



THIRD SESSION – EIGHTH PARLIAMENT

SPECIAL REPORT

**OF THE PORTFOLIO COMMITTEE ON HEALTH AND CHILD CARE ON
PUTTING TUBERCULOSIS ON THE POLITICAL AGENDA: THE ROLE OF
PARLIAMENTARIANS IN SUPPORTING TUBERCULOSIS CONTROL IN
ZIMBABWE.**

Presented to Parliament November, 2015

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ORDERED IN TERMS OF STANDING ORDER No. 17:

- (1) At the commencement of every session, there must be as many committees to be designated according to government portfolios as the Standing Rules and Orders Committee may deem fit.
- (2) Each select committee must be known by the portfolio determined for it by the Standing Rules and Orders Committee.

TERMS OF REFERENCE OF PORTFOLIO COMMITTEES S.O 20

Subject to these Standing Orders, a Portfolio Committee must-

- (a) examine expenditure administration and policy of government departments and other matters falling under their jurisdictions as Parliament may, by resolution determine;
- (b) consider and deal with all Bills other than a Constitutional Bill and statutory instruments or other matters which are referred to it by or under a resolution of the House or by the Speaker;
- (c) consider or deal with an appropriation or money Bill or any aspect of an appropriation or money Bill referred to it by these Standing Orders or by or under resolution of this House; and
- (d) monitor, investigate, enquire into and make recommendations relating to any aspect of the legislative programme, budget, policy or any other matter it may consider relevant to the government department falling within the category of affairs assigned to it, and may for that purpose consult and liaise with such department;
- (e) consider or deal with all international treaties, conventions and agreements relevant to it, which are from time to time negotiated, entered into or agreed upon.

On Thursday, 24 September 2015, the Speaker announced that the Committee on Standing Rules and Orders nominated the following members to serve on the Portfolio Committee on Health and Child Care

Hon. Bhuda S.
Hon. Chibagu G.
Hon. Dr. Chimedza P.
Hon. Chivamba K.
Hon. Kachepe N.
Hon. Dr. Labode R.
Hon. Madzinga P.
Hon. Mahiya M.
Hon. Majaya B.
Hon. Makweya M.
Hon. Mapiki J.
Hon. Dr. Mataruse P.
Hon. Matsunga S.
Hon. Matuke L.
Hon. Mguni N.
Hon. Moyo L.
Hon. Mufunga A.
Hon. Munengami F.
Hon. Ndlovu M.S
Hon. Ndoro L.
Hon. Nkomo M.
Hon. Sibanda P.D
Hon. Sibanda L.
Hon. Simbanegavi Y.
Hon. Tshuma D.
Hon. Vutete M.
Hon. Zhou P.
Hon. Zwizwai M.

Hon. Dr. Labode to be Chairperson

1.0 INTRODUCTION

- 1.1 Members of the Portfolio Committee on Health and Child Care together with the Thematic Committee on HIV/AIDS attended a two-day Workshop organized by the Ministry of Health and Child Care (MoHCC) in conjunction with the World Health Organisation at the Kadoma Ranch Motel from 31 July to 1 August 2015. The Workshop was held under the theme: - **Putting Tuberculosis (T.B) on the Political Agenda**. Members at the workshop also visited Kadoma General Hospital to appreciate the operations of the hospital.
- 1.2 Hon. Dr. Ruth Labode, the Chairperson of the Portfolio Committee on Health, gave the opening remarks in which she thanked the Ministry of Health and Child Care for spearheading the collaborative efforts that would give the Members of Parliament an opportunity to work with their communities on an informed platform and bring to the fore issues that affect the communities they live in and work with on TB, and as well ensure that people have access to appropriate medication.

2.0 WORKSHOP OVERVIEW

- 2.1 The Meeting received updates on the Implementation of T.B/HIV Collaborative efforts Globally and Nationally.
- 2.2 **Global Perspective**
 - 2.2.1 Globally HIV associated T.B remains a major public health concern;
 - 2.2.3 One third of 35 million People Living with HIV (PLHIV) worldwide are infected with latent T.B;
 - 2.2.4 Persons co-infected with T.B and HIV are 30 times more likely to develop active TB disease;
 - 2.2.5 TB is the most common presenting illness among PLHIV including those who are taking ART;
 - 2.2.6 TB is the leading cause of death among PLHIV accounting for 1 in 5 HIV related deaths; and
 - 2.2.7 PLHIV face emerging threats of Multiple Drug Resistant-Tuberculosis (MDR-TB) and Extensively Drug Resistant-TB (XDR-TB).
- 2.3 **Country Perspective**

Zimbabwe like other 22 highly burdened countries in the world with the prevalence of T.B continues to be severely hamstrung by the dual T.B-HIV epidemic.

 - There is HIV prevalence among 15 - 49 year group of 15% (Zimbabwe Demographic Health Survey 2010/11);
 - The current estimation of T.B prevalence is 345/100,000 population; and
 - There is 69% HIV co-infection in all T.B cases (Global TB Report 2014).
- 2.4 **HIV Epidemic in Zimbabwe**

There is a National adult HIV prevalence (15 to 49 years) of estimated 15% (2013 HIV Estimates). The following have been identified as best practices in tackling the Epidemic:

 - There is need to set up coordinating bodies for effective TB/HIV activities at all levels;

- The need to conduct surveillance of HIV prevalence among TB cases;
 - Need to carry out joint TB/HIV planning;
 - Urgent need to monitor and evaluate collaborative TB/HIV activities;
 - Establish intensified TB case finding;
 - Ensure TB infection control in health care and congregate settings;
 - Decrease burden of HIV among TB patients;
 - Provide HIV testing and Counseling;
 - Introduce HIV prevention methods holistically;
 - Introduce co-trimoxazole preventive therapy;
 - Ensure that there is HIV/AIDS care and support;
 - Make ARV's accessible at all levels in Zimbabwe; and
 - Escalate the Implementation of TB/HIV Collaborative Activities in Zimbabwe.
- 2.5 It was observed that while significant milestones have been attained in strengthening TB/HIV collaborative efforts in the country, there is, however room for improvement in the following areas: Improving Anti-Retroviral Drugs coverage among TB/HIV co-infected, Improvement of TB infection control and the need for mobilizing resources for the management of dual epidemics.
- 3.0 GENERAL OUTLINE OF THE EPIDEMIC IN ZIMBABWE**
- 3.1 The Committees received an outline of the different types of TB.
- 3.2 Drug-resistant Tuberculosis (DR-TB)**
This is the type of tuberculosis (TB) caused by a bacterium (*Mycobacterium tuberculosis*) that has developed a genetic mutation(s) such that a particular drug (or drugs) is no longer effective against the bacteria (See Notes).
- 3.3 TB Treatment in Zimbabwe**
The following is an outline of the cost of treatment of TB in Zimbabwe;
Drug susceptible TB – 6 to 9 months \$31;
Multidrug resistant TB – 20 to 24 months \$2571; and
Extensively Drug Resistant TB – 24 to 36 months \$31000
In this regard, with the economic strains facing the country, prevention and control of the disease becomes key to TB management in the country.
- 4.0 ADVOCACY COMMUNICATION AND SOCIAL MOBILIZATION AND COMMUNITY TB**
- 4.1 It has become imperative to note that the TB disease mostly impacts people in the prime of their lives, from age 15–50, decreasing their ability to contribute to their country's economy and to support their families.
- 4.2 In this regard, there is need to have a broad set of coordinated interventions designed to place TB high on the political agenda, foster political will and increase financial and resource allocations.
- 4.3 Apart from availing the necessary resources, the following interventions should be done:
- partnership meetings, parliamentary debates on the epidemic, political events to highlight the problem, bilateral negotiations, petitions to relevant authorities, campaigns, mass media support and audiovisual and written communications on the subject matter, TB.

5.0 TB LABORATORY AND DAGONSTIC SERVICES

- 5.1 The meeting received a presentation on the Laboratory and Diagnostic services that are provided which are key to the early detection and treatment of TB.
- 5.2 It was noted that; the geological spread of the system is as follows:
2 Reference Laboratory (NTRL);
5 Central/ National Hospital Laboratories;
10 Provincial Hospital Laboratories;
180 District/ Mission Hospital Laboratories; and
1000 Healthcare Centres/ Clinics Laboratories
- 5.3 The following challenges were observed with regards to Laboratory and Detection Systems:
- That Staffing levels are low;
 - There are skills flight of (54% staffing levels) (which is a worrisome situation);
 - In essence, the remaining staff is over-stretched;
 - There is reduced intake of students into the field at Universities and Colleges;
 - Generally, there is inadequate funding for most activities;
 - There are challenges in infrastructure, with some labs constructed before independence which do not conform to current international standards;
 - The preponderance to have obsolete equipment which face recurrent breakdowns and are expensive to maintain;
 - There is donor fatigue with most activities either being scaled down or closed totally; and
 - There is a skewed distribution of TB lab services.

6.0 INVESTING IN TB

- 6.1 In their presentation, the MoHCC highlighted that in eight low-income high-burden TB countries (HBCs), domestic funding represents less than 7% of National TB budget needs. Despite the critical need for increased TB resources, donor funding for TB decreased by nearly 10% in 2014 (Zimbabwe Scenario). Again this situation is a cause for concern.
- 6.2 The TB Programme is funded from GOZ, the Global Fund and many other partners.
- 6.3 The budgetary constraints in the economy continues to affect the revenue streams to the Treasury thereby affecting adequate allocations to the Ministry of Health & Child Care.
- 6.4 It can be observed that there is a funding gap which is used to determine if there is a difference between desired financial performance and actual performance.
- 6.5 There is need to improve domestic TB financing initiatives to avert the risk of foreign funding drying up. The National Aids Council (NAC) should also set aside a defined proportion of TB activities and financing.

7.0 PUTTING TB ON THE POLITICAL AGENDA- ROLE OF PARLIAMENTARIANS IN SUPPORTING TB CONTROL IN ZIMBABWE

- 7.2 Presenting a paper, Hon. P.D Sibanda delivered the major oversight roles of the Legislative arm which involves: Monitoring, investigating, enquiring into and making recommendations relating to any aspect of the legislative program, budget, policy or any other matter that may be considered relevant to the Government. Since Parliament has a say in the Budget process it can leverage its influence to allow for more resources towards TB Programs in the Country.
- 7.3 Parliamentarians are the voice of the poor and other vulnerable groups and should ensure that development plans are informed by the real priorities on the ground and, by adopting requisite legislation.
- 7.4 Parliamentarians face the harsh reality of lack of halfway houses for Multi Drug Resistant patients, lack of sufficient nutritional diet, lack of adequate awareness, lack of resources to transfer sputum from remote health centers to hospitals with laboratories for tests and lack of access to health facilities as some of the common challenges which were hampering the control of Tuberculosis in Zimbabwe.
- 7.5 In this regard, there is need for Legislators to constantly liaise with medical authorities in their constituencies to assist, where possible in dealing with challenges that they may be facing, to disseminate TB related information during feedback meetings. Legislators should be catalysts for provision of required resources for health institutions and communities to properly deal with TB and access TB treatment, e.g. halfway houses, nutritional food, adequate laboratories, motor vehicles and other accessories.
- 8.0 WHO GLOBAL END STRATEGY**
- 8.1 The Legislators were exposed to the Parliamentarians Global TB Summit which was founded in October 2014 following a meeting of parliamentarians from around the world who are committed to fighting TB. The Global TB Caucus is an International network of Parliamentarians who are committed to the fight against tuberculosis (TB).
- 8.2 The first meeting, held in Barcelona 2014, was the inaugural Global TB Summit.
- 8.3 The Barcelona Declaration is an initiative of the Global TB Caucus. It is a representation of the worldwide political commitment to end the TB epidemic.
- 8.4 A second Global TB Summit is planned to take place in Cape Town at the end of November 2015.
- 8.5 To show how serious the initiative is, by 29 July 2015: 488 Parliamentarians from 72 countries had managed to sign the Barcelona Declaration.
- 8.6 Members of Parliament present, managed to sign the Declaration. They took up the challenge educate and engage their political colleagues about the disease and the Declaration and also urge them to sign up.
- 9.0 VISIT TO KADOMA GENERAL HOSPITAL**
- 9.1 The attendees to the Workshop took time to visit the Kadoma General Hospital which put to light all the concerns that were raised during the Workshop. The Medical Staff led by Dr. Munyaradzi, the Medical Superintendent took the Committee Members

through the state of the Hospital and highlighted the following problems and observations:

- Erratic supplies of running water;
- The Boiler is out of service;
- The Hospital is in dire need of repainting;
- There is no air-conditioning in the main theatre;
- Since the year 2013, the Mortuary has been down;
- The hospital has 5 Ambulances and one service vehicle. The service vehicle faces frequent breakdowns to an extent that food is sometimes delivered in an Ambulance;
- The Hospital has no dental therapist;
- The Hospital, up to the time of the visit had only received US\$10 000.00 from Treasury;
- The hospital tests up 500 sputum per month under very difficult circumstances;
- Of the \$230 000.00 budgetary allocation to the hospital, only received US\$10 000. 00 was released by July 2015.
- The generator has no switch changeover despite it having been paid for by the previous management;
- In the children's wards, mothers sleep on the floor whilst attending to the children.

In summary these are some of the problems being faced by the Hospital.

10.0 WAY FORWARD

The following observations were made as recommendations:

- 10.1 Parliamentarians as representatives of the people should spearhead Community response to TB.
- 10.2 There is need to resuscitate well-known TB Centres such as Chest Centre in Bulawayo, Makumbe Centre, Driefontain (Muwonde), Gwanda and others and close the long distances gap to health facilities that provide adequate TB testing and treatment facilities.
- 10.3 Government should move swiftly to reduce the exorbitant cost of 2nd line TB treatment.
- 10.4 The State should provide an enabling environment to allow for retention of staff. The Human resource establishment was last reviewed in the 80s.
- 10.5 Government should warm up to its responsibility of providing domestic funding for TB.
- 10.6 TB among prisoners and artisanal miners should be a top priority issue and needs to be addressed with the urgency it deserves.
- 10.7 The Health budget for TB at 7 percent is a mockery as compared to the devastating effects of the disease.
- 10.8 Capacity Building Programmes for Parliamentarians are the key to involving them as

Community advocates to the epidemic. The programme such as the Kadoma Advocacy Workshop should extend to all Members of Parliament and Staff in Government Departments.

- 10.9 There is need to Screen Parliamentarians for T.B., as Community Leaders they become exemplary.
- 10.10 Committee Members should encourage others to sign the Global TB Caucus Barcelona Declaration. An effort should be made to allow Members of the Committee to attend the Cape Town Meeting.

11 ACTION POINTS FROM PARLIAMENTARIANS

- 11.1 Legislators should influence the allocation of sufficient resources for TB.
- 11.2 Members of Parliament should put TB on the political agenda
- 11.3 Parliament should closely monitor the disbursement of allocated budgetary funds towards TB.
- 11.4 Members of Parliament should push for revision of budgetary priorities towards Health in general. The National Budget allocates only 8% of its recurrent expenditure for disease control
- 11.5 There is an urgent need to establish a taskforce to advance TB issues at Parliament. A Committee with a shared perspective should be set up to work out the modalities of operation.
- 11.6 Parliamentarians should be empowered with information to raise awareness on TB in and out of Parliament.
- 11.7 Initiatives should be made to integrate TB programmes into existing development meetings that are routinely held in Constituencies.
- 11.8 More liaison needs to be made with Provincial Medical Directors (PMDs) and District Medical Officers (DMOs) to establish TB gaps and address them swiftly and appropriately.
- 11.9 The Committee should lobby the donors and Minister of Finance to invest more in TB Programme
- 11.10 The management of DR-TB in Zimbabwe is an integral component of the National Tuberculosis Control Program (NTP). The aim is to provide the best possible outcomes for patients and the program through: - early detection of DR-TB cases.
- 11.11 Once the diagnosis has been made/established, there should be prompt initiation of appropriate therapy.

12.0 COMMITTEE RECOMMENDATIONS

The Committee recommends that:

- 12.1 The Ministry of Health and Child Care should ensure that at least 40% of 2016 recurrent budget be allocated to the disease control line item, instead of present situation where the ratio is 6:1 in favour of curative services.
- 12.2 The Ministry of Health and Child Care must as a matter of urgency include in the 2016 budget the recurrent of mobile clinics, so as to improve access to:
 - a) Early diagnosis;
 - b) Early initiation of appropriate treatment;
 - c) Monitoring and Evaluation of the treatment response.
- 12.3 The Ministry of Health and Child Care must ensure that National Pharmaceutical Company of Zimbabwe as the drug procuring and distribution agent for government, is allocated adequate funds in the 2016 budget to be able to facilitate the continuous availability of drugs. This would reduce new strain of tuberculosis called Multiple-Drug-Resistant-Tuberculosis which is expensive and difficult to manage.

13.0 CONCLUSION

- 13.1 The Committee is of the opinion that there is need to include TB activities into the main activities of Parliament's work and called for sustained action from Government to combat the disease. It is in this regard, that sustained lobbying should be made on the Executive to prioritize the disease while politicians should continuously foster synergies that will allow for the epidemic to be put on the political agenda.
- 13.2 The Committee through the Speaker's Office is encouraging all Members of Parliament to sign the Barcelona Declaration attached to this report.

NOTES

Types of Drug resistance

Drug-susceptible: No resistance to any first-line anti-TB drugs (HRZE).

Monoresistance: Resistance to one first-line anti-TB drug.

Polyresistance: Resistance to more than one first-line anti-TB drug other than isoniazid and rifampicin.

Multidrug resistance (MDR): Resistance to at least isoniazid and rifampicin, the two most potent anti-TB drugs.

Extensive drug resistance (XDR): MDR plus resistance to at least one of the fluoroquinolones, and at least one of three injectable second-line drugs (capreomycin, kanamycin, and amikacin).

The burden of MDR or XDR-TB is not known in the country

The last TB-DRS was conducted in 1994-95 and it found MDR-TB in 1,9% (95% CI 1,1-3,3) of new TB cases and 8,3% (95% CI 2,9-21,8) of previously treated cases

Based on this survey and the 2013 notifications, WHO estimated that the country had 820 MDR cases among all TB cases in 2014.

This means that the estimated number of XDR patients in 2014 was around 89.

There are two main forces driving the DR-TB pandemic globally.

The first is generation of DR-TB through mismanagement of patients being treated for pan-susceptible disease.

The second is ongoing transmission of drug-resistant TB in the community.

The Barcelona Declaration

We, the undersigned, as political representatives of various peoples of the world, recognising that every man, woman and child should be able to live their lives free from the tyranny of disease, HEREBY DECLARE:

1. That tuberculosis (TB) has killed a greater number of people than any other infectious disease in human history and continues to be responsible for 1.5 million deaths a year, often affecting the most vulnerable, and that it should be a global political priority.
2. That the current rate of progress in combatting TB is too slow, such that the disease will remain a threat to the social and economic wellbeing of millions of citizens around the world for centuries to come, and that accelerating progress against the disease should be recognised by all governments to be in the interests of all.
3. That drug-resistant TB demonstrates a collective failure to address the disease properly, imposing an often unbearable burden of treatment on patients and threatening to set back progress against the disease at the grave cost of millions of lives, and that it should be the focus for urgent action.
4. That the current drugs for TB treatment are inadequate, that vaccines and diagnostics are insufficient, and that the commercial market for pharmaceutical development has failed TB patients.
5. That TB imposes on patients a triple burden, combining the devastating health impact of the disease itself, the harsh burden of treatment, and the isolation of social exclusion driven by stigma and fear, and that these problems should be addressed holistically by national health programmes.
6. That TB co-infections such as HIV and diabetes compound the challenges faced by patients during treatment, hindering efforts to reduce rates of disease and increasing the mortality and morbidity associated with TB, and that healthcare systems should integrate programmes for key co-infections. We therefore commit to use all the means at our disposal to urge sustained action from our governments, to secure the necessary international and domestic resources to combat TB, and to press for the prioritisation of the disease on political agendas, specifically:
7. To demand that every patient, regardless of who they are, where they live, or their ability to pay, shall have access to quick, accurate diagnosis and high quality treatment, and that TB diagnosis and treatment never result in the impoverishment of patients or their families.
8. To call for a model of research and development that is driven by public health need and will support and enhance existing pipelines of desperately needed new drugs, diagnostics and vaccines, to ensure that new treatments are accessible and affordable for the patients who need them.
9. To insist that patients and vulnerable groups are placed at the heart of the response to the disease, supporting the engagement of communities and civil society groups in every aspect of TB prevention, detection, and treatment, puncturing stigma and giving patients a stronger voice in the response to the epidemic. And to this effect WE HEREBY AGREE to establish a new global parliamentary caucus to press

for a more effective response to the TB epidemic, working with official organisations including the World Health Organisation, UNITAID, the Global Fund, the Stop TB Partnership, the Union and UNAIDS, and with nongovernmental organisations across the world, reaching across political and geographical divides and seeking to build commitment in our own countries and beyond, to secure an end to the TB epidemic within a generation.

Signed by:
