



Published on *AIDSFree* (<https://aidsfree.usaid.gov>)

[Home](#) > [Resources](#) > [AIDSFree Guidance Database](#) > [TB Guidance Database](#) >

---

## Zimbabwe

The following provides a summary of specific guidelines from the country's national TB guidance strategy. Use the jump links in yellow to access details on case definitions, diagnostic methods, standard protocols, and DOTS recommendations. This summary can be downloaded or e-mailed to yourself or a colleague. The original country guidance document can also be found below the jump links for download.

**Patient Population** [Download summary page as PDF](#) [E-mail this page](#)

### Suggest Updates

- [Adults](#)
- [Children](#)

### Adults

### Year Issued:

2010

### TB Screening Frequency for PLHIV:

All PLHIV should be screened for TB at every contact with health services

### Screening Recommendations during TB Treatment:

**New sputum smear positive PTB:** Examine sputum at end of months 2, 5, 6.

**New sputum smear negative TB:** Examine sputum at month 2 only, thereafter by clinical monitoring.

**Previously treated sputum smear positive PTB:** Examine sputum at the end of Months 3, 5, 8.

### Case definition:

The following are bacteriological definitions of pulmonary TB:

- Pulmonary tuberculosis, sputum smear-positive (PTB+)
- One or more sputum smear examinations positive for AFB (irrespective of quantity of AFBs seen on microscopy).
- Pulmonary tuberculosis, sputum smear-negative (PTB-)
- Two or more negative smears, and
- Radiographic abnormalities consistent with active PTB as determined by a clinician, and
- Decision by a medical officer to treat with a full course of anti-TB medicines and
- Following failure to respond to an adequate course of broad-spectrum antibiotics (not including fluoroquinolones, streptomycin and other anti-TB medicines). All HIV positive patients should receive a course of broad spectrum antibiotics. The response to treatment should no longer be used to diagnose PTB in PLHIV as they may have two or more chest infections including PTB.

Such patients are likely to improve on broad spectrum antibiotics and PTB will be missed - This group includes patients whose sputum smears are negative but whose culture is positive.

## Diagnostic methods:

Sputum smear examination

Sputum Culture

Chest x-ray

Other tools for diagnosing TB:

- Tuberculin skin test (TST)/ Mantoux test
- Light-emitting diode (LED) fluorescence microscopy has been recently introduced and will be widely available in due course
- The investigations below will be available in major centres in the country:
- Molecular line-probe assays.
- Automated liquid culture and DST.

## Standard TB Treatment Protocols:

New TB Patient:

2HRZE/4HR

Previously treated TB Patient:

2SHRZE/1HRZE/5HRE

## Alternatives:

Patients with renal failure: INH, rifampicin and pyrazinamide are excreted almost entirely by the hepatobiliary system or metabolised into non-toxic compounds. In severe renal failure, give pyridoxine to prevent INH-induced peripheral neuropathy. Streptomycin and ethambutol are excreted by the kidneys, and should be avoided unless there is specialised care.

The safest regimen to give in renal failure is **2HRZE/4HR**.

## DOTS Recommendations:

Directly observed treatment is one of the core elements in the DOTS strategy. This requires a supervisor to watch a patient swallowing the tablets. This ensures that the patient takes right drugs, in the right doses and completes the treatment. The best supervisors are health workers and community health workers and least being family members/guardians.

## Children

### Year Issued:

2010

## TB Screening Frequency for PLHIV:

Children known or suspected of having HIV infection should be screened for TB at each visit; recent TB exposure and/or symptoms suggestive of TB should be documented routinely. Children, in particular HIV-infected children, can develop TB more than once.

## Screening Recommendations during TB Treatment:

Remember to assess nutritional status of every child and manage according to national guidelines

Children should be reviewed 2 weeks after starting therapy and monthly thereafter. The following should be done: symptom assessment and clinical examination, weight check, adherence and adverse events. Response to therapy is assessed by clinical response, weight gain and improvement in general well-being.

Radiological features such as mediastinal lymph node enlargement may persist for more than year after successful treatment therefore CXR should not be routinely used to monitor.

## Case definition:

**Notify and start TB treatment in the following situations:**

### Children with CONFIRMED TB:

- a. AFB are seen on microscopy
- b. Culture of M. tuberculosis has been obtained from any body tissues, fluids or secretion.

### Children with PROBABLE TB:

- a. Positive (Mantoux test) tuberculin skin test
- b. CXR showing unilateral hilar or paratracheal adenopathy, or a miliary picture
- c. Histology suggestive of TB.

### Children with SUSPECTED TB:

- a. Very young and acutely ill children in the absence of robust evidence of disease

If the child is older and not acutely ill, there is no urgency for starting the treatment. Wait and assess. Any child with a persistently negative Mantoux reaction and whose condition remains good or improves over months does not have TB.

## Diagnostic methods:

Recommended approach to diagnose TB in children

1. Careful history (including history of TB contact and symptoms consistent with TB)
2. Clinical examination (including growth assessment)
3. Tuberculin skin testing
4. Bacteriological confirmation whenever possible
5. Investigations relevant for suspected pulmonary TB and suspected extrapulmonary TB
6. HIV testing

## Standard TB Treatment Protocols:

**New Cases:** All forms of intra-thoracic disease without cavitation or extensive alveolar consolidation

- Uncomplicated extrapulmonary disease e.g.
- TB lymphadenitis and Tuberculous pleural effusion.
- Sputum smear-positive disease
- Extensive parenchymal involvement on CXR
- Cavitating pulmonary TB
- TB pericarditis
- Abdominal TB
- All children with HIV co-infection: 2HRZE/4RH --TB meningitis, miliary TB and osteo-articular TB: 2HRZE/10RH.

**Retreatment:** Previously treated smear-positive pulmonary TB

- Relapse
- Treatment after interruption
- Treatment failure: 2HRZES/ 1HRZE/5HRE

## **DOTS Recommendations:**

Directly observed treatment (DOT) in Children

A treatment supervisor should be identified, and this will usually be the caregiver. Many children with TB are orphans. Adherence to INH preventive therapy can be monitored at Family and Child Health clinics. Good records and proper notification are paramount for successful treatment.

---

**Source URL:** <https://aidsfree.usaid.gov/resources/guidance-data/tb/zimbabwe>