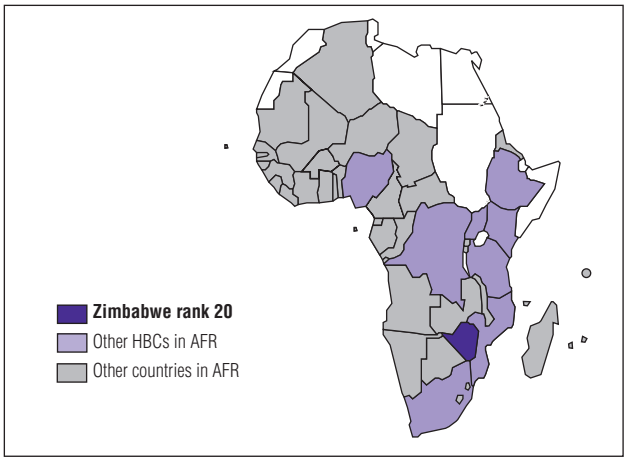
Zimbabwe

While the Zimbabwe NTP has a policy of testing TB patients for HIV, and providing ART and CPT to HIV-positive patients, no data are available on the number of patients tested or treated. There is no designated TB/HIV coordinator in either the NTP or the national AIDS control programme. Treatment outcomes are poor and have shown no improvement over the past 8 years; large proportions of patients die, default or are lost to follow-up during transfer. Funding and disbursement problems continue; budgets and funding for 2007 and 2008 are considerably lower than in previous years.

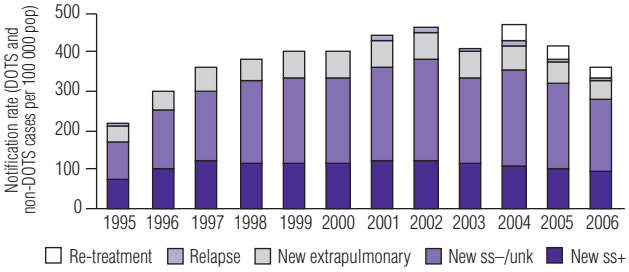
SURVEILLANCE AND EPIDEMIOLOGY, 2006

Population (thousands)[a]	13 228
Estimates of epidemiological burden[1]	
Incidence (all cases/100 000 pop/yr)	557
Trend in incidence rate (%/yr, 2005–2006)[2]	**-6.8**
Incidence (ss+/100 000 pop/yr)	227
Prevalence (all cases/100 000 pop)[2]	**597**
Mortality (deaths/100 000 pop/yr)[2]	**131**
Of new TB cases, % HIV+[bv]	*43*
Of new TB cases, % MDR-TB (1995)[c]	1.9
Of previously treated TB cases, % MDR-TB (1995)[c]	8.3
Surveillance and DOTS implementation	
Notification rate (new and relapse/100 000 pop/yr)	335
Notification rate (new ss+/100 000 pop/yr)	96
DOTS case detection rate (new ss+, %)	**42**
DOTS treatment success (new ss+, 2005 cohort, %)	**68**
Of new pulmonary cases notified under DOTS, % ss+	35
Of new cases notified under DOTS, % extrapulmonary	15
Of new ss+ cases notified under DOTS, % in women	47
Of sub-national reports expected, % received at next reporting level[d]	100
Laboratory services[3]	
Number of laboratories performing smear microscopy	180
Number of laboratories performing culture	1
Number of laboratories performing DST	1
Of laboratories performing smear microscopy, % covered by EQA	6
Management of MDR-TB	
Of new cases notified, % receiving DST at start of treatment	0.0
Of new cases receiving DST at start of treatment, % MDR-TB	–
Of re-treatment cases notified, % receiving DST	0.0
Of re-treatment cases receiving DST, % MDR-TB	–
Collaborative TB/HIV activities	
National policy of counselling and testing TB patients for HIV?	Yes (to all patients)
National surveillance system for HIV-infection in TB patients?	No
Of TB patients (new and re-treatment) notified, % tested for HIV	0
Of TB patients tested for HIV, % HIV+	–
Of HIV+ TB patients detected, % receiving CPT	0
Of HIV+ TB patients detected, % receiving ART	0

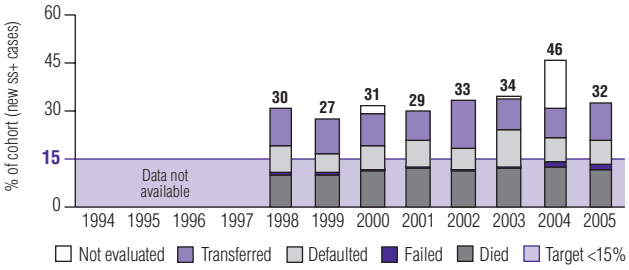
WHO Africa Region (AFR)
Rank based on estimated number of incident cases (all forms) in 2006



Case notifications
Significant decline in ss– notifications in recent years



Unfavourable treatment outcomes, DOTS
Reporting of outcomes rate improved over 2004 cohort, but outcomes of treatment showing no improvement since 1998



DOTS expansion and enhancement	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
DOTS coverage (%)	–	0.0	0.0	100	12	100	100	100	100	100	100	100
DOTS notification rate (new and relapse/100 000 pop)	–	–	–	381	400	402	440	460	411	431	385	335
DOTS notification rate (new ss+/100 000 pop)	–	–	–	117	115	114	120	124	112	112	100	96
DOTS case detection rate (all new cases, %)	–	0.0	0.0	65	65	62	63	66	59	65	63	58
DOTS case detection rate (new ss+, %)	–	–	–	50	47	45	45	46	41	44	41	42
Case detection rate within DOTS areas (new ss+, %)[e]	–	–	–	50	409	45	45	46	41	44	41	42
DOTS treatment success (new ss+, %)	–	–	–	70	73	69	71	67	66	54	68	–
DOTS re-treatment success (ss+, %)	–	–	–	–	66	65	61	63	62	53	60	–

IMPLEMENTING THE STOP TB STRATEGY[1]

DOTS EXPANSION AND ENHANCEMENT

Political commitment, standardized treatment, and monitoring and evaluation system

Achievements
- Finalized national strategic plan for TB control 2006–2010
- Revised NTP manual
- Produced annual report of NTP activities

Planned activities
- Train health workers on DOTS
- Distribute new NTP manual

Quality-assured bacteriology

Achievements
- Developed plan for training of laboratory technicians, including training by NRL of 45 microscopists in smear microscopy, malaria microscopy and HIV rapid testing
- Procured reagents and materials to resume culture and DST
- Provided support and supervision to peripheral-level laboratories

Planned activities
- Train laboratory technicians
- Secure external technical assistance for DST

Drug supply and management system

Achievements
- Developed plan for nationwide adoption of FDCs

Planned activities
- Train health workers on FDC management and initiate distribution of FDCs
- Carry out forecasting and quantification exercise to guide improved management of anti-TB drug stocks
- Train health providers on drug management

TB/HIV, MDR-TB AND OTHER CHALLENGES

Collaborative TB/HIV activities

Achievements
- Developed plan to strengthen collaboration between NTP and NAP
- Set up a national coordinating body
- Revised monitoring and evaluation tools to capture HIV information

Planned activities
- Develop comprehensive policy on collaborative TB/HIV activities
- Develop guidelines on TB/HIV for health providers
- Pilot test provision of IPT in selected health centres

Diagnosis and treatment of multidrug-resistant TB

Achievements
- Published national guidelines for treatment of MDR-TB
- Developed MDR-TB/XDR-TB emergency strategic plan

Planned activities
- Update MDR-TB guidelines
- Finalize MDR-TB/XDR-TB response plans

High-risk groups and special situations

Achievements
- Screened prisoners for TB on admission
- Implemented TB diagnosis and treatment in prisons

Planned activities
- Provide transport free of charge to TB patients

HEALTH SYSTEM STRENGTHENING, INCLUDING HUMAN RESOURCE DEVELOPMENT

Achievements
- Involved broad range of partners from health and other sectors in planning for TB control

Planned activities
- None reported

ENGAGING ALL CARE PROVIDERS

Achievements
- None reported; no formal PPM activities in place

Planned activities
- Revise PPM policy and guidelines
- Train private health providers on TB diagnosis and treatment in line with NTP guidelines
- Disseminate ISTC

[1] Unless otherwise specified, achievements are for financial year 2006; planned activities are for financial year 2007.

EMPOWERING PEOPLE WITH TB, AND COMMUNITIES

Advocacy, communication and social mobilization

Achievements

- Commemorated World TB Day

Planned activities

- Commemorate World TB Day
- Develop ACSM strategy
- Develop multimedia information package to raise awareness of TB

Community participation in TB care

Achievements

- Involved community members in some districts in referral of suspects and DOT, but without formal training
- Provided travel warrants enabling patients to travel to hospital for follow-up

Planned activities

- Develop strategy for community-based TB care
- Involve communities in all districts in TB suspect referral and DOT, with support from NGOs and formal training for community members
- Develop alternative mechanism to provide transport to patients, as current system relies on transport operators accepting warrants, which they are reluctant to do given reimbursement delays

Patients' Charter

Achievements

The Patients' Charter was published in 2006 and was therefore not available for use in countries until then.

Planned activities

- None reported

RESEARCH, INCLUDING SPECIAL SURVEYS AND IMPACT MEASUREMENT

Achievements

- None reported

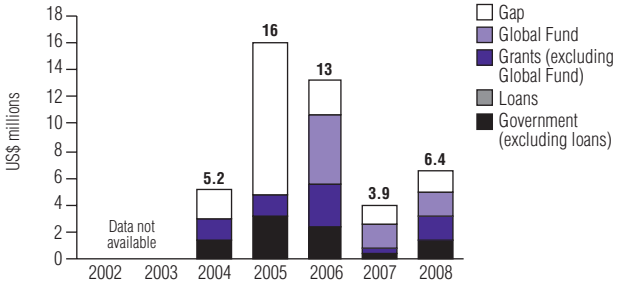
Planned activities

- None reported

FINANCING THE STOP TB STRATEGY

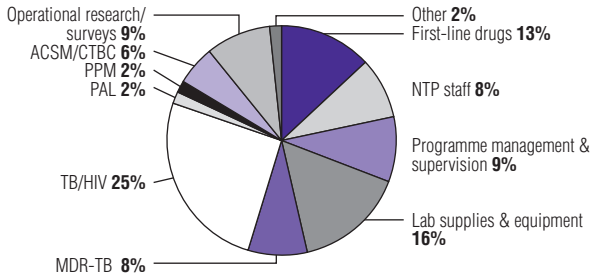
NTP budget by source of funding

Decreased budget reported in 2007 and 2008 despite 27% increase in expected number of patients to be treated in 2007 compared with 2006



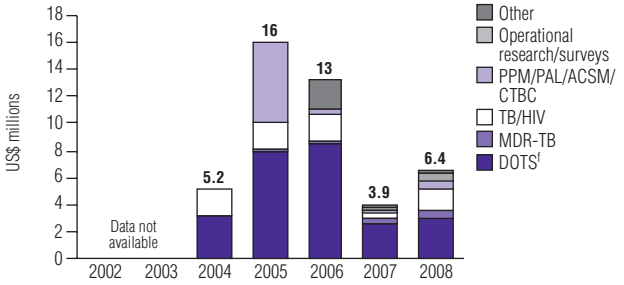
NTP budget by line item, 2008

Largest share of budget is for DOTS component (45%) and collaborative TB/HIV activities (25%)



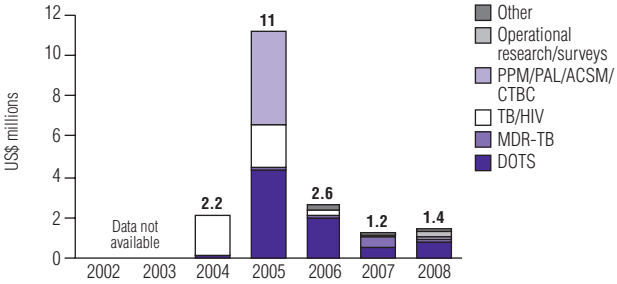
NTP budget by line item

Decreased funding within DOTS component mainly due to reduced budget for first-line drugs and routine programme management and supervision activities



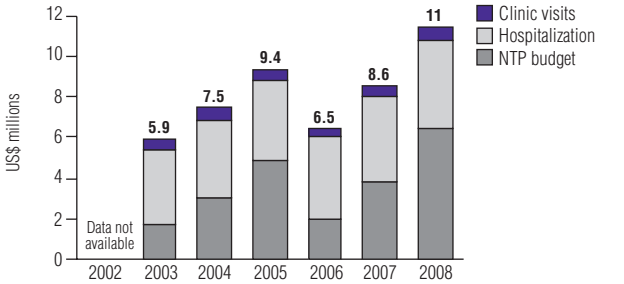
NTP funding gap by line item

Funding gap within DOTS component mainly for dedicated NTP staff and first-line drugs



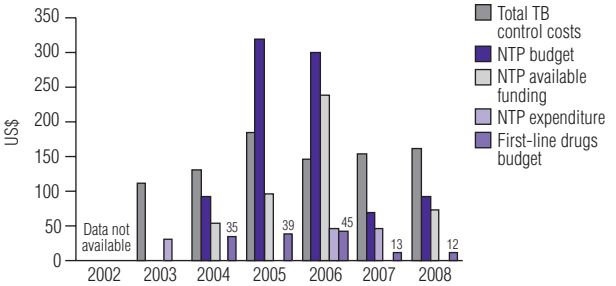
Total TB control costs by line item[4]

Hospitalization costs are for 1660 estimated dedicated TB beds



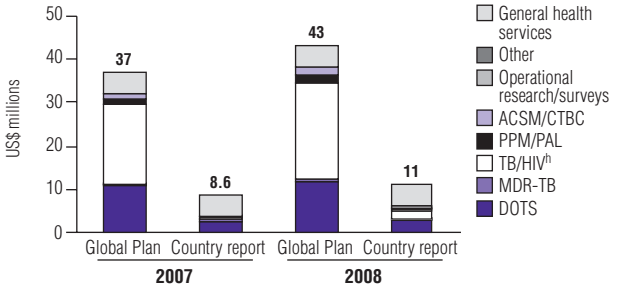
Per patient costs, budgets and expenditures[5]

Cost and budget per patient substantially lower in 2007 and 2008 compared with the previous two years



Comparison of country report and Global Plan:[g] total TB control costs, 2007–2008

Substantial differences between country report and Global Plan; Global Plan allows DOTS budget to increase in line with expected number of patients whereas country report does not; big discrepancy in TB/HIV costs, as in several other HBCs



NTP budget and funding gap by Stop TB Strategy component

(US$ millions)	2007 BUDGET	2007 GAP	2008 BUDGET	2008 GAP
DOTS expansion and enhancement	2.6	0.6	3.0	0.9
TB/HIV, MDR-TB and other challenges	1.0	0.6	2.2	0.1
Health system strengthening	0.02	0.02	0.1	0.05
Engage all care providers	0.02	0.02	0.1	0.05
People with TB, and communities	0.1	0.03	0.4	0.03
Research	0.1	0.04	0.6	0.3
Other	0.05	0.03	0.1	0.04

Financial indicators for TB

Government contribution to NTP budget (including loans)	9.1%	21%
Government contribution to total cost of TB control (including loans)	59%	55%
NTP budget funded	68%	78%
Per capita health financial indicators (US$)		
NTP budget per capita	0.3	0.5
Total costs for TB control per capita	0.7	0.9
Funding gap per capita	0.1	0.1
Government health expenditure per capita (2004)	13	
Total health expenditure per capita (2004)	27	

SOURCES, METHODS AND ABBREVIATIONS

[a–h] Please see footnotes page 169.

1 Incidence, prevalence and mortality estimates include patients infected with HIV. Incidence estimate originally based on assumption of 60% ss+ case detection rate in 1997 (DOTS and non-DOTS). Trend in incidence estimated from 3-year moving average of notification rate (new and relapse, DOTS and non-DOTS).

2 MDG and STB Partnership indicators shown in bold. Targets are 70% case detection of smear-positive cases under DOTS, 85% treatment success, to ensure that the incidence rate is falling by 2015, and to reduce incidence rates and halve 1990 prevalence and mortality rates by 2015. Estimates for 1990 are prevalence 246/100 000 pop and mortality 47/100 000 pop/yr.

3 For routine diagnosis, there should be at least one laboratory providing smear microscopy per 100 000 population. To provide culture for diagnosis of paediatric, extrapulmonary and ss-/HIV+ TB, as well as DST for re-treatment and failure cases, most countries will need one culture facility per 5 million population and one DST facility per 10 million population.

4 Total TB control costs for 2003 and 2006 are based on expenditure, whereas those for 2004–2005 are based on available funding, and those for 2007–2008 are based on budgets. Estimates of the costs of clinic visits and hospitalization are WHO estimates based on data provided by the NTP and from other sources. See Methods for further details.

5 NTP available funding for 2004–2006 is based on the amount of funding actually received, using retrospective data; available funding for 2002–2003 and 2007–2008 is based on prospectively reported budget data, and estimated as the total budget minus any reported funding gap.

– indicates not available; pop, population; ss+, sputum smear-positive; ss–, sputum smear-negative pulmonary; unk, pulmonary – sputum smear not done or result unknown; yr, year.