TB News

Second Edition, November 2016

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FROM THE EDITOR'S DESK

Dr Charles Sandy

Welcome to the second edition of TB News, our own platform to tell TB stories from in and outside the country. I hope will shall find this edition as informative and exciting as the previous one.

In the last half of 2016 we noted important milestones. We successfully conducted the TB Program External Review in June and an epidemiology assessment whose findings are going to inform the development of the next National Strategic Plan for the TB program for the period 2018 to 2020.

The Global Fund (GF) Office of the Inspector General (OIG) was in country to review the TB grant implementation. The Ministry of Health and Child Care is the current Principal Recipient of the GF TB grant.

In an effort to ensure treatment adherence and completion among pediatric TB cases, we will from January next year be introducing flavoured TB formulations for the treatment of Childhood TB. This is a welcome development to the country and most importantly to our TB patients.

In this edition we carry a special feature of the voices from the community and our partners. It is noteworthy that we have cadres who are making various sacrifices in contributing towards ending TB in Zimbabwe. We recognize and appreciate all your efforts. As always we welcome your comments, contributions and views in making this newsletter a success.

Lastly, the festive season is upon us, I would like to wish you all season's greetings and a happy New Year.

Meet you in 2017 with yet another exciting edition of TB News!!!

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INSIDE TB NEWS

UPCOMING EVENTS AND COURSES

Operational Research Course on Child Lung Health Singapore, Singapore — 13 February - 24 February 2017
http://www.theunion.org/what-we-do/courses/tb-and-mdr-tb/operational-research-course-on-child-lung-health

World TB Day, March 24, 2017

Principles of Tuberculosis Care and Prevention: Translating Knowledge to Action Bulawayo, Zimbabwe — 27 March - 5 April 2017
http://www.theunion.org/what-we-do/courses/tb-and-mdr-tb

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ZIMBABWE CONDUCTS AN EXTERNAL TB PROGRAM REVIEW

Dr Chakaya- Lead Consultant External TB Review

The National Tuberculosis Program (NTP) carried out an external program review in June, 2016. The overall objective was to take stock of progress made in implementing the current National TB Strategic Plan, to inform development of a follow-on strategy.

Key review findings and recommendations

Overall the TB response in Zimbabwe is performing well.

Below are some of the key findings and recommendations from the exercise:

- The TB response depends highly on external resources. There is need to progressively increase the proportion of financial resources for the TB response that are mobilized from domestic sources.
- MoHCC was nominated the Principal Recipient (PR) for the TB and Malaria grants in the current GF funding cycle. There is need to appraise all key players on GF processes and enhance communication among all key players for successful program implementation.
- The dwindling of the health care worker retention scheme calls for the MoHCC and her partners to go into the emergency mode to identify and mobilize the resources required to sustain the scheme at least in the medium term.
- There is need for optimal use of Xpert MTB / RIF as the initial test for all presumptive TB cases in high HIV endemic settings, strengthen Childhood TB diagnosis and strengthen contact investigation
- To enhance the laboratory support towards universal Drug Susceptibility Testing (DST) to all the people, it is recommended that clinical and laboratory efficiencies are enhanced through adequate investments in the national sputum transport system including eHealth innovations and information management system for real-time data capture and monitoring at the national level.
- While the response to TB/HIV co-infection is exemplary, there is need to review the IPT program to understand the barriers to implementation and then revise the program appropriately to enhance its quality with careful phased expansion.
- With a treatment success rate of 75%, the treatment outcomes for DR-TB are among the best

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Presentations during the External TB Review feedback meeting

Dr Rudo Chikodzore administers a health facility questionnaire to nurses during the field exercise

ZIMBABWE ADOPTS A SHORT TREATMENT FOR MDR-TB

Breakthrough study demonstrates far shorter, more effective treatment for multidrug-resistant tuberculosis (MDR-TB), with majority cured.

Final results demonstrated nine-month treatment had 82% success rate, compared with previous standard that required more than 20 months of treatment and achieved cure rates below 55%

Findings announced at 47th Union World Conference on Lung Health, Liverpool UK

By Dr M. Ngwenya

Multidrug-resistant tuberculosis (MDR-TB) is a public health crisis and a global health security risk carrying grave consequences for those affected. Zimbabwe is one of the 30 African countries with a triple burden of TB, TB/HIV and MDR-TB. In 2015 an estimated 1100 people developed MDR-TB in Zimbabwe. Out of these, 468 cases were diagnosed and 433 were put on treatment. Standard treatment duration for MDR-TB is usually for 18 months or more.

Attempts to reduce the length of conventional MDR-TB regimens and to use a combination of drugs which is tolerable have been ongoing for several years. Recently, a standardized treatment regimen lasting less than 12 months was introduced for trials. It showed promising results in selected MDR-TB patients. Based on data from these trials, WHO updated its treatment guidelines for drug-resistant TB in May 2016 and included a recommendation on the use of the shorter MDR-TB regimen under specific conditions.

This new recommendation has a number of benefits: it is cheaper and costs less than $1,000 per patient and it also reduces patient loss due to decreased duration for treatment.

However the regimen cannot be used yet in pregnancy and extra-pulmonary tuberculosis. The regimen is also contraindicated in patients with second line drug resistance. There are serious risks for worsening resistance if the regimen is used inappropriately (e.g. in XDR-TB patients). WHO encourages ongoing and future randomized controlled clinical trials to strengthen the evidence base for shorter and more effective regimens. Furthermore, monitoring for effectiveness, harm and relapse is needed, with patient-centered care and social support to enable adherence.

The regimen is expected to be in use in Zimbabwe before the end of the first half of 2017 under programmatic conditions as well as enrolment of a small proportion of people that will be treated under the Standardized Treatment Regimen of Anti-Tuberculosis Drugs for Patients with MDR-TB (STREAM) clinical trial.

Between 1961and 1964 air recreational unit and Memorial sanatoriums were opened throughout the country to isolate TB patients from the community to minimize the spread of the infection.

BREAKING FREE: MADZIMAI VIOLA DEFIES CHURCH DOCTRINE AND SEEKS TREATMENT FOR DR-TB

Viola Chakanyuka (Credit: Andrew Nyambo)

By Mahwe DTC Makoni

Viola Chakanyuka, 27 years, is a woman from Dewedzo area of Makoni District, in Manicaland province. She is a member of one of the conservative apostolic sects (Johane Marange) that believe in divine healing for all forms of illness.

Viola stayed in South Africa for a while. Upon her return to Zimbabwe in 2013, she realised she was unwell. Despite her church's position on visiting health facilities, she decided to visit Rusape General Hospital for help after seeing that her health was deteriorating.

Baseline investigations done on her confirmed that she had MDR-TB. She was admitted at the hospital for two months before being referred to Nedewedzo Rural Hospital, which is about two kilometres from her home for further management and care.

On July 20, 2015 Viola was declared cured after she successfully completed her treatment course and faithfully going for routine reviews.

Viola is grateful to the Makoni district TB team for supporting her on her journey from cough to cure.

“The health care workers constantly visited me at home and were very helpful each time I went to the hospital for my routine check-up. Without their help I would not have made it on my own,” said Viola.

As words of encouragement to those diagnosed with TB, she had this to say:

“You can only get treated and cured of TB at the health facility. Listen to what the nurses tell you, adhere to your treatment and have a positive attitude.”

The country conducted the first Tuberculosis Prevalence Survey in the history of Zimbabwe which revealed that:
- The TB Prevalence Rate was 275/100 000 per population compared to WHO estimates of 406/100 000 per population.
- The WHO estimates for Case Detection was revised upward to 70% in 2015 from 42% in 2014.

INTRODUCING FLAVOURED TB FORMULATIONS FOR CHILDREN

By M. Dube and Dr N. Mugwagwa

The World Health Organization (WHO) estimates that 10% of the 9.6 million cases of tuberculosis (TB) worldwide in 2014 occurred in children aged 0–14 years, and that there were around 136 000 TB-related deaths among children. In Zimbabwe, children have constituted 8-10% of all notified cases in recent years. In 2010, WHO revised the recommendations for the treatment of TB in children which Zimbabwe subsequently adopted. However, health workers and care givers faced unforeseen challenges in implementing the revised recommendations.

To address this challenge, WHO recently prequalified Rifampicin 75mg/Isoniazid 50mg and Rifampicin 75mg/Isoniazid 50mg/Pyrazinamide 150mg dispersible tablets. The improved formulations have been developed in line with the revised dosing published in the 2014 WHO Guidance on childhood TB. They have higher doses of rifampicin and isoniazid as compared to those currently in use thereby reducing the pill burden for patients. Moreover, the significantly higher dose of isoniazid eliminates the need to add additional isoniazid as has been the practice with the available formulations which were proving difficult to administer to children.

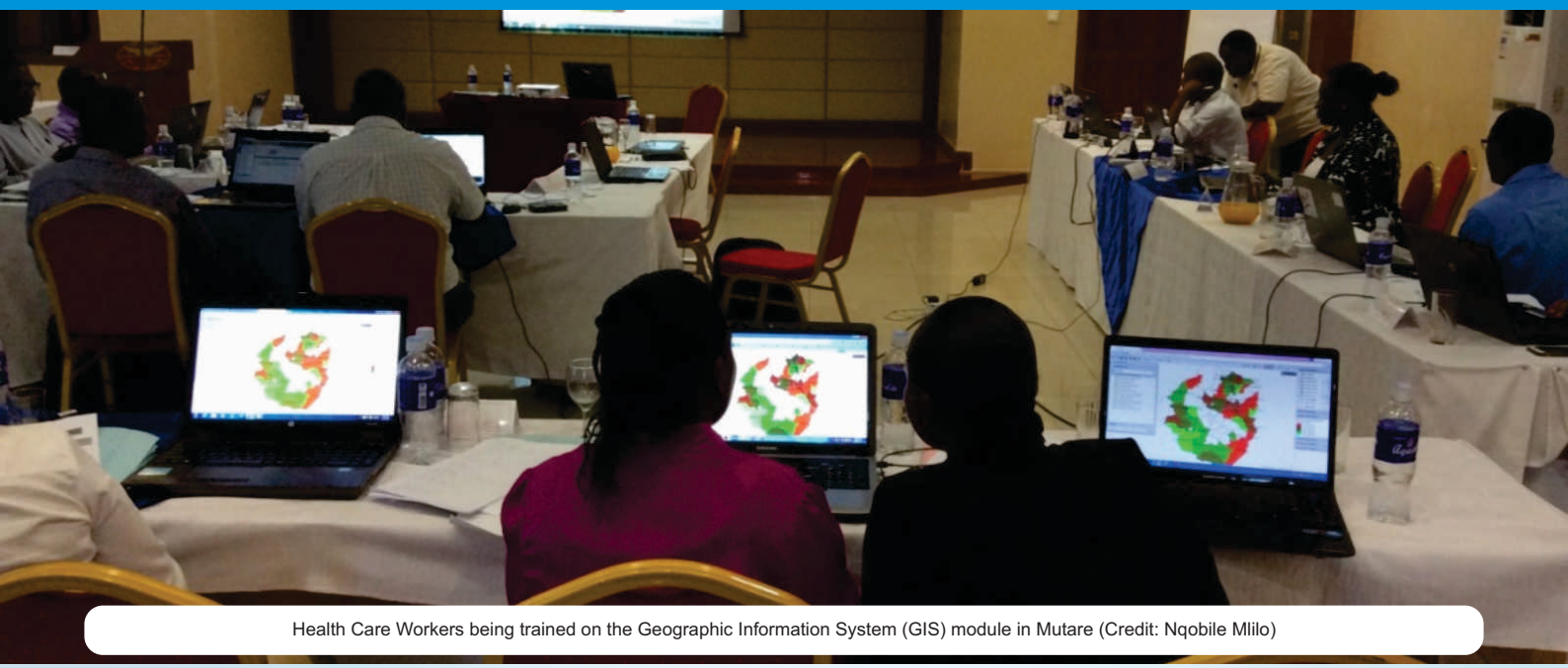
The improved formulations are flavoured making them more palatable than the formulations currently in use. It is important to note that the fixed-dose combinations (FDCs) are not new drugs, but rather improved formulations of presently used medicines recommended for the first line treatment of TB.

Zimbabwe will start using the formulations in January, 2017. It is envisaged that the new formulations shall contribute to improved treatment adherence and outcomes resulting in no child succumbing to TB.

Benefits of new formulations

- The right medicines in the right doses will increase adherence and save more lives
- Simple TB medicines for children ease the TB burden on healthcare systems
- Child-friendly medicines improve the daily lives of children and their families struggling with TB.

The right medicines in the right doses will increase adherence and save more lives



Health Care Workers being trained on the Geographic Information System (GIS) module in Mutare (Credit: Nqobile Mlilo)

Strengthening TB data management through District Health Information Software Version 2 (DHIS2)

Electronic recording and reporting systems not only facilitate the assessment of data quality but have other benefits, such as reducing loss to follow-up during treatment and assisting with the management of drug supplies. Zimbabwe has traditionally relied on a paper based system which has meant it was hard to assess and compare performance at different levels of the health system, data analysis was difficult and time consuming, and sometimes paper reports have simply been lost.

In 1984 the Government of Zimbabwe adopted the Primary Health Care concept and TB was integrated into the general health services. Since then the Ministry of Health Child Care has made huge strides across the spectrum of Tuberculosis expanding health services to the community through the construction of primary health care facilities

Through the USAID funded Challenge TB project, an electronic recording and reporting system (District Health Information Software Version 2) has been installed and customized to enable the reporting of TB surveillance data in real time. The software is user-friendly, open source and web-based, with features to view and analyse data originating from facility level. This has been rolled-out to all districts, city health departments, provincial health offices, the Ministry of Health and the Child Care national office. Key staff have been trained to use the software for data entry and analysis, and Challenge TB supplied 75 laptop computers to facilitate the roll-out of the software.

Within four months of implementation, 1,569 out of 1,657 (95%) health facilities had their 2015-2016 data entered into the system. The TB data entered are available online and in real time to provincial and national managers. The managers can generate site specific data analysis reports, including comparisons over time, across facilities, districts and provinces. This has made it much easier for them to identify non-performing facilities and districts, and to prioritize them for support. The data generated will ease planning as resources can be channelled to where the need is greatest.

AN INNOVATIVE OUTREACH APPROACH TO FIND MISSED TB CASES IN COMMUNITIES

Zimbabwe has a high prevalence of TB with 275 cases per 100,000 population and worryingly an estimated 10,000 people with TB are not identified by health services and may continue spreading the infection in the communities they live. Some high risk groups, such as those living in remote settlements and the growing population of highly mobile miners have limited access to healthcare services, which further compounds the problem.

Miners operate in poorly ventilated areas which makes the spread of TB easy. The lack of sunlight and airflow facilitate the spread of TB bacteria which puts workers at high risk of getting infected if one of their colleagues has TB. These workers can in turn pass the disease to unsuspecting family members and friends outside the work environment.

With support from the USAID funded Challenge TB project and Global Fund, the country embarked on an innovative outreach approach to increase the detection of missing cases in key populations such as miners. High risk communities were first mapped and were then targeted by outreach services using two mobile trucks equipped with digital X-ray machines and manned by a team of health care workers in six prioritized districts.

Between July and September 2016, a total of 11,870 people were screened for TB of which 4,931 showed signs and symptoms of TB and were tested. In total, 185 were diagnosed with TB, three of which had drug-resistant TB. Those diagnosed with TB were promptly initiated on appropriate treatment at their nearest health facility.

People with weak immune systems, because of chronic diseases such as HIV or diabetes, are at a higher risk of progressing from latent to active TB. So everyone who was screened for TB was also offered an HIV test and those with symptoms suggestive of diabetes had their blood glucose level tested.

"I work in the mine without any protective clothing. We inhale a lot of different substances. I do not have enough money to go to the clinic closest to me, so I am happy I am able to access services for free."

***David Jemekaya** - a miner who was screened and found TB free.*

A total of 4,764 people took an HIV test. Out of these, 326 tested positive and were linked to treatment and care services. The blood glucose level of 2,875 was tested and 124 had an elevated blood glucose level and were referred for further management at their nearest health facility.

Through continued support this outreach approach has the potential to find many additional TB patients missed by routine services in high risk communities in Zimbabwe. This will significantly contribute towards the country's efforts of ending TB by 2035.

Views from the community during the outreach

"Tirikufara chaizvo nechirongwa ichi chekuongororwa TB mahara. Nhasi ndichabva ndakuziva kuti hutano hwangu hwakamira sei," (We are glad that the ministry has come to offer us free TB services. Today I shall leave this place knowing my health status) ***Tambudzai Kabikira***

" Isu tinoshanda munzvimbo dzine huruva saka ndinoziva tiri panjodzi yekubata TB. Ana mbuya vezvehutano vari pano vatidzidzisa kuti tingazvidzivirire sei kubatira TB," (We work in dusty environments and this puts us at risk of getting TB. The village health workers here have taught us how to prevent getting TB) ***Shorai Ndalahoma***

"Ndinoziva kuti TB haina zera saka ndauya kuzoongororwa. Mari yekuenda kuchipatara inonetsa kuwana saka ndafara kuti nhasi ndirikurapwa mahara," (I know anyone regardless of age can get TB that is why I have come for screening. I do not have transport money to go to the clinic close to me so I am happy I am accessing the services at no cost. ***Eriya Kweche***

COLLAGE OF PHOTOS FROM THE COMMUNITY DURING THE OUTREACH

A client being screened for HIV and DM

Women receiving instructions from VHW before having chest X-rays taken

Mr and Mrs Gatsi from Kanyaga in Makonde District had never been screened for TB. They were all smiles after they were declared TB free.

Women receiving instructions from VHW before having chest X-rays taken

Young artisanal miners wait for their turn to be screened for TB in Chegutu

PARLIAMENT COMMITS TO END TUBERCULOSIS IN ZIMBABWE

Dr Ruth Labode (far left front row) joins other African Leaders in Durban to launch the African TB caucus in July

On July 13, 2016 in Harare, Zimbabwe Parliament made a landmark undertaking to end Tuberculosis (TB) by launching a national Caucus on TB under the theme "Uniting leadership to END TB" as part of government's commitment to end TB in the country.

The launch comes at a time when African leaders have decided to unite to push for greater domestic investment in TB care and prevention with particular focus on the twin epidemic of TB and HIV. The national caucus is in line with the global commitment by political representatives to end TB.

The Chairperson of the parliament portfolio committee Dr Ruth Labode on Health & Child Care was elected as co-Chairperson of the African TB caucus as Zimbabwe joined 18 other African countries to launch the African TB caucus during the AIDS conference that was held a week after.

In 1954 Rhodesia Association for the Prevention of Tuberculosis (RAPT) was established to champion the control of TB in the country.

It is envisaged that the continued parliamentary engagement of the Zimbabwean legislators will result in increased domestic funding for TB.

Overview of the Global TB Caucus

The Global TB Caucus is a unique international network of political representatives with support in more than 100 countries. Led by its members for its members, the members of the Caucus work collectively and individually to end the TB epidemic under the vision “A world free from TB”

Members of the Caucus adhere to the principles outlined in the founding document, the Barcelona Declaration. In particular they commit:

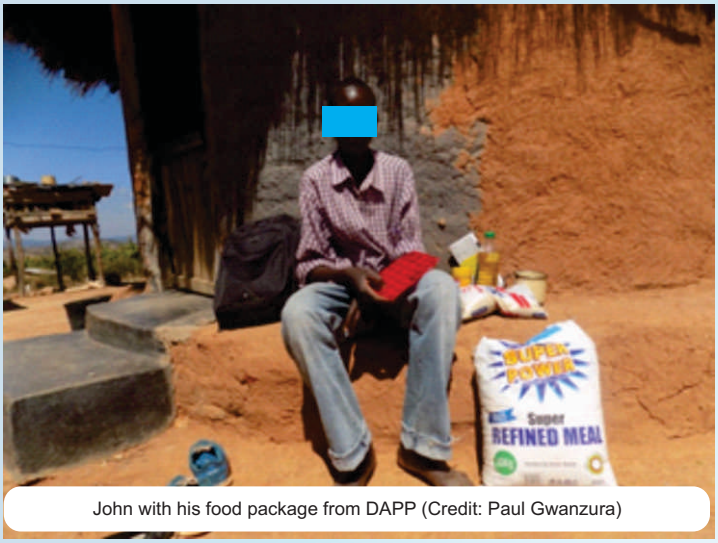
- To working across geographical and political divides in a non-partisan and inclusive fashion;
- To engaging with civil society and all other stakeholders involved in the fight against the TB epidemic; and
- To confront stigma and social isolation associated with the disease.

The Caucus is committed to developing and supporting local political representatives to lead the fight against the disease in their own context. To that end delegates have committed to establishing regional and national level Caucuses under the auspices of the Global TB Caucus.

From an initial 14 signatories to the Barcelona Declaration in August 2015, the number of Zimbabwean parliamentarians who have signed the declaration now stands at 137.

(http://www.globaltbcaucus.org/about)

DAPP SUPPORTS TB-HIV PATIENTS IN MUTASA DISTRICT



John with his food package from DAPP (Credit: Paul Gwanzura)

*John is a 17 year old boy from Nyamunokora Village in Mutasa District. He is co-infected with TB and HIV. He lives with his grandmother, a brother and two sisters. At such a tender age he is the family breadwinner juggling between school and gardening as his grandmother is too old to fully fend for his siblings who are all younger than him. He is among the hundreds of patients receiving support from Development AID from People to People (DAPP)'s TB-HIV integrated project after being identified through the door to door visits conducted by community volunteers in his area.

John was diagnosed with TB in June this year and is currently on anti-TB treatment. He knows that the disease is curable while HIV is not. He also knows that he has to continue adhering to his anti-retroviral treatment even after he gets cured of TB.


TRIO member observes John taking his TB Treatment

His diagnosis of TB

"I had fever, shortness of breath, night sweats and I was losing weight. This went on for about a month and a half while I thought that since I was HIV positive, maybe I was just experiencing some of the downsides of taking ART. I did not see the need to go to the clinic. It was when the DAPP community volunteers visited our homestead and carried out TB screening that they advised me to go to the clinic for TB testing. After being diagnosed of TB I was promptly started on treatment," explains John.

The 17 year old is thankful to DAPP for; the health education on TB/HIV, support from the TRIOs that are supervised by trained community volunteers and the food package that consists of mealie meal, peanut butter, sugar , cooking oil and beans.

Plans for the future

John who is writing his ordinary level examinations this year hopes to recover well and be able to carry out his normal duties. He wishes to join the TB and HIV awareness team of community volunteers in his area to support awareness campaigns at school and community level.

(A TRIO is a home based support approach that comprises of three people; the patient and two family members that are nominated by the patient. TRIOs ensure on going care and support to the patient on a daily basis from within his/her family.

They are trained on basic information about TB and HIV, adherence support, nutrition awareness, vegetables and fruit growing on demonstration plots, and cooking demonstrations. The TRIO representatives are provided with vegetable seeds to start their own backyard gardens.)

**John is not his real name*

In 1965: mobile X-ray unit was introduced in the country to screen mining employees and their families.

MAKING A DIFFERENCE IN COMMUNITIES: MEMORY SHARES HER EXPERIENCE IN TB-HIV WORK

Memory Paunganwa disseminating information on TB-HIV during a door to door visit (Credit: Paul Gwanzura)

Memory Paunganwa hails from Mutasa district, Ward 12, Mawoko Village. She is one of DAPP's community volunteers in the TB-HIV integrated program. She shares her experiences of the work she is doing in her community:

Before I joined DAPP TB and HIV integrated program as a Community Volunteer, I was one of the residents of Mawoko village who had misconceptions about TB-HIV. I had no idea about the existence of Village Health Workers (VHWs) up until my mother got sick and was bed ridden. A VHW would come to check on her and give her medication. Seeing what she was doing for my mother, I felt it in my heart that I wanted to save people's lives as the VHW was doing. This prompted me to be a Community Volunteer.

To equip her for her new role, Memory received a three day training from the Ministry of Health and Child Care (MoHCC) where topics such as; qualities of a good volunteer, basic information on TB and HIV, health education on TB and HIV, early identification of presumptive cases, facilitating sputum collection and referring people for HIV test, supporting and supervising clients on treatment adherence, tracing lost to follow up patients, nutrition awareness and infection control practices in the community, were covered.

She goes on with her story…

After the training I began to conduct door to door visits providing information on TB-HIV, screening people for TB, facilitating sputum collection and referring people for HIV testing. During initial days it was a challenge as people resisted the services I was giving them due to their limited knowledge about the twin epidemic. With the support from DAPP field officers and local leaders who were also capacitated in stigma reduction, I managed to penetrate and reach most people at their homes thereby maximizing confidentiality in all services provided. Even the conservative apostolic sect members started opening up and inviting me to their homes to provide these services.

Memory is grateful that her work is making a difference to people in her community. She shares that the majority of the people in her ward are now aware of their HIV status and have been screened for TB. Her hopes are to continue doing voluntary work, fighting for a TB and HIV free community.

Memory instructs and observes a TB Presumptive case cough up sputum. She also ensures that the client firmly closes the sputum mug in order to prevent the contents from leaking during transportation.

** Memory is one of the 270 community volunteers Development AID from People to People (DAPP) identified and trained as part of the TB and HIV integrated Project in Mutasa and Chimanimani districts. The project seeks to increase TB-HIV awareness, actively find TB cases and offer HIV testing services to community members in the two districts.*

ZNNP+ COMMUNITY STRUCTURES PLAY AN IMPORTANT ROLE FIGHTING TB IN HARARE

The Zimbabwe National Network of People living with HIV (ZNNP+) has been instrumental in building capacity of peer educators and District Focal Persons (DFPs) on TB prevention, treatment, Care and Support in Harare Metropolitan Province. The cadres who work on voluntary basis, are playing a very significant role as far as fighting TB is concerned, especially in their communities through bridging the gap between the community and health centers.

“Since time immemorial, we used to have community sisters, who used to visit communities for lost to follow cases and monitoring of TB patients but this is now a thing of the past, following shortage of staff at clinics. ZNNP+ Peer educators and DFPs have filled in the gap playing that important role in communities of Harare Province,” shares Mrs Manyarara, the ZNNP+ Community Focal Person.

The community volunteers frequently visit clinics to get names of lost to follow clients on TB treatment for tracking and linking them back to their respective clinics for treatment continuation. They also screen people for TB in communities using the TB screening tool and they refer all presumptive TB clients to health centers where they get early attention. Follow up is also done to check whether referred cases reach the clinics for assistance.

Why community volunteers are important in TB response,

- Assist in tracking TB lost to follow up cases
- They refer Presumptive TB cases to their nearest clinics
- They frequently visit and monitor those initiated on TB treatment.
- They raise awareness and provide health education on TB prevention, treatment, care and support.
- They also screen people for TB.

ZIMBABWE CONDUCTS AN EXTERNAL TB PROGRAM REVIEW

From page 5

in the world. NTP should coordinate a national dialogue to consider introducing use of shorter MD-RTB treatment regimens in the country.

- NTP has a good TB recording and reporting system which has recently been incorporated into the national DHIS2.
- NTP needs to continue enhancing TB research through the development of a TB research agenda based on analysis of the country's TB situation and needs.
- To ensure the continued implementation of activities in Advocacy, Communication Social Mobilization (ACSM) there is need to set aside adequate funding for Advocacy and Communication with community engagement when budgeting.

TB IN ACTION

A community leader goes through the TB News after an interview during the External TB program review field exercise in Manicaland.

KAP Survey data collection field work

COMMENDABLE STRIDES IN TB INFECTION CONTROL AT TONGOGARA REFUGEE CAMP

Chipinge District TB Coordinator, Mr. Muponda leading Tongogara Refugee peer educators in group work during TB Infection Control Training in Chipinge

TB remains a major public health problem in Chipinge District. High TB burdened areas include major congregate settings in the district namely Zimbabwe Chipinge Prison Service and Tongogara Refugee Camp. These are target areas for active case finding with a high risk of sensitive and drug resistant TB.

The occurrence of active TB in refugee camps is generally reported to be much higher than the average levels reported for the corresponding general population. This can be attributed to overcrowding and undocumented immigrants from areas with a high incidence of TB, poor nutrition status and late detection.

Tongogara has an estimated population of 12000 refugees from DRC, Rwanda, Burundi, Eritrea, Ethiopia, Somalia, Uganda, and Ivory Coast. Previously, efforts to curb TB at Tongogara Refugee camp was mainly through passive TB case finding which however was ineffective.

After noting this gap, Zimbabwe National Network of People Living with HIV working in close collaboration with National Aids Council and Ministry of Health and Child Care's AIDS and TB Unit in Chipinge District, trained peer educators from Tongogara Refugee Camp as a major strategy to empower community in TB screening and improve TB case finding in congregate settings.

Thirty trained peer educators from eight administrative camps now play a pivotal role in case finding and community education on TB prevention and treatment. Moreover, they are also acting as DOT observers. Their efforts have resulted in increased early case detection and improved adherence to TB medication, which are critical in controlling TB in the most at risk population. In addition, community education sessions have generated increased awareness on TB prevention and signs and symptoms which has helped promote early health care seeking for TB services.

As part of their commitment and efforts in TB infection control, the peer educators at Tongogara refugee camp have formed a steering committee on TB and HIV which meets monthly to review progress and gaps in TB and HIV activities.

UNITED KINGDOM PRE-DEPARTURE TUBERCULOSIS DETECTION PROGRAMME

Approximately 9,000 cases of tuberculosis are reported each year in the United Kingdom (UK). The majority of these cases are between the ages of 15 and 44, and predominately foreign-born.

Upon request by the UK Home Office, International Organization for Migration (IOM) initiated a pilot United Kingdom Tuberculosis Detection Programme (UKTBDP) for migrants applying for a six months plus visa to stay in the UK. Clients ranged from student visas, resettlement cases, family reunion cases, work visas amongst other category.

The objectives were to address public health concerns about the spread of infectious TB in the UK by preventing the entry of people suffering from the disease until they have been successfully treated, and to improve access to diagnosis and treatment of TB in the countries of the migrant's origin. The program involved screening visa applicants using chest x-ray, TB sputum smear microscopy by concentration method and TB sputum cultures on solid and liquid media, depending on, and only in cases of positive radiological findings suggestive of TB.

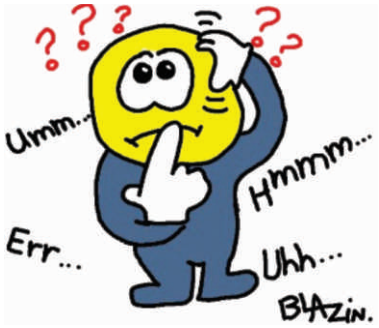
Since the start of the programme in January 2013, a total of 5022 visa applicants were screened for TB among whom 15 cases were TB positive. The latter were referred for treatment in their countries of origin. The program is still on-going with an additional 1132 clients having been screened between January and August 2016.

For more information please contact
Blessing Kanengoni on +263 772 565 898.
Alternatively, e-mail bkanengoni@iom.int.

Home Office
UK Border Agency

IOM • OIM

Competition Time



There are lots of exciting prizes to be won for participants who get the answer correct.

In which year did the Government of Zimbabwe adopt the Primary Health Care concept?

Send your answer to andrewnyambo@gmail.com and copy pmagaya@theunion.org

Submission Deadline January 31, 2017

KAP SURVEY REVEALS LOW KNOWLEDGE ABOUT TB IN COMMUNITIES

KAP Survey enumerator hands a TB pamphlet to a participant after interviewing her during the field exercise (Credit: Paidamoyo Magaya)

With support from Challenge TB, the National Tuberculosis Control Program conducted a survey to assess the community's knowledge, attitudes and practices (KAP) towards TB in five provinces of the country.

The survey revealed that the knowledge about TB was low and levels of stigma significantly high. Only 16% of the targeted population had comprehensive knowledge about TB while 81% perceived they were not adequately informed about TB. In addition, 75% were not aware of Drug Resistant TB (DR-TB) and 51% would avoid people with TB.

Communities in rural areas preferred getting information on TB from health care workers (HCWs) and community health workers whereas urban communities preferred radios and televisions.

Key findings and recommendations from the survey informed the development of the national communication strategy for TB which will guide community and communication interventions to address the gaps identified.

PHOTO MONTAGE

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