

CORRESPONDENCE

Preparing national tuberculosis control programmes for COVID-19

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Dear Editor,

We read with interest the article by Pang and colleagues¹ on the impact of COVID-19 on tuberculosis (TB) control in China, where it is postulated that restricted movement, increased time spent indoors, treatment interruptions and fear of travelling to health facilities could disrupt TB control efforts.

Sub-Saharan Africa is bracing for the inevitable storm that is about to come from COVID-19.^{2,3} Zimbabwe, in southern Africa, has to date reported nine cases and one death.⁴ The country has gone into lockdown to try and prevent community transmission and spread as much as possible. The Stop TB Partnership has issued guidance about how people with TB can protect themselves and how TB control programmes might adapt to the onslaught of COVID-19 and the lockdowns.⁵ This global advice is augmented by an urgent call for practical planning for COVID-19 in Africa.⁶

In this article, we have used Zimbabwe as an example of a high HIV and TB burden setting that is under threat to illustrate the response needed. In this regard, the Ministry of

Health and Child Care (MOHCC) through its National Tuberculosis (NTP) and HIV/AIDS Control Programmes (NAP) is preparing for continued delivery of essential TB-HIV services in this new environment of restricted movement.

First, the MOHCC has asked its funding partners to partly re-channel funds towards providing personal protective equipment (PPE) to all health facilities, especially in urban settings where the risk of contact with people who are asymptomatic and symptomatic for COVID-19 may be higher.

Second, the NTP will procure many more sputum containers in the expectation that increasing numbers of people will present with cough and fulfil criteria for presumptive TB. Rather than have patients arrive at health facilities that could easily become overcrowded, mechanisms are being developed for sputum specimens to be collected in batches through community health workers. If people with a cough do appear in outpatient departments, attention will be given to triaging, cough etiquette, hand hygiene and social distancing of 2 meters between individuals. Special care is needed for laboratory personnel handling these specimens to ensure they are not contaminated with droplets of coronavirus SARS-CoV-2. Mechanisms to continue HIV testing and referring HIV-positive patients to clinics providing antiretroviral therapy will be put in place. Attempts are also being made to procure SARS-CoV-2 cartridges for use on GeneXpert (Cepheid, Sunnyvale, CA, USA) machines to test how many patients presenting with a cough have COVID-19.

Third, the NTP will look to provide TB patients currently receiving weekly supplies (during the intensive phase) with monthly supplies of anti-TB medicines, and up to 3-month supplies for the continuation phase of treatment. This will help to limit their need to travel to health facilities. With the help of funding partners, community health care workers will be incentivised to contact patients who have missed their scheduled appointments by either phone or household follow-up visits. These visits can also be used to deliver anti-TB drugs, enquire about household contacts and consider TB preventive therapy and HIV testing.

Finally, the NTP (working in close collaboration with the NAP) will distribute a fact sheet in the local languages about COVID-19: how it is transmitted, the symptoms and signs, and how it can be prevented. The unknowns are when the storm will arrive, how severe it will be and how long it will last. The Ebola virus disease outbreak in Sierra Leone and Liberia in 2014 took the two West African countries by surprise. The restrictions in travel, “no touch” policies and community fear of health facilities adversely affected the ability of the NTPs to diagnose TB, to continue with HIV testing and, in the case of Liberia, ensure good treatment

outcomes.^{7, 8} Preparedness is key. Guinea was able to weather the Ebola virus storm and managed to uphold TB services during this difficult period.⁹

Over the past decade, Zimbabwe has documented a gradual decrease in TB case notification rates (Figure), largely through scaling up of antiretroviral therapy to its HIV-infected population and through implementation of sound TB control policies.¹⁰ If the mechanisms proposed by the NTP can be rapidly implemented and policy and practice adapted to the situation at hand, patients with presumptive and diagnosed TB should continue to be well served. In this way, the TB case notification trajectory should continue to gradually decline and treatment outcomes should not be adversely affected. We look forward to hearing how other TB programmes are preparing for COVID-19.

Conflicts of interest: none declared.

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Figure TB case notification rate per 100,000, Zimbabwe, 2010–2019.

