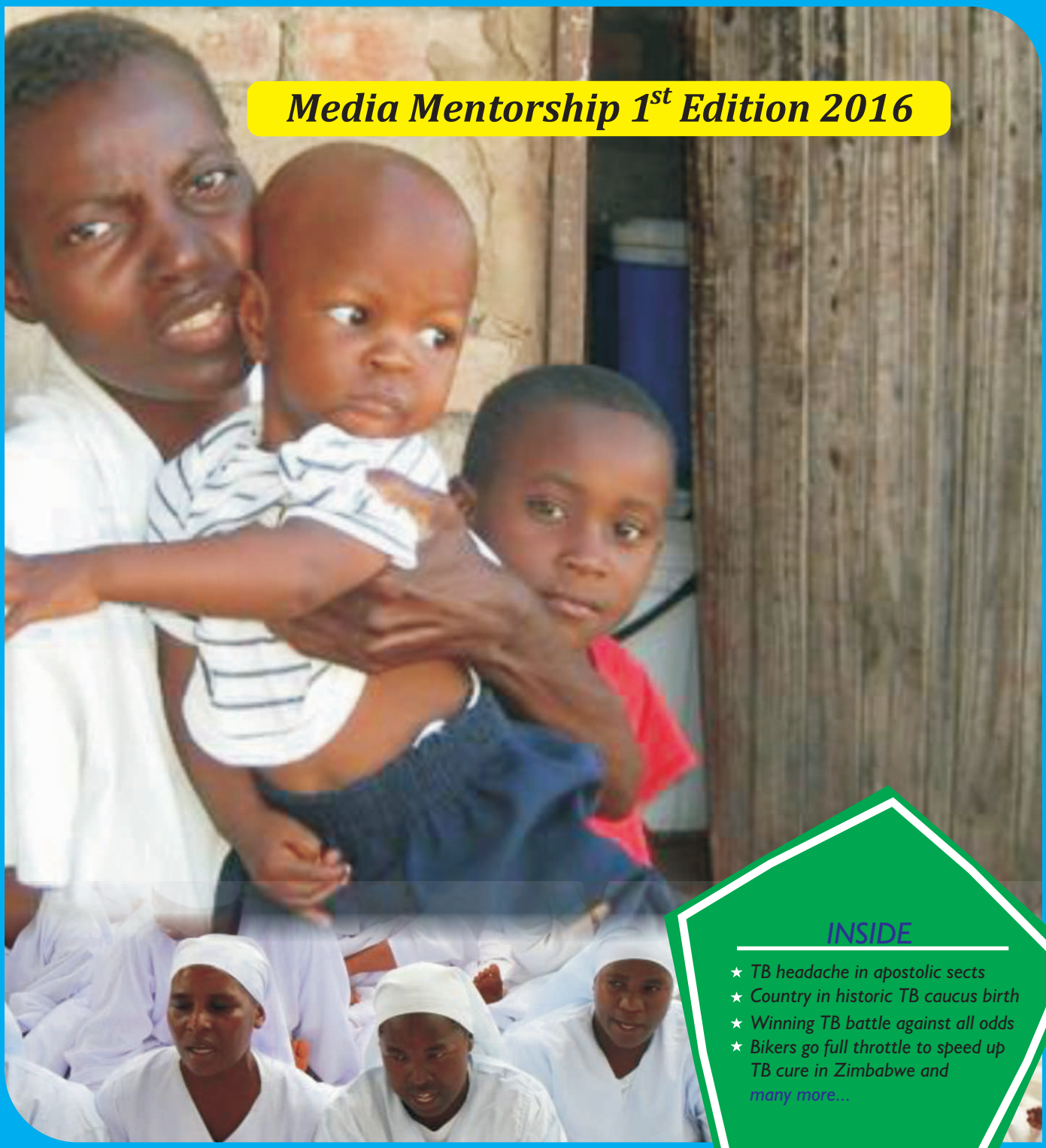
Strengthening coverage of TB stories in Zimbabwe

NATIONAL TUBERCULOSIS CONTROL PROGRAM



Media Mentorship 1st Edition 2016

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Acknowledgements

The Ministry of Health and Child Care through the National Tuberculosis Control Program (NTP) would like to extend its sincere appreciation to the following health journalists who took part in this maiden media mentorship: Mirirai Nsingo, Thulani Munyandi, Sharon Kavhu, Thandeka Moyo, Hazvinei Mwanaka, Lynette Manzini, Mary Taruvinga, Sophia Mapuranga and Vivian Mugarisi. You worked tirelessly to put TB back on the national agenda through your reportage of the program.

A special mention goes to the mentors who provided their media expertise to the mentees which resulted in increased coverage of well-crafted and in-depth TB stories; Tatenda Chipungudzanye, Lawson Mabhena, Anna Miti, Roselyne Sachiti, Clemence Manyukwe, Joseph Munda and Phillip Chidavaenzi. Stephen Tsorotsi from Financial Gazette you helped lift the TB program flag high across the region.

To the communications technical team comprising Andrew Nyambo and Paidamoyo Magaya who championed this program and made it a reality, thank you for your persistence and hard work.

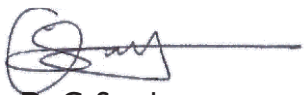
To The Union Country Director Dr Zishiri, all the various technical officers, health care workers and partners who were approached to share updates and answer questions, your contributions cannot go unmentioned.

The TB program will be incomplete if we do not acknowledge the community. The community played a critical role in this mentorship program through sharing their experiences and championing the TB program. We are indebted to you all.

Lastly, appreciation goes to USAID Challenge TB for supporting the program through provision of resources for the field work for the journalists.

We hope this is the beginning of greater coverage of the TB program beyond mentorship, as we strive to put TB on the national agenda.

Thank you



Dr C. Sandy
Deputy Director, AIDS and TB Unit

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**** Some of the contents of the stories have been edited for correct information dissemination*

TB headache in apostolic sects

By Mirirai Nsingo

Members of the Vapostori worshiping at a shrine in Harare (Credit: Moses Chibaya)

PEBBLES and holy water were the only orthodox treatment she could take, at least according to the Johane Marange doctrine.

Seeking health care would be taboo as 'shewe' (her husband) and the church elders would have none of it.

Even after enduring a three-month persistent cough, she could not take cough syrup or anything for the pain.

Shupikai (not her real name) had been in Masvingo where she had gone to nurse her daughter who had tested TB positive.

When she returned home in Macheke after the four-month stay, she wouldn't stop coughing, lost a bit of weight and had night sweats even on a cold night.

With all these symptoms, she still could not access a health facility because the church wouldn't allow her to.

"I felt really sick but all I could use were muteuro nematombo. My sister then invited me over to her house in Marondera and after spending the night at her place and seeing how sick I was, she took me to the clinic the next day.

"I was tested for TB among other tests. I was found to be TB positive and started on treatment and for two months I stayed with my sister as she monitored my progress," chronicles the 50-year-old mother of five.

When it was time to go back home, she says her headache was how she would be able to keep her medication without shewe noticing.

"By the time I went back home I was feeling much better and was determined to continue with treatment against all odds. Before leaving, I had been educated about the dangers of defaulting first line TB drugs so I told myself I would finish treatment against all odds before being referred to the nearest clinic in my area.

TB headache in apostolic sects

"Back home, shewe even acknowledged that I was looking much better from what I was when I left. I told nurses at the local clinic about my predicament and how I shouldn't be seen collecting the medication or else the church would deal with me.

"They really understood and we made an arrangement that I would pick them at night until I finished my course. At home I also made sure that I kept them away from shewe or else I would face the full wrath of his law," she says.

"It was not easy but because I had told my daughter about the situation, she would sometimes remind me to take my medication."

She acknowledges that while the church denies members to seek healthcare, medication was the best remedy for any disease management rather than 'holy water and pebbles'.

Reminiscing on the cholera days back in 2008, Shupikai says she had lost a 15-year-old daughter as the head of the house would not allow her to seek treatment for the child.

"I watched her die and I still curse myself. Then shewe had cholera that same week our daughter died and now he was begging me to take him to the clinic, I refused and vowed that he would rather die just like how we lost my child.

"Fortunately or unfortunately health workers started a door-to-door campaign after they heard that there had been a cholera death in the area and that is how he got treated. You see, I wish we could do away with some of these rules in the church. I could have also died from TB if I had not accessed treatment.

"I don't mean to be rebellious but it is mothers and children who suffer the most. Even when these men fall sick, they Nicodemously seek medical attention. So who are we cheating?" she argues.

Shupikai's life mirrors that of several other members of ultra-conservative apostolic sects where seeking healthcare is taboo.

While she was brave enough to go against the church doctrine and sought treatment, deputy director of TB Control in the Ministry of Health and Child Care, Dr Charles Sandy said there could be several missed cases of TB among this community.

He argues that while they are not immune to being infected by TB, they are a very hostile community when it comes to issues to do with healthcare and this posed a challenge in the country's management of TB.

"There are very high chances that there may be missed TB cases in such communities due to obvious reasons. Since they do not practice modern medicine and they do not go to clinics or hospitals so there is no diagnosis being done to those who are ill so even if it's TB no one would know.

"They usually are secretive when it comes to illness in their communities so it is usually not made public that a family member is not well.

"In most cases such communities are hostile to people who are not members of their religion so there is then no way an outsider would then know that there is any one suffering from TB in such communities," says Dr Sandy.

"Epidemiologically they are also not immune to being infected by TB as they are humans like any other people. So considering all the above they are very high chances that TB cases could be missed in these communities and the magnitude of the missed case is not known."

Dr Sandy says the country mainly relied on engagement at all levels hence the programme makes all efforts to ensure that all communities are informed about TB through various means of communication, thus most communities take decisions from informed view point.

TB headache in apostolic sects

Members of the Vapostori worshiping at a shrine

"The most available resource is to engage the husband and the church leaders so they understand the implications of that patient not taking treatment on the family, the husband included, as well as the congregation at large," Dr Sandy said, in relation to Shupikai's case.

TB remains the world's most deadly infectious disease after HIV and although prevalence is reportedly coming down, TB burden is still at crisis level in the country.

TB is a treatable and curable disease. Active, drug-susceptible TB disease is treated with a standard six-month course of four antimicrobial drugs that are provided with information, supervision and support to the patient by a health worker or trained volunteer.

According to World Health Organisation, ending the TB epidemic by 2030 is among the health targets of the newly adopted Sustainable Development Goals.

In support of this goal to end the TB epidemic, International Union Against Tuberculosis and Lung Disease (The Union) through Challenge TB in Zimbabwe seeks to have TB put on the health agenda strategy and to also strengthen national level management capacity.

The Union director in Zimbabwe, Dr Christopher Zishiri says under Challenge TB in partnership with the National TB Programme, contact tracing, early diagnosis and active case finding are some of the effective ways of ending TB.

While Shupikai is grateful that she had TB detected early and had treatment, which she managed to complete, there could be several missed cases of TB among her community which could be an impediment in ending the TB epidemic by 2030.

http://allafrica.com/stories/201605210202.html

Disability, poverty, TB and HIV: where do you turn?

By Hazvinei Mwanaka

Ellen Banda's disability makes it difficult for her to access health services (Credit: Hazvinei Mwanaka)

Being disabled, HIV positive and having treatment for tuberculosis is a real challenge. Add to this, you are living in a rural area with no means of income, and the challenges become unimaginable. Yet this is the life that some people face in rural Africa.

Ellen Banda is 47 and lives in Mushandike village, in Masvingo in Zimbabwe. She tells her story: "I was first treated for tuberculosis in 2000 as well as 2002 before I tested HIV positive in 2008. I successfully finished the courses of treatment but it was very difficult. This year again I have tested positive for TB."

Banda, married with six children, is disabled and finds it difficult to walk. At times she has endured 4.5 kilometres to travel to the local clinic. She says: "We do not have a source of income. My husband does not work, he is mentally challenged. Two of my children are also mentally challenged and one is HIV positive.

"I have tested positive for TB the third time and I am already taking ARVs [antiretroviral] but it's now a challenge because I have to eat but we have nothing. I am not sure why the TB keeps repeating, but I believe the way we live with my family could be one of the reasons."

The drought that has hit many places in the country has not spared them and the family does not have enough food from the harvest. Struggling to contain tears, Banda said that at times they have one meal per day and this tempts her to stop taking her drugs.

"When taking the drugs you also need to take enough food which I am not capable to do. Sometimes I feel like fainting after taking the drugs, but since I need to see my kids growing I end up carrying on," she explains.

Disability, poverty, TB and HIV: where do you turn?

ADHERING TO TREATMENT REGIMES

Tavengwa Mazhambe is chairperson of the National Council of the Disabled Persons of Zimbabwe and he said that people are in need of food assistance. "This year in this region we did not harvest much. Most disabled people are living in poverty, they have nothing to eat, so we just appeal to responsible authorities to take action because failure to do that will see that most who are taking ARVs or are on tuberculosis treatment no longer take their drugs," he said.

Lack of funding is hampering the organisation's activities to support disabled people who are HIV positive and being treated for TB. "We do awareness campaigns on different issues especially human rights issues but lack of money is the major reason we are not reaching many," said Mazhambe.

People like Banda also face stigma and discrimination. She says: "You know when one is disabled usually you face discrimination but it gets worse when people know that you are HIV positive as well as being treated for TB. Few respect the way you are. I have nothing, my children did not go to school and they are also disabled, so I just appeal to everyone willing to help."

A NEED FOR APPROPRIATE SERVICES

The situation is serious. According to UNAIDS, globally, 9.6 million people were diagnosed with tuberculosis in 2014 and 1.5 million people died of the disease. Tuberculosis also remains the leading cause of death among people living with HIV, accounting for one in three AIDS-related deaths every year. This is around 390,000 of 1.2 million AIDS-related deaths in 2014.

Dr Zishiri, Country Director of the International UnionAgainst Tuberculosis and Lung Disease (The Union) in Zimbabwe, said: "We believe that people with disabilities have the same general health care needs as everyone, including access to TB services. Article 25 of the UN Convention on the Rights of Persons with Disabilities (CRPD) reinforces the right of persons with disabilities to attain the highest standard of health care, without discrimination".

Earlier this year on World Tuberculosis Day UNAIDS called for a stronger partnership and a united approach to end the twin epidemics of tuberculosis and HIV. Michel Sidibé, executive director of UNAIDS, said: "We achieve the most when we work together and use all our strengths to reach ambitious goals. Harnessing the potential of everyone involved in the response to HIV and TB is needed now more than ever to end these epidemics and create a healthier world as part of the sustainable development goals.

Banda is clear about what she needs. She urges the government to construct more health facilities so that she does not have to travel the long distances to the clinics. She also wants projects for disabled people who are living with HIV and are being treated for TB.

http://www.keycorrespondents.org/2016/06/14/disability-poverty-tb-and-hiv-where-do-you-turn/

"We achieve the most when we work together and use all our strengths to reach ambitious goals."
Michel Sidibe, Executive Director of UNAIDS

Country in historic TB caucus birth

By Mirirai Nsingo

Hon Jacob Mudenge congratulates Dr Labode at the launch of the national TB Caucus (Credit: Innocent Makawa)

The country's policy makers made a historic move by launching a national caucus on Tuberculosis in July 2016.

This came at a time Zimbabwe is ranked among the 80 high-burdened countries for TB.

The birth of the country's TB caucus preceded the launch of the Africa TB caucus during the recently held 21st International AIDs Conference in Durban, South Africa where Health Parliamentary Portfolio Committee Chairperson, Ruth Labode, was elected the joint chairperson for the African chapter.

While the country is highly burdened by the epidemic, TB programmes are heavily funded by donors, a development which many say was a time bomb in the event that funders pull off their funding and might be a major impediment in the country's vision of a free-TB country by 2020.

Among other functions, the TB caucus seeks to lobby for more fiscal space to be allocated towards TB programming as well as increasing awareness on TB in communities as the country seeks to end TB by 2020.

The Minister of Health and Child Care, David Parirenyatwa says TB is a serious public health problem in Zimbabwe with a high morbidity and mortality rates with the HIV epidemic also fuelling the TB cases.

Minister Parirenyatwa describes the birth of the TB caucus as a maiden formal engagement of legislators and the Ministry of Health and Child Care as they seek to advocate for increased political commitment in the fight against TB.

"Political commitment is most effectively measured through the amount of funding made available to the health sector.

Country in historic TB caucus birth

"The national TB response has benefited tremendously from various partners without which the success we see today may not have been attained," says Minister Parirenyatwa.

Noting how TB programmes were mainly funded by Global Fund and USAID respectively, Minister Parirenyatwa is optimistic that the birth of the TB caucus marks a turning point where the lawmakers will now take a responsibility to mobilise local resources to fight TB.

Community working Group on Health director and civil society focal person for TB caucus in Zimbabwe hailed the legislators for the bold move saying that this came at a time when the country is grappling with the growing epidemic of the drug-resistant TB affecting mainly the poor and vulnerable populations.

"It shows some great political will and commitment by our parliamentarians.
"We call upon our government to take necessary steps to address and strengthening the health system, invest resources to preventing TB transmission and expanding access to early diagnosis and effective treatment for all forms of TB.

"TB is a problem driven by poverty, poor housing, inadequate nutrition and overcrowded transport systems and whose transmission is aggravated by unsafe working conditions on the mines. We know that this situation is a violation of the right to health as provided for in the 2013 Zimbabwe Constitution," argues Rusike.

"We also know that lack of drug development for TB is responsible for the situation where patients with DR-TB have to take drugs that have many side effects and are of poor efficacy because drug companies have not developed drugs for TB because it is not profitable to do so – TB is a disease of the poor and there is no money to be made from the poor populations.

"This is a situation where people who need it most do not enjoy the benefits of science and scientific progress which is used to develop drugs for populations that are wealthy enough to pay and give the pharmaceutical industries profits.

"We therefore call on the Zimbabwean government to take active steps to realise the right to health to providing accessible and quality services for patients with DR-TB.

"TB is everyone's problem and we should take action to address it. We continue calling on the Zimbabwean government to improve our housing backlogs."

Rusike urges the parliamentarians to play their oversight role to hold the Government accountable and also making sure that adequate resources are allocated for TB programmes from our own domestic resources towards meeting regional and international commitments such as the Abuja target of allocating at least 15 per cent of the total national budget to health.

Speaker of Parliament, Advocate Jacob Mudenda also urges the legislators to address the funding gaps in the national Tb programmes by lobbying for increased healthcare budgets, to fight poverty which hinders treatment adherence and to also challenge the laws that make prisons a breeding ground for TB transmission.

Hon Labode says apart from lobbying for funding, the legislators will use the caucus to raise awareness about the dangers of TB, DR-Tb and TB/HIV challenges in their respective constituencies.

"The caucus will ensure that TB as a disease is not forgotten or allowed to kill HIV infected people and eroding the gains the country achieved in controlling HIV/AIDS. The caucus will fight for adequate funding for the disease control vote in the national budget.

"One thing I know for sure that the caucus will have is in creating awareness and getting the mining companies to support their employees affected by TB by extending sick leave days on pay.

Country in historic TB caucus birth

"By launching this, we have joined other African Parliamentarians to advocate for an increase in the funding for TB prevention and treatment from international donors," says Dr Labode.

Running under the theme: Uniting leadership to End TB, the caucus is spearheaded by the International Union Against Tuberculosis and Lung Disease (The Union) under its Challenge TB programme on behalf of the Ministry of Health and Child Care.

The Union Zimbabwe director, Dr Christopher Zishiri says this could be the country's tool to ending TB considering that currently national TB programmes heavily relies on donor funding which is not sustainable.

"In order for the country to move towards the ending of TB there is need to increase local/domestic funding and invest more in disease prevention and treatment. Through the TB Caucus, we shall continue to lobby the policy makers to advocate for an increase in government allocation for the TB program.

"More so, the caucus' role is to engage civil society and all other stakeholders involved in the fight against disease. As such we shall support the caucus in creation of a multi-sectorial response to the epidemic. This will result in many players working towards ending TB in Zimbabwe.

"We have also created a parliamentarian taskforce on TB comprising the portfolio committee on Health and Child Care's leadership, MoHCC, The Union and WHO. The taskforce will meet biannually to share updates, achievements and challenges in the TB program in a bit to lobby for policy shift towards the disease. We want to make sure TB remains high on the political and national agenda so that it receives the maximum support it needs," says Dr Zishiri.

Apart from lobbying for funding and raising awareness, the lawmakers face a mammoth task of tackling issues of stigma and social exclusions in the communities which are rife.

"Another responsibility of the caucus is to confront stigma and social exclusion associated with the TB disease. We shall therefore engage the parliamentarians to be our opinion leaders and TB champions in their respective constituencies, educating the communities on correct TB knowledge and creating conducive environments that allow community members to access health services early.

"There is a lot of stigma still attached to the disease and this is one big hindrance to accessing treatment and care. Furthermore stigma has cause a lot of treatment defaulting and loss to follow up as patients disappear because they do not want to be known to be taking medication for TB.

"We shall work with the Caucus to champion early health seeking behaviours among presumptive (Suspected) TB cases and treatment adherence among confirmed cases," adds Dr Zishiri.

The birth of the TB caucus at a time when the epidemic is a serious public health threat, as the country also grapples with the increase in DR-TB cases, the milestone achievement sets a mammoth task for the legislators to lobby for funding, increase awareness on TB among other duties.

http://hmetro.co.zw/country-in-historic-tb-caucus-birth/

"In order for the country to move towards the ending of TB there is need to increase local/domestic funding and invest more in disease prevention and treatment."
Dr Christopher Zishiri

Zimbabwe: Diabetics at High Risk of Contracting TB

By Sharon Kavhu

Sithabile Mpofu is among thousands of people who have experienced a phase of infection by Tuberculosis (TB) while living with diabetes in Southern Africa. The 52-year-old woman from Lobengula, Bulawayo in Zimbabwe's second largest city has been diabetic for the past decade. She was diagnosed with TB in September last year and underwent eight months treatment. Mpofu completed her TB treatment in May, 2016 and The Herald Features caught up with her recently.

"I was diagnosed of TB last year in September. I contracted TB from my grandchild who is among seven family members that stay at my homestead," said Mrs Mpofu.

What initially confused Mrs Mpofu is that of all the people that were staying at the homestead, she was the only one who contracted TB, and yet she rarely spent time with her grandchild.

Instead, her daughter, the mother to the boy who had TB, spent more time with him but never got infected.

She added: "At the hospital they told me that TB was an airborne infection, but what surprised me was that of all the seven people that stay at my homestead, I was the only one who contracted it. Family members slept in the same room with the child never contracted any TB."

Several experts speak on the possible reasons why Mrs Mpofu is vulnerable to TB and unpack the link between diabetes and TB.

City of Harare Director of Health Services, Dr Prosper Chonzi said the initiative is a positive approach towards the two conditions because diabetic people have an immune system that is very amenable to infections.

"What we know is that TB is normally detected in the young and very old. Diabetic people are at high risk because they have a suppressed immune. Their system is very respective to infections," said Dr Chonzi.

"Previously we were only screening TB among people living with HIV and testing HIV in TB infected people, thus the development is a positive step towards TB response."

International Union Against Tuberculosis and Lung Disease (The Union) country director, Dr Christopher Zishiri explained the link between the two conditions, some of which have been documented.

"The association between diabetes mellitus (DM) and infectious diseases has been well documented owing to the fact that DM weakens the immune system. TB and DM are two of the world's leading causes of death and disability," said Dr Zishiri.

"DM triples the risk of developing TB and diabetes is a common co-morbidity in people with TB."

Dr Zishiri said the two infections needed to be taken seriously because the combination could be deadly.

He said: "TB patients with DM co-morbidity are at an increased risk of TB relapse, treatment failure and death. DM patients with TB co-morbidity also have challenges in controlling their blood sugar levels thus increasing the likelihood of developing complications from DM."

"Diabetic patients also experience some gastro paresis which impairs absorption of a number of TB drugs.

"The drug interactions between diabetes and TB medications can also have negative implications. Patients with DM also experience some gastro paresis which impairs absorption of a number of TB drugs."

Zimbabwe: Diabetics at High Risk of Contracting TB

He said diabetes is fueling the spread of TB and this negatively impacts on global efforts to end TB by 2035.

According to The Union, the growing burden of TB - DM is changing the landscape of TB care and prevention. There is now abundant evidence of high rates of diabetes in people with TB and often diabetes is only discovered if actively screened for. The same is true of TB rates among people living with diabetes.

However, there is a general assessment that has shown that the prevalence rates of TB tend to be higher among the older populations and among people living in urban versus rural areas.

Like most developing countries, Zimbabwe has been experiencing an increase in the number of non-communicable disease particularly diabetes.

In addition the country is among the high burden countries that account for more than 80 per cent of TB-HIV and MDR-TB cases globally.

Given the close association of these two epidemics there is greater need to provide integrated patient centred care and treatment for both TB and DM.

This can be done by ensuring that patients with TB are screened for DM and conversely patients with DM are screened for TB regularly.
On the other hand, Ministry of Health and Child Care's Deputy Director HIV, TB unit, Charles Sandy said TB infection may lead to metabolic changes that make management of sugar in a diabetic hard.

"Co-infection may lead to poor outcomes for the patient if both conditions are not well managed e.g. diabetic complications, failure of ant-TB treatment and even death," said Dr Sandy.

Today, Southern and Eastern Africa are on a pilot programme to have a two - way approach on TB and Diabetes through Zimbabwe and Uganda respectively.

Zimbabwe and Uganda's pilot programme on TB, diabetes integrated approach is proceeding well although it is too early to get a clear assessment.

This follows the disbursement of $289 974 to the two countries by the Diabetes Foundation (WDF).
To date, 10 health facilities from each country have started the pilot. In Zimbabwe it is currently running at: Mabvuku, Glenview, Budiriro, Mufakose, Kuwadzana, Rujeko, Warren Park, Mbare, Rutsanana and Highfield polyclinics.

In Uganda, the pilot programme is being held at Kiswa Health Centre, Murchison Bay Hospital, Kisugu Health Centre, Nsambya Hospital, Mengo Hospital , Kisenyi Health Centre, Kawaala Health Centre, Kitebi Health Centre and Nahuru Hospital.

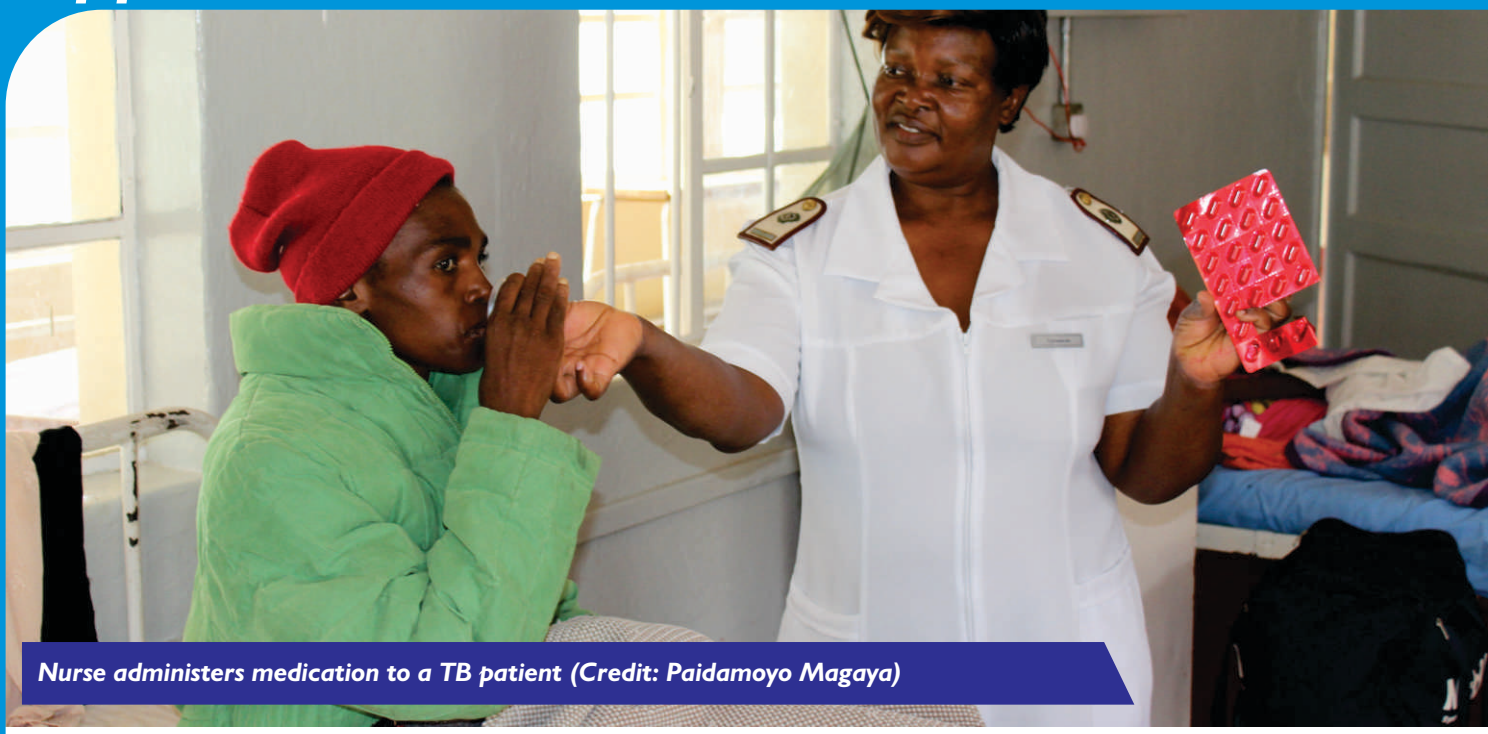
TB patients are being offered free blood test for diabetes in order to establish the prevalence of diabetes among TB patients.

The assessment and outcomes of the pilot programme will determine whether or not it should be a policy to screen TB patients for diabetes.

http://allafrica.com/stories/201608310055.html
http://www.herald.co.zw/diabetics-at-high-risk-of-contracting-tb/

Great strides made in TB/HIV treatment: As authorities implement patient-centred approach

By Thandeka Moyo



Nurse administers medication to a TB patient (Credit: Paidamoyo Magaya)

THE City of Bulawayo was one of the first local authorities to implement a patient-centred approach which incorporates family members in the planning, delivery and evaluation of healthcare.

In the countrywide fight against Tuberculosis (TB) which according to statistics claimed 1.5 million lives in 2014 globally, the approach has helped improve the treatment success rate.
One major aim of the approach was to provide HIV testing services to HIV positive TB patients' family members and to link positive TB patients to HIV treatment, care and support.

Dr Charles Sandy, Ministry of Health and Child Care Aids and TB Programmes deputy director said the model of healthcare was designed to involve family as TB patients are sent back to their families after they are discharged.

"Great milestones have been achieved since the adoption of the programme. Zimbabwe recorded a TB case detection rate of 70 per cent, a treatment success rate of 82 per cent and a case notification rate of 210 over 100 000. This was made possible by a number of factors which came into play as a result of the programme," said Dr Sandy.

"The ministry has renovated and equipped 226 microscopy sites throughout the country. Patient and family centred care is an approach to health care that shapes policies, programmes, facility design, and staff day-to-day interactions. It leads to better health outcomes and wiser allocation of resources, and greater patient and family satisfaction."

Bulawayo City Council senior public relations officer Mrs Nesisa Mpofu said the approach dubbed the "One Stop Shop" TB-HIV initiative was being implemented at all the city's 19 clinics.

"The aim of the approach is to integrate TB and HIV care in order to improve the quality of life among TB patients infected with HIV," said Mrs Mpofu.

"So far, access to HIV testing has improved as ART uptake increased as evidenced by 90 per cent of HIV positive TB patients initiated on ART compared to 47 per cent before the approach. We have also recorded an increased access to health care for index patient's family e.g. screening for TB, HIV and other illnesses and this has greatly improved adherence to treatment as shown by

Great strides made in TB/HIV treatment: As authorities implement patient-centred approach

reduction in default rate which includes people who are lost to follow up," said Mrs Mpofu.

According to Mrs Mpofu, the approach has made communication with patients easier as health personnel now use cell phones courtesy of the International Union Against Tuberculosis B and lung disease.

"Health workers call the patients to relay any information to do with the patients' illness/treatment. They can, for example, call the patients to remind them that they are overdue for treatment, to come for tests or to see the doctor. The approach was initiated in 2007 at Magwegwe and Emakhandeni clinics and family support for the patient became easier to access and disclosure problems were reduced.

Sabelo Moyo* who at one time was admitted to the Thorngrove Hospital for Infectious Diseases said his family used to treat him with disgust before they were taught about TB during their hospital visits.

"When I finally opened up to my family that I had TB, they concluded I was going to die soon. They were happy when I got admitted as they felt I was now a health hazard to the toddlers we stay with," said Moyo.

"However, tables turned when one day during their visit, a nurse asked them a few questions about their knowledge of TB. From that day they saw my situation in different light and when they agreed to test for TB, I was convinced they had accepted my condition."

Moyo said his family now freely discusses TB and HIV and that they even share their knowledge with distant relatives who had misconceptions about the disease.

"The clinic helped me get TB treatment and after some time, I started taking ART as I am also living with HIV. I feel that nurses are more accessible now as I am free to express myself even when I am mistreated."

"When I was finally discharged, my wife and siblings started treating me differently and I believe it was because the nurses had taken time to involve my family in the road to recovery," said Moyo.

Another patient from Nkayi who is still taking TB medication said the integrated TB-HIV care model helped him bond with his family.

"I used to stay in South Africa where I started my TB treatment. When I came back home, I dreaded opening up about TB and ended up defaulting until I got very sick and had to be admitted," said Nkanyiso Thebe.

"The nurses however made opening up easy and in no time, I managed to reveal that I had been diagnosed with TB while I was still in South Africa. My family liked the discussions around TB that were initiated by health officials at the clinic," he said.

Thebe said the model had helped him interact freely with nurses whom he thought were hard to reach.

Dr Sandy said the approach is grounded in mutually beneficial partnerships among health care providers and patients.
"Patient and family-centred practitioners recognise the vital role that families play in ensuring the health and well-being of patients of all ages. They acknowledge that emotional, social, and developmental support is an integral component of health care," he said.

"It also fosters participation as patients and families are encouraged and supported in participating in care and decision-making at the level they choose."

Great strides made in TB/HIV treatment: As authorities implement patient-centred approach

Dr Sandy said families play an important role in supporting the treatment of one diagnosed with TB.

"When a patient is put on treatment, they are eventually sent back to their families on a treatment model called Direct Observed Treatment (DOT). Here a family or community is oriented to watch the patient take their treatment daily and report on any reactions to treatment. The patient does not get detached from their families and their roles in their families and communities considering the length of TB treatment (6-8months)."

The integrated TB-HIV care model is now being implemented at most health facilities throughout the country as the health delivery system endeavours to deliver quality service to all citizens.

"We adopted the approach because of the advantages it offers to the patient unlike in the past where programmes only concentrated on just treating the patient and forgot about what was happening to them when they leave hospital. When patients are discharged from hospital they go back to their communities hence the need to also involve the communities in which they live."

Dr Sandy urged everyone to go for early diagnosis should they exhibit any signs and symptoms of the disease such as coughing, loss of weight, night sweats among others.

"We also encourage regular screening for the following risk groups; HIV positive, diabetics, smokers, miners, health care workers. Once diagnosed with TB, we encourage close contacts of the TB patient to come for screening to prevent the spread of the disease. For patients on treatment we encourage adherence to medication. TB is curable."

Health care workers during training

Dr Christopher Zishiri from the International Union Against Tuberculosis and Lung Disease (The Union) said the approach had helped reach out to TB patients who were struggling with ART treatment.

"The Union is currently receiving USAID funding through the Challenge TB grant to support the Ministry of Health and Child Care in the national response against TB and HIV in Zimbabwe," said Dr Zishiri.

"We noted that ART uptake was very low among TB patients despite the fact that seven out of every 10 people with active TB are HIV positive in Zimbabwe. In addition, TB remains the commonest opportunistic infection and major cause of death in people living with HIV."

Dr Zishiri said TB services were an important entry point for HIV diagnosis and care.

"These services also offer an opportunity to manage both diseases simultaneously at least for the anti-TB treatment. By end of September this year, 46 primary health facilities will be implementing the model of care in all 10 provinces in Zimbabwe," he said.

Dr Zishiri said more resources were needed to roll out the programme countrywide.

"Health care personnel need to be trained as well and some sites need renovation to allow for one stop shop approach."

http://www.chronicle.co.zw/great-strides-made-in-tbhiv-treatment-as-authorities-implement-patient-centred-approach/

Winning TB battle against all odds

By Mary Taruvinga

LOOKING at him, one will never tell that the father-of-two almost lost his life to tuberculosis (TB) infection.

Takunda Nyikadzino (32), who is originally from Zimuto in Masvingo and formerly an artisanal gold miner, is HIV positive and has a captivating TB tale to tell.

Although Nyikadzino's story has a good ending, it is littered with several challenges associated with living with the condition in an ailing economy.

He narrated his ordeal to NewsDay recently while at his wife's vending table outside his lodgings in Chipadze, Bindura, where he now lives with his family working as a security guard.

After dropping out of school when he was in Form Three, faced with economic hardships in the country, Nyikadzino found himself in the Chachacha area near Shurugwi, where his mother's sister resided.

His cousin then introduced him to gold panning, which was a source of livelihood for almost every family in Svika village, where they stayed.

He mined gold for three years, using informal methods. He would go underground soon after blasting and would inhale explosive fumes. He was also exposed to mercury and other chemicals for processing and refining gold.

"We would mine gold along the river and in near-by areas. Gold panning was a source of livelihood for almost every family and people would continue to flock in and with time, the gold in the river was becoming scarce," he said.

According to Nyikadzino, the panners would then rely on mercury, a highly toxic substance supplied by the smugglers who buy their product, to trap the precious metal from the muddy river waters.

Public health and environmental experts say the consequences are disastrous. Mercury can contaminate drinking water for miles around and causes neurological damage, especially to children.

But pushed to the brink, Nyikadzino had to continue mining in order to bring food on the table.

Asked if they were not worried about their work hazards and if they ever received any protective clothing, he responded: "We were only worried about the police and Environmental Management Agency (EMA) officials, who would try to drive us out. We never saw any health experts in the area and we didn't use any protective clothing. In fact, we would put on vests and shorts to save our better clothes and I felt more comfortable working without even putting on my shirt."

Like many uneducated artisanal miners, he was unaware that direct contact with silica dust exposed them to contraction of TB.

As his fortunes improved, Nyikadzino graduated from being a mukorokoza to a gold buyer.

As gold availability continued to shrink in the area, he moved to Kitsiyatota near Bindura, where there was a gold rush in 2014. There, he returned to underground mining. It was during this period that he contracted TB.

Nyikadzino, fully cognisant of his exploits with women, feared he had contracted HIV. "I was becoming very weak and would sweat during the nights. That persisted for days before I started coughing continuously," said the survivor.

Nyikadzino soon became bed-ridden and within a month, he had severely lost weight owing to a complete loss of appetite. Nevertheless, he was still unwilling to get medical help. He gives credit to his mother, who kept on persuading him until he said "yes".

Winning TB battle against all odds

Tests found he had active TB and was HIV positive. He immediately commenced treatment, but as soon as he got better, he started defaulting, dreading the long journey to Zimuto Clinic and Maranda, also known as Gurajena hospital, being the nearest health facilities servicing his community.

Barely three months after commencing treatment, Nyikadzino found himself back in Bindura, where he continued with artisanal gold mining.

Three months down the line, the sickness was back and this time, he almost lost his life. He was back again at his rural home, where he was placed on Directly Observed Treatment Short (DOT) course.

The strategy emphasises the use of the most effective standardised, short-course regimen, and of fixed-dose drug combinations (FDCs) under observation to facilitate adherence to treatment.

By so doing, it stops TB at the source, and prevents the spread of the disease, the development of MDR-TB [multi-drug-resistant tuberculosis], and complications of TB, relapse and death.

"I would not have made it without the help of village health workers. Mai Muvirimi would ride her bicycle to my homestead every day and even help with making sure I was living in a recommended environment," Nyikadzino said, paying homage to the least paid, but hardworking community cadres.

After going through DOT Nyikadzino is now back on his feet although he has abandoned gold panning.

Doctor Charles Sandy, deputy director in the Aids and TB Unit in the Ministry of Health and Child Care, says TB treatment response has been improving of late, particularly in mining communities.

"There are projects currently underway, including mass screening projects targeting most at risk populations including miners," he said.

He, however, admitted that geographical access to diagnostic and care service is still inadequate coupled with insufficient availability of laboratory reagents and consumables.

Government, with support from Global Fund and Challenge TB, has rolled out a programme in the country's 24 districts to target mining communities that are at high risk of tuberculosis to reduce the spread of the infectious disease.

The International Union Against Tuberculosis and Lung Disease (The Union) country director, Doctor Christopher Zishiri, said the move was aimed at ensuring that all patients with active TB in mining communities were diagnosed early and put on effective treatment.

"We will be visiting communities that have a high risk of TB, particularly areas where formal and artisanal mining activities are carried out and screen people for TB," he said.

Recently, Dr Zishiri also said despite the nature of artisanal mining which is associated with migrant lifestyles, the group needs to be screened because they are continually exposed to silica dust in often poorly ventilated deep mine shafts increasing their risk of pulmonary tuberculosis.

Zishiri said trucks fitted with X-ray machines and manned by a radiographer have already been deployed to various districts across the country to avail screening services to anyone willing.

https://www.newsday.co.zw/2016/08/30/winning-tb-battle-odds/

Special Feature

Bikers go full throttle to speed up TB cure in Zimbabwe

By Stephen Tsoroti

A biker reaches a rural health service centre to deliver samples. (Credit: Stephen Tsoroti)

A programme with the health department sees motorbikes being used to deliver drugs to people in far-flung places who can't afford the fare.

Mazvita Chitsa stared down in fear at her two-year-old girl's emaciated body. Chipo lay on a rug on the cement floor of hut, coughing and sweating profusely.

It was about 8am and the sun was already blazing down on Mutirimuko village in Zimbabwe's Gutu district in the south of the country.

Chipo had been coughing incessantly for two weeks. Mazvita had lost track of how many times she had knelt at her daughter's bedside. "What was wrong?" Mazvita wondered. "Did someone bewitch her Chipo? Was it a lack of good food that caused the constant coughing and night sweats? Why was she so thin?"

Chipo began to squirm and shiver. Mazvita started to panic and realised she had to get her daughter to a doctor or nurse. But the nearest clinic was 21km away and she didn't have money for the bus fare. Mazvita began to sob.

The villagers collected money and, four hours later, Mazvita and Chipo arrived at Mukaro clinic in the town of Gutu.

A nurse told Mazvita her daughter displayed the classic symptoms of tuberculosis (TB): coughing for longer than two weeks, losing weight and sweating at night. The nurse took a sputum sample and sent it to the laboratory. After a week, the test came back positive. Both Chipo and her mother had drug susceptible, or ordinary, tuberculosis.

Bikers go full throttle to speed up TB cure in Zimbabwe

New technology and transport

Zimbabwe is one of the 30 high burden countries, which collectively account for 85-89% of the total TB cases globally. Tuberculosis continues to be a major cause of morbidity and mortality across the country. Drug resistant TB is an emerging public health problem in Zimbabwe and treatment outcomes remain suboptimal due to high death rates.

Charles Sandy, the deputy director for Aids and TB programmes in Zimbabwe's health department, says in many cases the country relies on a long-used method of smear microscopy to diagnose tuberculosis. It takes between one and four days to analyse a sputum sample.

Sandy says it's difficult to get patients diagnosed in time, because many health facilities are in areas with poor roads that are difficult to travel.

Zimbabwe is in the process of acquiring cutting-edge technology, known as GeneXpert machines, which can diagnose tuberculosis in two hours. Andrew Nyambo, the Advocacy, Communication and Social Mobilization officer in the ministry of health, says Zimbabwe has 120 GeneXpert machines that are spread across 59 districts.

Chipo's sputum sample had to be transported to a GeneXpert machine at the Gutu district hospital, about 70km away.

Ordinarily, it would take two to three weeks for Chipo and her mother to get their results. But Zimbabwe's Biker's programme, made it possible for them to be diagnosed in a week.

The Biker project started in 2010, according to Christopher Zishiri, Zimbabwe's country director for The Union against TB and Lung Disease, an international organisation partnering with Zimbabwe's ministry of health and child care. It operates in eight of Zimbabwe's 10 provinces, mostly in rural areas, and uses 50 motorbikes.

Research studies have shown that the earlier people with tuberculosis are diagnosed, the higher their chances of survival are, because they are more likely to complete their drug courses and the medicine is more likely to work.

A member of Zimbabwe's biker project, who delivers sputum samples to labs and medicines to TB patients in far-flung areas.

Bikers go full throttle to speed up TB cure in Zimbabwe

TURNAROUND TIME

Zishiri says a health department survey has shown that, over the past six years, the time it takes for patients to receive their TB test results has been cut in half in 42 districts. "With this [Biker] programme, the average turnaround time from sample collection to health centre receipt of laboratory results has been reduced from seven to three days," explains Zishiri. "Twenty-five per cent of TB cases diagnosed so far in the country are attributed to the bikers."

The Bikers programme is funded by United States Agency for International Development.
In addition to collecting sputum samples, bikers also deliver patients' treatment to their homes once a month. This helps to cut people's transport costs to and from the clinics and also increases treatment adherence.

Morgan Meza is one such biker. On an overcast Thursday afternoon in January, he's on duty. His destinations are the places around the gold-rich areas of Kadoma town, in the central parts of Zimbabwe.

For the next two to three hours he knocks on people's doors to deliver medicine and find out how patients are doing.

"For me, this is the most important part of my mission is to create relationships. I realise my job is not just to collect samples and deliver them to health centres. It's interacting with the affected communities that make a difference in TB treatment," Meza says.

"TB treatment is a horrible experience. Imagine the number of tablets one has to swallow in a given day - for six months. To finish the course patients need a lot of encouragement. Spending the time to talk to patients helps them to finish their treatment."

IT'S ALSO ABOUT ENCOURAGEMENT

Meza visits five to six patients a day and works for five days a week. His motorbike is provided by the Biker's programme and he also receives a stipend for his services.

Meza says he once visited a man undergoing TB treatment who suffered terrible nightmares and was unable to find a reason to live. Each night the man was haunted by the faces of his two daughters, who had succumbed to tuberculosis.

"The man told me his worst fear was to die in a painful way, like his daughters. But after two visits to his homestead, things began to change and the man started taking his medication correctly and attended community health clubs to encourage others to finish their treatment," Meza says. "To me the visits and talks boost patients' confidence and makes them trust in the health care system."

Spiwe Makeleni lives in Kadoma and is being treated for multidrug-resistant TB, which can take up to two years to cure. She says: "Because of the bikers we no longer have to walk lengthy distances to clinics or worry about bus fare. Once you are diagnosed with TB, the bikers help fetch the medicines for us. It's unlike the clinic or hospital environment where benches and long queues wait for you."

Makeleni says she can now concentrate on taking odd jobs to help feed her family. "I only visit the clinic for my reviews [check-ups]."

"Twenty-five per cent of TB cases diagnosed so far in the country are attributed to the bikers."
Dr Christopher Zishiri

Bikers go full throttle to speed up TB cure in Zimbabwe

Mazvita and Chipo are responding well to treatment. (Credit: Stephen Tsoroti)

In Mutirimuko village, Mazvita and Chipo have been on tuberculosis treatment for three months, half way to getting cured. The two-year-old has picked up weight and is no longer coughing. Both are also no longer infectious.

A biker drops off their treatment to their home once a month. Mazvita strokes her hand over her daughter's head and smiles: "Without the drop-offs, I'm not sure that we would have completed our treatment course. TB pills are tough to take and the clinic is 21km away. I'm very grateful for the bikers."

http://world.einnews.com/article/319759567/xVPbU_6twpvP-FMo

Twin evils of malnutrition, TB ravage children in rural communities

By Sophia Mapuranga

FOLLOWING the El Nino-induced drought which ravaged parts of the country, Rachel Gumbo (38)* and her family were left with no choice, but to survive on a meal a day.

The drought left an estimated 2,8 million Zimbabweans struggling to cope with food insecurity, lack of water and vulnerable to disease.

Drought was not a new phenomenon for Gumbo from the Matide area under village head Wilfred Chitsunge in Buhera, so she could absorb the shock.

But watching her two-year-old baby girl, Tariro*, wasting away after having been severely malnourished, made her curse the gods over the dry spell, which saw her fail to reap even a single bucket of maize.

Sitted on a rag in the company of her older sibling, Tariro chuckled while responding to her mother's smile, obviously unaware of her predicament.

The child's stomach was bigger than the rest of her body and it visibly protruded, making the T-shirt she was wearing look like it was borrowed.
Tears welled in her mother's eyes as Gumbo lifted her baby from where she was sitting and placed her on her lap.

"I almost lost her," she said, her voice full of emotion. "No one ever thought that she had TB. The nurse at Nyazvivi clinic had indicated that she had malnutrition and that was the reason why she was not growing well."

She, however, said Tariro sweated a lot at night and her body was generally weak.

"I attributed the loss of appetite to our poor diet. We ate sadza and vegetables day in, day out

Twin evils of malnutrition, TB ravage children in rural communities

whenever we managed to source mealie meal," said Gumbo, narrating the ripple effects of drought on her family.

She told of how it was then very difficult to link her daughter's symptoms to TB.

"She was not responding to the recommended diet and that is when the doctor suggested more tests," she said.

The family had to commit their meagre resources to running more tests.

Gumbo said the agony of watching her daughter continue deteriorating due to ill health made her follow the doctor's advice.

Since Tariro was not coughing, Gumbo recalled how it was very difficult to collect sputum.

"I tried every trick in the book, but the sputum would not come out," she said, forcing a smile. "The first sputum I collected was thrown away because they said it was just saliva. It took days, until I managed to get it right."

According to the Global TB Report 2015, children represent about 11% of all TB cases, with at least one million children falling ill with the disease annually.

A woman waits for her turn to have her child tested of TB

In 2014 alone, 136 000 children died of TB, translating to nearly 400 children daily, on a global scale.

Of these, 81 000 of the TB deaths were among HIV-negative children, while 55 000 TB deaths were recorded among HIV-positive children, the report said.

The World Health Organisation (WHO) attributed the high incidence of TB among children to vulnerable immune systems. These included very young ones, HIV-infected or severely malnourished.

"Any child living in a setting where there are people with infectious TB can become ill with TB, even if they are vaccinated," the report reads in part, adding that malnourished children were at risk of falling ill or dying from TB because their immune systems were weak.

WHO also revealed that TB illness in children was often missed or overlooked due to non-specific symptoms and lack of sensitive and child-friendly diagnostic testing.

Tariro's diagnosis with TB brought with it fresh challenges. She continued losing weight and even sent tongues wagging in the community. "Some of the people openly told me to 'juice up' my baby with anti-retroviral treatment," Gumbo recalled.

The stigma and discrimination that she suffered began taking its toll on the single mother, who said she feared disclosing that Tariro had TB because of the disease's relationship with HIV.

"I assumed that people would think that my child had HIV. At first, I kept this a secret, but it made my situation very difficult," she revealed.

Gumbo said she failed to give her daughter TB medicine at the prescribed times every day, since secrecy made her skip some doses.

Twin evils of malnutrition, TB ravage children in rural communities

Gumbo said with time, she managed to appreciate that her child's adherence to the TB medicines was a priority which she should not compromise. She then scheduled her daily routine such that she would give her daughter the medicine at the same time.

"The support I got was from an aunt whose child had also been successfully treated of TB," she said.

Gumbo said through her daughter's experience, she had discovered the importance of staying on TB medication until one completes their course.

"My worst fear is that if I do not give her the medicine as directed, she can then develop another type of TB that is drug resistant," she said.

Head of the AIDS and Tuberculosis Unit in the Ministry of Health and Child Care, Dr Owen Mugurungi, said childhood TB remained a challenge in Zimbabwe.

"It is difficult to diagnose," he said, emphasising the importance of capacitating stakeholders involved in providing health care for children and in TB control initiatives.

The deputy director for the HIV, Aids and TB programme in the Health ministry, Dr Charles Sandy, said regardless of one's age, the ministry encouraged everyone to go for early diagnosis should they exhibit any signs and symptoms of the disease, some of which include coughing, loss of weight and night sweats.

"Prophylactic treatment should be provided to those at risk of the disease especially children," he said, adding that once diagnosed with TB, patients on treatment were encouraged to adhere to medication because TB is curable.

The International Union Against Tuberculosis and Lung Disease (The Union), an influential global network of 500 experts based in 12 offices and 17 000 members working in 156 countries, reported that childhood TB had been identified as an important cause of morbidity and mortality in children in TB-endemic countries including Zimbabwe.

According to the organisation, the burden of childhood TB infection and disease represents recent and on-going transmission in communities. It recognised the importance of contact screening and management as strategies that can identify 'at-risk' children who will benefit from preventative strategies while increasing the case detection of TB disease.

The Union deputy director Dr Ronald Ncube has called on the government and other stakeholders to intensify efforts in TB screening as a strategy to increasing case detection especially in vulnerable communities.

He said since Zimbabwe was in the top 30 countries that have a high TB burden, there is need to intensify efforts to find and treat all TB cases if the country is to meet the target of ending TB by 2030.

*Not real names

https://www.newsday.co.zw/2016/09/29/twin-evils-malnutrition-tb-ravage-children-rural-communities/

Childhood TB still a problem

By Vivian M. Mugarisi

Prince sees a bright future ahead of him. (Credit: Shepherd Machekera)

TUBERCULOSIS in Zimbabwe has remained a major public health threat with country estimates reporting that at least 30 percent of TB cases remain undiagnosed due to various reasons.

Due to clinical similarities of TB symptoms with other diseases, detecting TB in children remains a major challenge especially in a country where diagnostic tools are not being adequately used, forcing TB in children to remain in the shadows.

Experts say that childhood TB is widely under-reported and can represent as much as 40 percent of the TB caseload in some high burden settings such as Zimbabwe.

Identification of TB in children depends on the alertness and knowledge of nurses and doctors, and fortunately for an 18-month-old boy, Star, a nurse at Mbiro clinic in Chivhu suspected TB after finding him HIV negative.

"He was losing weight and having prolonged coughs, sometimes taking at least 15 minutes for him to stop," said Mrs. Fortunate Chiripanyanga, the boy's mother.

"At first they tested him for HIV but he was found negative, that is when the sister at Mbiro advised us to go to Parirenyatwa for a TB scan and the doctors at the hospital confirmed he had TB meningitis," she added.

Star was immediately put on treatment.

Though Star was very lucky, not every child is and has been as fortunate as him.

According to the World Health Organisation (WHO) 136 000 children died of TB in 2014 and this includes 81 000 deaths among HIV-negative children and 55 000 among those who were living positively.

Ministry of Health and Child Care Permanent Secretary Dr. Gerald Gwinji said TB in children is often missed or overlooked due to non-specific symptoms and difficulties in diagnosis.

He said the challenges in TB diagnosis in children are the difficulty confirming the presence of TB bacteria because of the difficulty in sample collection as children cannot cough up sputum.

Childhood TB still a problem

"The question with childhood TB is 'are we missing or misdiagnosing some cases' given the challenges in TB diagnosis in children," he said.

"It is likely that some childhood TB cases are missed and most children succumb to TB – that is the situation not only in Zimbabwe but globally."

This has made it difficult to assess the actual magnitude of the childhood TB epidemic, which according to the Ministry, represented approximately 10 -20% of all adult TB cases and between 8 and 10% of annual notified TB cases over the past five years.

The International Union against Tuberculosis and Lung Disease (The Union) Country Director, Dr Christopher Zishiri, said the country could be detecting half the number of children affected due to challenges in detecting.

"Diagnosis of TB itself, children are not like adults and it is difficult to get sputum so we to use other diagnostic methods to detect TB in children.

"TB in children is a mimic and can present like malnutrition, weight loss sometimes present as recurrent pneumonia, chest infections, high temperature which are just not like straight TB symptoms so this needs lots of training and a lot of clinical skill," said Dr Zishiri.

He therefore added that treatment has not been a problem, though introduction of child-friendly formulations expected by the end of this year will make treatment in children easier and bearable.

WHO National Professional Officer for TB/HIV Dr. Patrick Hazangwe however said treatment of tuberculosis (TB) in children can be made easier through multi-departmental approach and strengthened contact tracing.

"There has been a myth which has really been perpetuated for a very long time that TB in children is difficult to diagnose and that has made the children to not have access to TB treatment," he said.

"But if there is collaboration among the TB unit, HIV unit and mother to child health unit, TB in children can also be easily diagnosed especially when you take the symptoms like when the child is failing to thrive.

He said research and development remains central in dealing with childhood TB and strengthened contact tracing will ease the burden as young children are normally infected by those who take care of them.

He also added that decentralisation of services is critical to ensure that the services are where they are needed the most, like Mbiro clinic.

"Children get TB from their caregivers so if we manage to get a good contact tracing of any adult with TB, we will quickly pick up on any child with signs and symptoms suggestive of the disease.

"We need to ensure that our health workers are well-equipped and trained to presume TB in children early and we also need to ensure that there is access to other diagnostic tests especially the x-rays.

"The ministry has managed to get digital X-rays for central hospitals and provincial hospitals but if it remains at provincial level it still remains inaccessible because there is need for bus fare to come to that hospital," added Dr Hazangwe.

He also said despite government efforts to come up with guidelines and training material on the epidemic, there was need to involve the family as childhood TB is a family affair.

Government, he added, should take advantage of the new formulations for children to increase adherence and eliminate TB within global targets.

"As WHO, we are recommending countries to quickly adopt these formulations because when we talk of patient-centred treatment, that is exactly what we need.

"It will improve adherence to treatment and when there is good adherence there is also good outcomes, when there is great outcomes cure rate is good, meaning TB reduction and any person cured means we are stopping TB right there," he said.

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The Global Health Bureau, Office of Health, Infectious Disease and Nutrition (HIDN), US Agency for International Development, financially supports this publication through Challenge TB under the terms of Agreement No. AID-OAA-A-14-00029. This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Challenge TB and do not necessarily reflect the views of USAID or the United States Government.