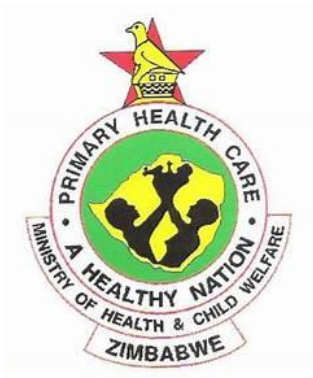

Final Report

Tuberculosis Stigma Assessment in Zimbabwe

Implementing institutions:

National Tuberculosis Programme (NTP) and Jointed Hands Welfare Organization (JHWO)

December 2024

This assessment was made possible with support from:

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Acronyms

DR:	Drug-resistant
DS-TB:	Drug-sensitive TB
DST:	Drug susceptibility test
HER:	Electronic Health Record
FGD:	Focus Group Discussion
HCW:	Health Care Worker
JHWO:	Jointed Hands Welfare Organization
KII:	Key Informant Interview
MDR-TB	Multidrug resistant TB
MoHCC:	Ministry of Health and Childcare
MRCZ:	Medical Research Council of Zimbabwe
NSP:	National Strategic Plan
NTP:	National TB program
OVC:	Orphans and Vulnerable Children
PiCS:	People who live in Congregate Settings
PPS:	Probability Proportional to Size
RR:	Rifampicin-resistant
VHW:	Village Health Worker
SPSS:	Statistical Package for the Social Sciences
TB:	Tuberculosis
TOC:	Theory of Change
UNHLM	United Nations High-Level Meeting
UNGASS	United Nations General Assembly

Acknowledgements

We would like to extend our sincere gratitude to all those who contributed to the successful completion of this report on the Tuberculosis Stigma Assessment in Zimbabwe. Firstly, we acknowledge the invaluable contributions of the Consultant, whose expertise and guidance were instrumental throughout the assessment process. We also express our deep appreciation to the National Tuberculosis Programme (NTP) and Jointed Hands Welfare Organization (JHWO) for their unwavering support and collaboration.

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Executive Summary

Introduction

Tuberculosis (TB) is the world's leading infectious killer disease. Despite international efforts, the annual decline in TB incidence of 1.5% is far behind the required 7-10% to meet the Sustainable Development Goal of ending TB by 2030. Jointed Hands Welfare Organization (JHWO), an organization that envisions harm and disease-free society, implements multiple interventions across the country under five strategic pillars of health, social development, resilient strengthening, disaster risk management, strategic information, and knowledge management. Under the health pillar, JHWO hosts the Stop TB Partnership Zimbabwe, a country-level platform that coordinates efforts to end TB. The Ministry of Health and Child Care (MoHCC)'s National TB program (NTP) conducted conducted a national TB Stigma Assessment in Zimbabwe, working collaboratively with JHWO. The main objective was to determine the levels and dimensions of anticipated stigma, self-stigma, enacted stigma, observed stigma, secondary stigma, perceived stigma and structural stigma and support the development of recommendations to ensure quality TB services that are available, accessible, and acceptable to all, especially key, vulnerable, and underserved populations.

Methodology

The assessment employed a mixed-methods approach, combining quantitative and qualitative data collection techniques. This included a desk review, a survey across all the ten provinces and 12 districts with 416 persons diagnosed with TB (PWTB), a focus group discussion (FGD) with a multistakeholder group, and key informant interviews (KIIs) with 30 family members of PWTB, 30 community members and 30 healthcare workers all linked to the interviewed PWTB. The data collection aimed to capture the different dimensions of TB stigma, including anticipated, self, enacted, observed, and structural stigma.

Findings

The assessment revealed that TB stigma is a significant barrier to accessing and providing TB services in Zimbabwe. Key findings include:

1. The assessment shows that 59.9% (n=249) of PWTB had completed treatment within the last 12 months preceding the assessment, while only 0.2% (n=1) had never had treatment.
2. A total of 60.1% (n=250) were last diagnosed with drug-sensitive TB, while 32.2% (n=134) did not remember. Female participants constituted 38.7% (n=161), and most of the respondents (51.9%, n=216) were aged between 25 to 44 at the time of the assessment. Persons living with HIV (22.8%, n=95), TB contacts (14.2%, n=59), and miners or ex-miners (11.1%, n=46) were the most common KVP groups that respondents belonged to.
3. The assessment revealed that 40.9% (n=170) of the persons diagnosed with TB have felt stigmatized because of their TB status.
4. Among different sex groups, more females (44%, n=72/161) reported that they felt more stigmatized than males (38%, n=98/255) and the difference was significant ($p<0.001$). Disaggregating by TB diagnosis, most of those who felt stigmatized had been last diagnosed with drug-sensitive TB (69.4%, n=118) compared to 52% (n=84) among the non-DR TB, statistically significant at $p<0.001$.
5. Among the malnourished PWTB, 66.7% (n=8) felt stigmatized, followed by PWTB who self-identified as miners/ex-miners (53.8%, n=56) and PWTB who use or inject drugs (24%, n=6) felt the least stigmatised. Among the PWTB who did not belong to any key and vulnerable group (KVP) group, 33% (24/73) felt stigmatized, 20% (n=47/231) felt stigmatized among those who belonged to one KVP group and 89% (n=99/112) felt stigmatized among those who belonged to two or more KVP groups.
6. Among the 170 (40.9%) who had experienced stigma, the top five TB journey stage-setting combos reported by PWTB in Zimbabwe involved stigma experienced at the stage of:

- **recognising symptoms** by community/neighbours, in the home/family, at hospitals/clinics and workplaces (21%, n=36).
- **Seeking care** by community/neighbours, in the home/family, at hospitals/clinics and workplaces (20%, n=34).
- **getting treatment adherence support** from the community/neighbours, in the home/family, at hospitals/clinics and workplaces (20%, n=34).
- **beginning treatment** by community/neighbours, in the home/family, at hospitals/clinics and workplaces (16%, n=27).
- **getting an accurate diagnosis** by community/neighbours, in the home/family, at hospitals/clinics and workplaces (13%, n=22).

7. The stigma radar shows to what extent stigma PWTB faced in different settings inhibited them from accessing TB services: 22% stigma in the community, 10% PWTB own self-stigma, 10% stigma in the family or home, 5% by healthcare workers and 6% in the workplace. Regarding stigmatising attitudes, those who agreed to at least five scale items were 52% (n=220/416) among PWTB (self-stigma), 23% (n=7/30) among family members (secondary stigma), 93% (n=28/30) among community members (against PWTB) and 43% (n=13/30) among healthcare workers (against PWTB).
8. The assessment interviewed 30 family members, and among them, 10 (33.3%) indicated that they had experienced stigma. The top five TB journey stage-setting combos reported by family members or relatives in Zimbabwe involved stigma experienced at the stage of;
    - **beginning treatment** by family/relatives, community/neighbours and at hospitals/clinics (80%, n=8).
    - **recognising symptoms** by family/relatives, community/neighbours and at hospitals/clinics (60%, n=6).
    - **getting treatment adherence support** from family/relatives, community/neighbours and at hospitals/clinics (60%, n=6).
    - **getting an accurate diagnosis** by family/relatives, community/neighbours and at hospitals/clinics (60%, n=6).
    - **getting treatment adherence support** by family/relatives, community/neighbours and at hospitals/clinics (60%)
9. A total of 30 healthcare workers were interviewed, and 10 (33.3%) reported that they had felt stigmatized because of their work, which involved interacting with people with or who have had TB. About 70% (n=7/10) mentioned that they had experienced stigma at the hospital, 40% (n=4/10) by community/neighbors, and 30% (n=3/10) by family or relatives.
10. A total of 102 (24.5%) of the PWTB confirmed that they know of other people with or who have had TB being stigmatized because of their TB status. The top five TB journey stage-setting combos reported by PWTB involved stigma that was experienced at the stage of;
    - **recognizing symptoms** by the community/neighbours (11%, n=11), in the home/family (9%, n=9) and at the workplace (4%, n=4).
    - **seeking care** by the community/neighbours (12%, n=12), in the home/family (8%, n=8) and at the workplace (4%, n=4).
    - **getting treatment adherence** support from the community/neighbours (9%, n=9), in the home/family (8%, n=8) and at the workplace (4%, n=4).
    - **getting an accurate diagnosis** by the community/neighbours (8%, n=8), in the home/family (8%, n=8) and at the workplace (4%, n=4).
    - **beginning treatment** by the community/neighbours (8%, n=8), in the home/family (7%, n=7) and at the workplace (4%, n=4).
11. A total of 66.7% (n=20) of the community respondents indicated that they had seen or heard stigma by the community/neighbors, in hospitals and clinics, and at the workplace.

The top five journey stage-setting combos observed by the community involved stigma observed at the stage of;

- **recognising symptoms** by the community/neighbors, in hospitals and clinics and at the workplace (85%, n=17),
- **seeking care** from the community/neighbors, in hospitals and clinics and at the workplace (80%, n=16)
- **getting an accurate diagnosis** by the community/neighbors, in hospitals and clinics and at the workplace (80%, n=16),
- **completing treatment** by the community/neighbors, in hospitals and clinics and at the workplace (80% each, n=16).
- **beginning treatment or getting post-treatment follow-up services** from the community/neighbors, in hospitals and clinics and at the workplace (65%, n=15 - each).

12. One third (33.3%, n=10) of the family members/relatives indicated that they had seen or heard stigma by the family/relatives, by the community/neighbors, and at hospitals/clinics. The top five journey stage-setting combos observed by the family involved stigma observed at the stage of;
    - **recognising symptoms** by the family/relatives, by the community/neighbors and at hospitals/clinics (90%, n=9),
    - **seeking care** by the family/relatives and by the community/neighbors (60%, n=6)
    - **beginning treatment, getting treatment adherence support, completing treatment or getting post-treatment to follow-up services** by the family/relatives, by the community/neighbors and at hospitals/clinics (50%, n=5 each),
    - **getting accurate diagnosis** by the family/relatives, by the community/neighbors and at hospitals/clinics (40% each, n=4).
13. The summary of specific TB journey stage-setting combos that have the most stigma reported across (experience and/or observed) by PWTB, family, community, and HCWs was as follows;
    - **recognising symptoms**: community/neighbours
    - **seeking care:** family/relatives
    - **getting an accurate diagnosis**: community/neighbours
    - **beginning treatment**: hospital/clinics
    - **getting treatment adherence support**: family/relatives and community/neighbours
    - **completing treatment:** community/neighbours and hospital/clinics
    - **getting post-treatment follow-up services**: family/relatives

    Community setting is where stigma takes place the most (4 out of 7 stages).

14. More than a third (35%, n=7/30) of healthcare workers knew of other healthcare workers being stigmatized in different settings. The top settings reported by HCW where stigma was observed were hospitals/clinics (57%, n=4), by community/neighbors (57%, n=4), and family/relatives (57%, n=4).
15. Regarding self-stigma among PWTB, the following were the top 3 scale items that the respondents (N=416) agreed or strongly agreed with:
    - A4: I keep a distance from others to avoid spreading TB germs (71%, n=295),
    - A9: I choose carefully who I tell about having TB (60%, n=249), and
    - A8: I feel guilty because my family has the burden of caring for me (55%, n=187).

    Those with drug-sensitive TB and those who did not remember the type of TB they were last diagnosed with had the highest proportions contributing to the 3 top scale items, while more females than males ($p<0.001$) and those aged 25-44 years had higher proportions than the rest of the age groups ($p<0.01$). Among the specific KVPs, the malnourished, TB

contacts, PLHIV and the miners/ex-miners had higher proportions, and those who belonged to 2 or more KVP groups contributed more to the 3 top scale items than those who belonged to only one or zero groups ($p<0.01$).

16. Regarding secondary stigma among family members/relatives, the following were the top 3 scale items where the respondents (N=30) agreed or strongly agreed:
    - A9: I have noticed changes in my family member since the TB diagnosis (57%, n=17),
    - A10: I am worried about becoming infected (50%, n=15), and
    - A4: My family member hides his/her TB diagnosis from the community (30%, n=9).

    As with PWTB, those with drug-sensitive TB had the highest proportions contributing to the 3 top scale items, while more females than males ($p<0.001$) and those aged 25-44 years had higher proportions than the rest of the age groups ($p<0.01$). Among the specific KVPs, the malnourished, PLHIV and the miners/ex-miners had higher proportions, and those who belonged to 2 or more KVP groups contributed more to the 3 top scale items than those who belonged to only one or none of the groups ($p<0.01$).
17. Regarding community stigmatizing attitudes against PWTB, the following were the top 3 scale items where the respondents (N=30) agreed or strongly agreed:
    - A5: Some people keep their distance from people with TB (90%, n=27),
    - A1: Some people might not want to drink or eat with friends who have TB (83%, n=25), and
    - A2: Some people feel uncomfortable being near those who have TB (83%, n=25).

    For the top 4 scale items in this category, more males than females agreed or strongly agreed ($p<0.001$), while for A1, A2 and A8, those aged 25-44 years contributed the highest proportions to the items A1, A2 and A8 while the 45–64-year-olds contributed the highest to scale item A5.
18. Regarding stigmatizing attitudes towards PWTB by healthcare workers, the following were the top 3 scale items where the respondents (N=30) agreed or strongly agreed:
    - A9: Some healthcare workers think taking TB treatment should be forced if necessary (87%, n=26),
    - A2: Some healthcare workers feel pity for TB patients (70%, n=21), and
    - A1: Some healthcare workers are nervous about treating TB patients (67%, n=20).

    For all the top 3 scale items (A1, A2 and A9), females had a higher proportion than males ($p<0.001$), and those aged 25-44 and 45 – 64 had equal contributions to the top 3 scale times.
19. The multistakeholder group conducted a focus group discussion and reviewed the laws and policies in line with the objectives of the assessment, which revealed that all the rights and freedoms were covered by the existing laws and policies, with some areas requiring improvement on enforcement and media coverage.

Recommendations

The assessment makes the following recommendations that were validated by the Core group and the multistakeholder meeting.

A. Short-term recommendations

1. Community Education Programs targeting

Recommendation: Develop and implement community education programs to raise awareness about TB, its transmission, and treatment. These programs should aim to dispel myths and misconceptions about TB, reduce fear, and promote supportive behaviors towards people diagnosed with TB. Utilize local media, community leaders, and educational institutions to disseminate information effectively.

2. **Healthcare Worker Training**

Recommendation: Provide comprehensive training for healthcare workers on TB stigma, its impact on patients, and strategies to provide non-discriminatory care. This training should include sensitivity training, communication skills, and the use of standardized protocols to ensure respectful and supportive interactions with TB patients and manage the stigma against themselves.

3. **Improve the presence of Support Groups for TB Patients.**

Recommendation: Increase the presence and coverage of support groups for TB patients and their families to provide a safe space for sharing experiences, receiving emotional support, and accessing information about TB treatment and care. This will address stigma in the family/relatives specifically attitudes around sharing information by PWTB. These groups can be facilitated by trained counsellors and healthcare workers.

4. **Media Campaigns to Reduce Stigma**

Recommendation: Launch media campaigns to reduce public TB stigma by promoting positive stories of TB survivors, educating the public about TB, and encouraging supportive attitudes towards people diagnosed with TB. Utilize various media platforms, including social media, radio, and television, to reach a wide audience.

B. **Long-term recommendations**

1. **Legal Protections for TB Patients**

Recommendation: Advocate for the implementation and enforcement of legal protections for TB patients to prevent discrimination and ensure their rights are upheld. Advocate for policy reforms to address structural stigma by ensuring that laws and policies are inclusive, non-discriminatory, and supportive of TB patients' rights. Engage policymakers, legal experts, and civil society organizations in the advocacy efforts.

2. **Strengthening Social Support Systems**

Recommendation: Strengthen social support systems for TB patients and their families by providing financial assistance, counselling services, and access to social services to alleviate the burden of TB. Collaborate with social service agencies and non-governmental organizations to provide comprehensive support.

3. **Collaboration with Civil Society Organizations**

Recommendation: Collaborate with civil society organizations to implement stigma reduction programs, provide support to TB patients, and advocate for their rights. Partner with organizations that have experience in addressing stigma and discrimination.

4. **Monitoring and Evaluation of Stigma Reduction Programs**

Recommendation: Establish monitoring and evaluation mechanisms to assess the effectiveness of stigma reduction programs and make necessary adjustments to improve their impact. Use data from these evaluations to inform future interventions and policies.

5. **Research on TB Stigma**

Recommendation: Strengthen ongoing research on TB stigma reduction to better understand its dimensions, impact, and effective strategies for reduction. This research should inform the development of evidence-based interventions to address TB stigma and could be implemented by strengthening and institutionalising TB stigma surveillance through digital platforms such as One Impact. Collaborate with academic institutions and research organizations to conduct studies and disseminate findings.

6. **Key Populations and Stigma**

Recommendation: Tailor stigma reduction interventions to address the unique challenges faced by people diagnosed with TB belonging to multiple key population groups and those not belonging to any key population groups.

Conclusion

The findings from the Tuberculosis Stigma Assessment in Zimbabwe highlight the pervasive nature of TB stigma and its detrimental impact on individuals and communities. The assessment revealed that stigma manifests in various forms, including anticipated, self, enacted, observed, and structural stigma, affecting people diagnosed with TB, their families, and healthcare workers. The stigma experienced by people diagnosed with TB leads to delays in seeking diagnosis and treatment, which exacerbates the spread of the disease and hinders effective TB control efforts. The assessment underscores the need for comprehensive strategies to address TB stigma at multiple levels, including community education, healthcare worker training, and policy reforms.

Addressing TB stigma is crucial for improving access to TB services, enhancing treatment outcomes, and supporting the right to health for all individuals affected by TB. The recommendations from the assessment emphasize the importance of community education programs, healthcare worker training, support groups for TB patients, and media campaigns to reduce stigma. Additionally, long-term strategies such as advocating for legal protections for TB patients, strengthening social support systems, and collaborating with civil society organizations are essential for creating an inclusive and supportive environment for people diagnosed with TB. By tackling stigma, Zimbabwe can make significant strides towards ending the TB epidemic and ensuring that quality TB services are available, accessible, and acceptable to all.

1. Introduction

1.1 Background

Tuberculosis (TB) is the world's leading infectious killer disease. International declines in the incidence of 1,5% per year are lagging well behind the declines required (7-10%) if the Sustainable Development Goal of ending TB by 2030 is to be met[1]. Recognition that more needs to be done, particularly in meeting the needs of the large number of people who are not diagnosed or successfully treated (approximately 4.5 million people per annum globally), has resulted in a revitalised focus on the international TB response - not least with the convening of the first United Nations General Assembly (UNGASS) high-level meeting on TB set for September 2018. Concomitantly, international bodies and National TB Programmes are scaling up their efforts to meet the aims outlined in the Global Plan to End TB (2016– 2020): reach at least 90% of all people with TB, reach at least 90% of key populations (defined as the most vulnerable, underserved and at-risk populations), and achieve at least 90% treatment success for all people diagnosed.

Jointed Hands Welfare Organization (JHWO) is an organization that envisions a harm and disease-free society. JHWO implements multiple interventions across the country under the five strategic pillars of health, social development, resilient strengthening, disaster risk management, strategic information, and knowledge management. Under the health pillar, JHWO hosts the Stop TB Partnership Zimbabwe, a country-level platform that coordinates country-level efforts to end tuberculosis (TB). Working with the Ministry of Health and Child Care (MoHCC) National TB program (NTP) as part of the national TB response, JHWO is facilitating a national TB Stigma Assessment in Zimbabwe.

The Zimbabwe TB National Strategic Plan (TB NSP) is aligned with the End TB Strategy, and the MoHCC adopted the United Nations High-Level Meeting (UNHLM) targets. The TB NSP sets out goals and targets in pursuit of shared aspirations to End TB by 2035. Some of the strategic objectives of the TB NSP are to:

- increase the treatment coverage of drug susceptible TB from 83% in 2018 to 90% by 2026
- increase the treatment success rate of patients with drug susceptible TB from 83% in 2017 to 90% by 2026
- achieve universal HIV testing and ART coverage for TB cases by 2021 and sustain coverage through to 2026
- decrease the proportion of households facing catastrophic costs due to TB from 80% in 2019 to 50% by 2026

Several risk factors for TB have been identified in Zimbabwe and include undernourishment, HIV prevalence (12.8% of the general population), living in slums (33.5% of the urban population), stigma and discrimination against past and current TB patients and families, diabetes prevalence (1.8% of people aged 20-79 years) and unsafe prison and mining conditions (USADI, 2023). These risk factors contribute to the TB burden and need to be addressed to improve TB control efforts. Data sourced from the Stop TB Partnership emphasizes the need for a human rights-based approach to TB control, ensuring that all individuals across all gender groups have access to TB prevention, diagnosis, and treatment services.

The HIV Stigma Index Report (2022) reported that out of the 1,357 respondents, 7% (n=98) had been diagnosed with TB over the last 12 months preceding the survey (ZNNP+, 2022). In areas of high HIV prevalence, where HIV and TB co-infection are common, the link between the two diseases

[1] Stop TB Partnership, 'The Paradigm Shift 2016 - 2020'.

has contributed to the stigmatization of TB. TB is perceived as a marker for HIV positivity, and therefore, HIV-associated stigma is transferred to TB-infected individuals. Other causes of TB stigma include the perceived associations of TB with malnutrition, poverty, being foreign-born, and low social class. As with HIV, TB is stigmatized in this context because it is linked to other disvalued characteristics, which themselves are also social determinants of health.

Data has shown that countries cannot fully support the right to the highest standard of physical and mental health without addressing TB stigma, which leads to discrimination and other human rights violations. Stigma and discrimination are key barriers to ending the TB epidemic, affecting access to TB services and quality of life. Therefore, Zimbabwe must understand the levels and dimensions of TB stigma and develop evidence-based strategies to tackle it. This can help reduce vulnerability to TB, increase access to TB services, and improve treatment outcomes. By evaluating stigma, a root cause of discrimination, Zimbabwe can better support individuals' right to health.

Stigma is described as a process where individuals are devalued, discredited, or seen as a disgrace or danger. This often leads to stigmatized people being avoided by society. Stigma is a significant social determinant of health because it disrupts essential life aspects such as resources, social relationships, and coping behaviours, ultimately impacting the health of populations. It is a fundamental cause of health inequality. In the context of social diseases like tuberculosis, stigma is linked to various aspects of people's lives and is not mutually exclusive. Key populations affected by TB often face multiple reinforcing stigmas related to gender, sexual orientation, identity, legal status, financial status, profession and the presence of other illnesses such as HIV.

1.2 Research Objectives

Overall objective

The overall objective of the stigma assessment was to assess the extent to which and how TB stigma acts as a barrier to both accessing and providing services. The assessment findings will be used to support the development of recommendations to address stigma so that quality TB services are available, accessible, and acceptable to all, with special considerations given to the needs of key, vulnerable and underserved populations.

Specific objectives

Specific objectives of the TB Stigma assessment were to;

1. Determine the level and dimensions of **anticipated stigma, self-stigma, enacted stigma (stigma directly experienced), and observed stigma** among people diagnosed with TB:
    - *To determine how and the extent to which self-stigma manifests among people diagnosed with TB.*
    - *To determine the settings and stages of care in which TB stigma is being experienced and observed by people diagnosed with TB.*
2. Determine the level and dimensions of secondary TB stigma, stigma **directly experienced, and stigma observed by family members / primary carers** of people diagnosed with TB:
    - *To determine how and the extent to which secondary stigma manifests among family members and primary carers of people diagnosed with TB.*
    - *To determine the settings and stages of care in which secondary TB stigma is being experienced and observed by family members / primary carers of people diagnosed with TB.*
3. Determine the level of perceived TB stigma against people diagnosed with TB in **communities and the stigma observed by the community:**
    - *To determine how and the extent to which stigma against people diagnosed with TB takes place in communities.*
    - *To determine the settings and stages of care in which TB stigma against people diagnosed with TB is being observed by community members.*

4. Determine the level and dimensions of perceived TB stigma against people diagnosed with TB in **health care settings and stigma against health care workers.**
    - *To determine how and the extent to which perceived stigma against people diagnosed with TB manifests in healthcare facilities.*
    - *To determine the settings in which TB healthcare workers experience TB stigma.*
    - *To determine the settings in which TB stigma against health care workers is observed by other TB health care workers.*
5. Determine the extent to which **structural stigma** (any existing laws/policies, the enforcement of those laws/policies, and the corresponding media coverage) **could harm or protect people diagnosed with TB.**
6. Support the development of **recommendations to address TB stigma to reduce peoples' vulnerability** to TB infection, increase peoples' access to TB services, and improve treatment outcomes.

2. Literature Review

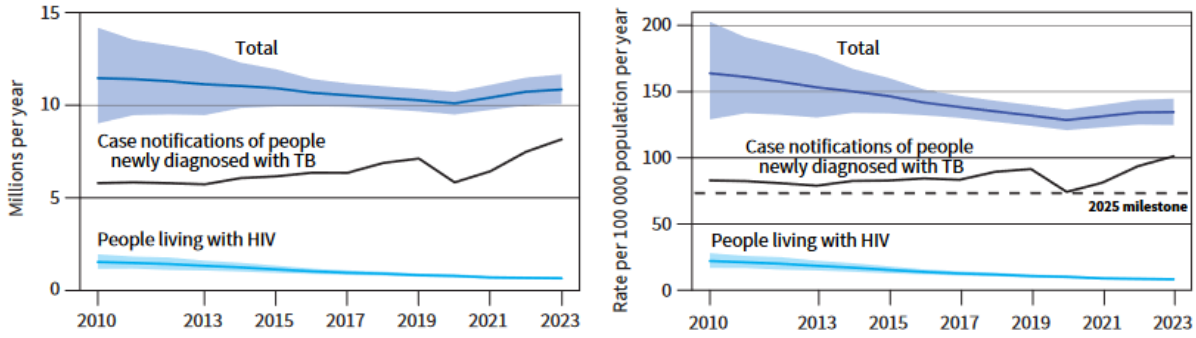
2.1 Global TB Overview

Tuberculosis (TB) is a preventable and usually curable disease. Yet in 2023, TB probably returned to being the world's leading cause of death from a single infectious agent, following 3 years in which it was replaced by coronavirus disease (COVID-19) (United Nations, 2024) and caused almost twice as many deaths as HIV/AIDS. Most of the people who develop TB disease each year are in 30 high TB burden countries, which account for 87% of the global total in 2023. Five countries accounted for 56% of the worldwide total: India (26%), Indonesia (10%), China (6.8%), the Philippines (6.8%) and Pakistan (6.3%) (WHO, 2024).

According to the Global TB Report of 2024, more than 10 million people continue to fall ill with TB every year, and the number has been rising since 2021 (WHO, 2024). According to this report, the global number of deaths caused by TB fell in 2023, reinforcing the decline that was achieved in 2022 after 2 years of increases during the worst years of the COVID-19 pandemic (2020 and 2021). TB caused an estimated 1.25 million deaths (95% UI: 1.13–1.37 million) in 2023, including 1.09 million among HIV-negative people and 161,000 among people with HIV. The total was down from best estimates of 1.32 million in 2022, 1.42 million in 2021 and 1.40 million in 2020, and below the pre-pandemic level of 1.34 million in 2019 (*Ibid*).

A global total of 8.2 million people were reported as newly diagnosed with TB in 2023, up from 7.5 million in 2022 and 7.1 million in 2019 and far above the levels of 5.8 million in 2020 and 6.4 million in 2021 (WHO, 2024). Those newly diagnosed in 2022 and 2023 probably included a sizeable backlog of people who developed TB in previous years but whose diagnosis and treatment were delayed by COVID-related disruptions. The global gap between the estimated number of people developing TB (incident cases) and the reported number of people newly diagnosed with TB (notified cases) narrowed to a best estimate of 2.7 million in 2023, down from about 4 million in both 2020 and 2021 and below the pre-pandemic level of 3.2 million in 2019 (*Ibid*).
Global data showed that from 2010 to 2023, there was a global decline in TB cases, with a slight increase around 2020. The number of TB notifications among people living with HIV also shows a steady decline, although the trend line for TB case notifications is not on track to meet the 2025 milestone (Figure 1).

Figure 1: Global trends in the estimated number of incident TB cases (left) and the incidence rate (right), 2010–2023.

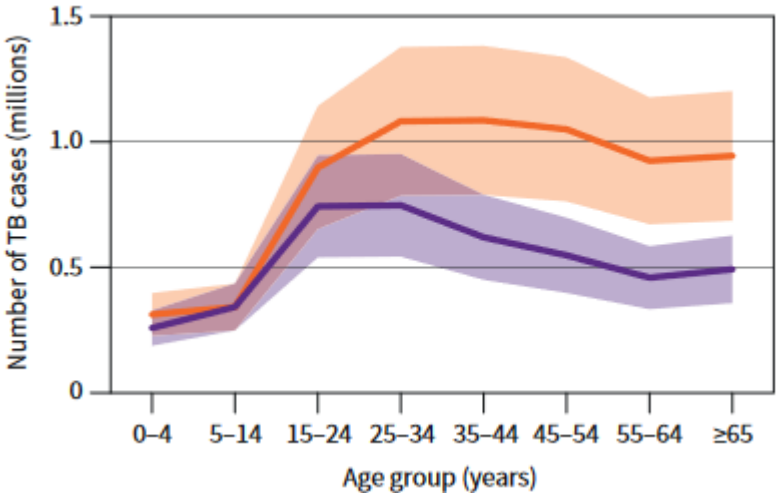


(Source: WHO, 2024).

The World Health Organization (WHO) reports more new TB cases among men than women each year. For instance, the 2024 WHO TB report indicates that adult men (aged ≥15 years) had the highest-burden globally, with an estimated 6.0 million cases (95% UI: 5.5–6.4 million) in 2023, accounting for 55% of the estimated total (Figure 2) (WHO, 2024). In comparison, there were an estimated 3.6 million cases (95% UI: 3.3–3.9 million) among adult women (aged ≥15 years), representing 33% of the total, and 1.3 million cases (95% UI: 1.2–1.3 million) among children and young adolescents (aged 0–14 years), accounting for 12% of the estimated total. The higher share of TB cases among men is consistent with evidence from national TB prevalence surveys, which show that TB disease

affects men more than women and that gaps in case detection and reporting are higher among men (WHO, 2021), as in Fig 2.

Figure 2: Global estimates of TB incidence disaggregated by age group and sex (female in purple; male in orange), 2023.



Source WHO (2024).

Death caused by TB continued to fall globally in 2023 after COVID-related increases. The estimated global number of deaths caused by TB fell for a second consecutive year in 2023, continuing the reversal of increases that occurred during the worst period of COVID-related disruptions to TB diagnosis and treatment in 2020 and 2021 (WHO, 2024). Globally, in 2023, TB caused an estimated 1.25 million deaths (95% UI: 1.13–1.37 million), including 1.09 million among HIV-negative people (95% UI: 0.98–1.20 million) and 161 000 among people with HIV (95% UI: 132 000–193 000). This total was down from estimates of 1.32 million (95% UI: 1.21–1.45 million) in 2022, 1.42 million (95% UI: 1.29–1.55 million) in 2021 and 1.40 million (95% UI: 1.27–1.54 million) in 2020; it was also below the pre-pandemic level of 1.34 million (95% UI: 1.22–1.46 million) in 2019.

It should be noted that TB is curable, but it still kills more people globally than any other single infectious disease (Stop TB Partnership, 2019a). This is mainly due to challenges in accessing quality, affordable and equitable TB services and care. Millions of people affected by TB endure its hardships and manage to survive despite these barriers, which are driven by and heightened by TB stigma. As such, countries need to understand the levels and dimensions of TB stigma to address the health disparities experienced by people with TB and inform interventions to end it (Stop TB Partnership, 2019).

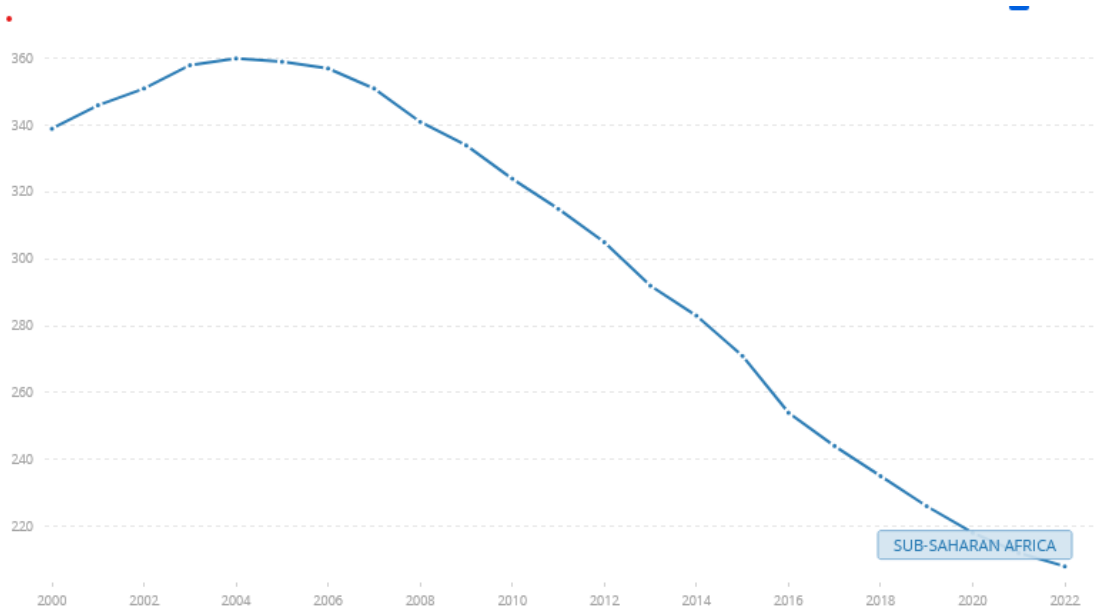
2.2 Sub-Saharan Africa Overview

Tuberculosis is principally a disease of poverty, with 95–98% of deaths occurring in developing countries and over 25% of those occurring in Africa (Heaton, 2021). In Sub-Saharan Africa (SSA), tuberculosis (TB) remains a major health issue, largely affecting those in poverty-stricken, high-density, and HIV-prevalent regions (Heaton, 2022). This is also attributed to high population density, which directly led to the high infection rates in SSA due to close contact and shared air spaces, increasing the chances of infection. Tuberculosis continues to be among the key global health challenges with SSA, which is also highly affected by the HIV epidemic, carrying the heaviest disease prevalence. Sixteen of the 30 countries with a high tuberculosis (TB) burden are in Sub-Saharan Africa (SSA) (Atake, 2023). In 2016 alone, 2.5 million people fell ill with tuberculosis in sub-Saharan Africa (SSA), accounting for a quarter of new tuberculosis cases worldwide (*Ibid).*

In 2004, the incidence of tuberculosis in sub-Saharan Africa was 359 per 100,000. By 2014, this figure had decreased to 283 per 100,000, and by 2019, it had further dropped to 226 (Heaton, 2022). The World Bank (2023) reported that, although TB remains a leading cause of death in sub-Saharan Africa, there has been a decline in TB incidence since 2000 (Figure 3). Despite this decline,

the case detection rate in sub-Saharan Africa is still estimated at only 57%, indicating that nearly half of all cases in the region go undiagnosed (Heaton, 2022).

Figure 3: Incidence of tuberculosis (per 100,000 people) - Sub-Saharan Africa



Source World Bank (2023)

The stigma associated with HIV/TB coinfection has led to increased treatment defaulting, thereby raising the prevalence of drug-resistant TB (Mtetwa, 2023). The stigma, discrimination and exclusion associated with HIV can amplify and be amplified by TB-related stigma (Daftary, 2012). In settings where women are disproportionately affected by HIV, they may also face a higher burden of TB than their male counterparts. This is the case in areas of SSA where young women, especially (18-24 years old) may face 2 to 3 times higher rates of new HIV infections than men of the same age (Global Fund, 2020).

2.3 TB Situation in Zimbabwe

Generally, since 2010, the number of people developing TB is decreasing in Zimbabwe (Figure 4). It is estimated that about 35,000 people fall ill with TB each year, and about 7,900 of this die (WHO, 2024). In 2020, about 2,100 people died because of TB, and this was a 20% increase from 2018. In the same year, the country was listed amongst the 30 high-burden countries for TB, TB-HIV and MDR-TB globally. However, in 2021, the country was removed from the high-burden countries list for TB but remains on the high-burden countries list for MDR-TB and TB/HIV comorbidity (Zinyuke, 2021).

From 2010 to 2024, Zimbabwe has experienced a fluctuating but generally declining trend in tuberculosis (TB) incidence, with significant efforts to improve detection and treatment. The TB incidence rate decreased from 605 per 100,000 people in 2000 to 204 per 100,000 in 2022, translating to 33,000 people with incident TB (Zimbabwe TB NSP External Midterm Review Report, 2022). In 2024, the estimated TB incidence remained around 204 per 100,000, with 18,222 TB cases notified. Despite these improvements, challenges persist, particularly with drug-resistant TB, as evidenced by 237 diagnosed cases of multidrug/rifampicin-resistant TB (MDR/RR-TB) in 2024. The country continues to strive towards better TB control and treatment outcomes, aiming to meet the targets set in the National Strategic Plan for TB Elimination by 2025

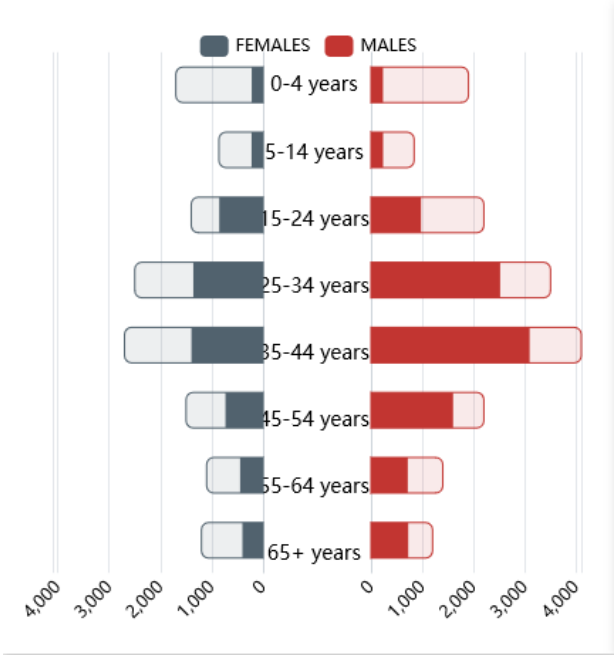
Globally, efforts to control TB are being made; however, TB case notification remains low in many countries. One potential contributor to low-case notifications is the lack of a robust TB Surveillance

System (Mupedziswa et al., 2024). The National TB Program (NTP) has aligned its 2021-2025 National Strategic Plan (NSP) with WHO's End TB Strategy, aiming for a TB-free Zimbabwe by 2035 by increasing treatment coverage, success rates, and scaling up access to HIV testing among TB patients (*Ibid*). The COVID-19 pandemic severely impacted TB response, resulting in a 25% decline in TB case notifications in 2020, as resources were redirected to COVID-19 management.

In Zimbabwe, there were approximately 13,500 missing individuals with tuberculosis (TB) in 2024, which was a 7% increase from 2012 of whom 2,500 are children (WHO 2024). This case detection gap not only complicates the prevention and care efforts needed to control the spread of TB but also exacerbates the challenges in allocating resources effectively, leading to poorer health outcomes and increased morbidity and mortality among vulnerable populations, particularly children.

As with the global situation, in Zimbabwe, male are disproportionally affected by TB as compared to their female counterparts (Figure 4). The Global Tuberculosis Report further notes that the reproductive age group (15-44 years) and men are mostly affected by TB (WHO, 2024).

Figure 4: Age/Sex disaggregation of People with TB, 2020



Source Stop TB Partnership (2020)

2.4 TB-related Stigma and Discrimination

The Stigma Index study (2014) found that 65% of people living with HIV and TB in Zimbabwe had experienced discrimination, either from others or, in some cases, through self-stigma (Zimbabwe National Network of People Living with HIV, 2014 and UNDP, 2019). A survey on community, rights, and gender (CRG) for TB response efforts in Zimbabwe reported that nearly one-third (31.6%) of respondents experienced TB-related stigma and discrimination from family members, communities, co-workers, and healthcare workers (MOHCC, 2021). Among those who reported experiencing stigma, 60.8% (101/166) were female, 37.3% (62/166) were male, and 1.8% (6/166) preferred not to disclose their gender. This stigma prevents TB patients from fully enjoying their right to health care services, as many face negative attitudes from health workers and long waiting hours at health facilities, which was attributed to limited community knowledge about TB disease.

The CRG assessment also noted that TB stigma is particularly rampant among key populations such as sex workers, miners, and transporters. These groups face additional barriers like transport costs, user fees, drug shortages, and negative attitudes from healthcare workers. The stigma and discrimination towards these groups result in hesitancy to seek health care services, further

exacerbating their vulnerability to TB. The assessment emphasized the need for the health system to be aware of the needs and rights of KPs to ensure they have access to adequate health services without feeling stigmatized or discriminated against.

The pervasive stigma and discrimination associated with HIV, AIDS, and TB can make public disclosure of one's status difficult and even dangerous, particularly for members of key populations (UNDP, 2019). Contributing to this stigma, faith-based narratives often link the epidemic to sexual promiscuity and sin, exacerbating discrimination (Ibid). Despite anti-stigma and non-discrimination protections in Zimbabwe's Constitution and other laws and policies, people living with HIV and members of vulnerable and key populations continue to face discrimination. The Prevention of Discrimination Act, for instance, does not extend protections to people living with HIV and TB, vulnerable groups such as people with disabilities, and key populations (UNDP, 2019).

2.5 Laws and policies: Health and TB-related issues

There exist varied International, Regional and National frameworks for accessing the right to health, including accessing TB services. Key among the international efforts include the United Nations (UN) 2018 first-ever UN High-level Meeting (UNHLM) on TB, which culminated in a UN General Assembly adopted Political Declaration on the Fight Against TB, which established targets to be achieved by 2022 to reach the Sustainable Development Goals of ending the TB epidemic by 2030 (MOHCC, 2021).

In addition to international laws, the government of Zimbabwe has also enacted domestic health legislation. For example, Zimbabwe's Constitution includes several human rights provisions relevant to HIV and TB, as well as to the protection of vulnerable and key populations. Research by the United Nations Development Programme (UNDP) and the National AIDS Council (NAC) (2019) shows that the government of Zimbabwe has made significant progress in legislation by including the following laws and policies in its constitution:

- **Section 56: Equality and Non-Discrimination Subsection (1):**

This right entails, among other things, the right to equal protection and benefit of the law. Persons who are living with TB and who are affected or impacted by TB have the right to equal treatment as any other person in the country.

- **Section 76: Right to Health Care Section 76 (1)**

Every citizen and every permanent resident has the right to access basic health care services, including reproductive health care services. Section 76 (2): While people living with TB are accorded the right to access basic health care services in the broad general provision that applies to every citizen, they are further specifically protected under Subsection 76 (2), which provides access to basic health care services for people with chronic illness.

- **Section 57: Right to Privacy**

This includes the right not to have one's health condition not to be disclosed. Although this provision does not specifically mention people with TB, it ensures that everyone, including those with TB, has the right to confidentiality regarding their health status. This protection helps prevent stigma and discrimination by safeguarding individuals' right to keep their diagnoses private.

- **Section 62: Access to Information**

Section 62(2) provides for the right of every person (including the media) to information held by any person, including the State, in so far as that information is required for the exercise or protection of a right. This accords people living with HIV, TB and vulnerable and key populations the right to access relevant information regarding protection, treatment, care, reproductive health and related matters.

- **Section 65: Labour Rights**

Section 65 (1) provides for the right to fair and safe labour practices and standards, and section 65 (4) ensures just, equitable and satisfactory conditions of work. Therefore, employees living with TB, as well as other vulnerable and key populations, have the right to fair and safe labour standards and to be treated equitably and in a just manner, notwithstanding their TB status.

- **Section 85: Enforcement of Fundamental Human Rights and Freedoms**

This provision seeks to enhance enforcement and enjoyment of the rights as outlined according to legal opportunity for any person, including those living with HIV or impacted and affected by HIV, as well as vulnerable and key populations, to approach/access the courts in cases where they are of the view that any of their rights are being infringed or are likely to be infringed. This is for the court to provide appropriate relief, including a declaration of the rights and, where applicable, a compensation award.

Zimbabwe does not have a comprehensive HIV- and TB-specific law, but people living with HIV and TB are protected by broad equality and non-discrimination provisions provided for by the Constitution, health and workplace legislation and policies (UNDP and NAC, 2019).

- **Health Legislation**

The Public Health Act does not refer specifically to the rights of people living with HIV, TB or key populations. However, the broad provisions of the Public Health Act to provide for health care apply to all persons and all matters of public health and would therefore also apply equally to people affected by HIV, AIDS and TB, including vulnerable and key populations. Zimbabwe's new Public Health Bill (2018) seeks to redress some of the imbalances in the Public Health Act. It seeks to strengthen and enhance HIV and TB awareness and, generally, the right to access quality healthcare services for vulnerable groups and key populations, including young populations. However, it also contains some provisions that have the potential to impact negatively on people living with HIV or TB. For example, section 57 (c) of the Public Health Bill provides for punishment by fine or incarceration of individuals for the "willful or negligent" exposure of others to infectious disease (UNDP and NAC, 2019).

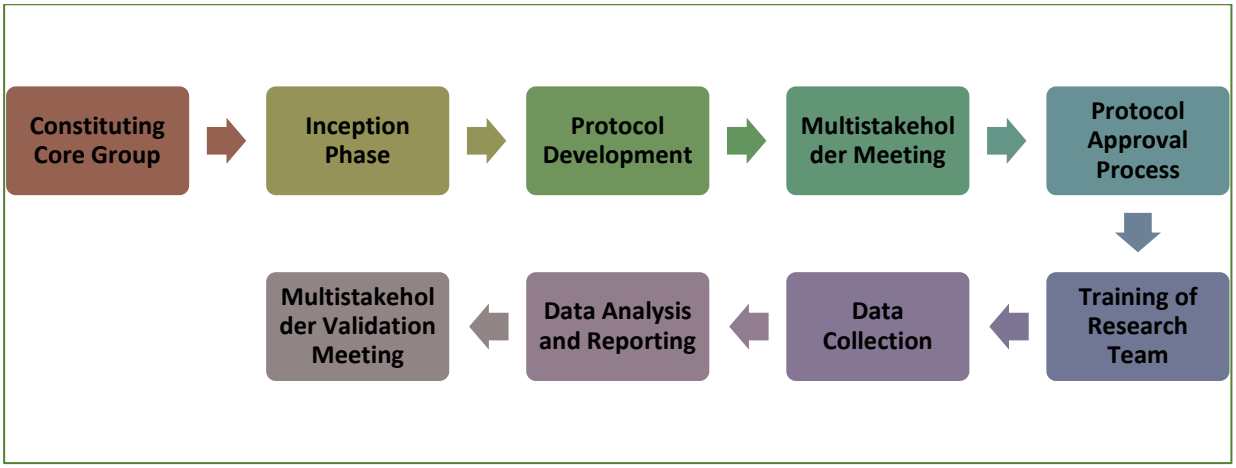
3. Methodology

This section highlights the TB stigma assessment process and methodology that was utilized to achieve the objectives of the assessment.

3.1 Assessment Process

The overall process adopted an implementation research approach, which aimed to address implementation bottlenecks, identify optimal approaches for specific settings, and promote the uptake of the assessment findings, leading to improved TB prevention, care and support. The process was a result of the involvement of multi-stakeholders to ensure buy-in and uptake of the recommendations at the highest level. The process was community-driven with strategic guidance from the NTP, with people affected by TB as equal partners in the process. The stages of implementing the TB Stigma assessment were as shown in Fig 5;

Figure 5: TB Stigma Assessment Implementation Process



Core Group and Multistakeholder Meetings

The assessment was led by the Core Group[2], whose mandate was to provide technical guidance and oversight of the TB Stigma Assessment process. The Core Group convened two multistakeholder meetings, bringing in stakeholders at the beginning of the assessment to discuss and endorse the assessment approach and methodology and the second meeting of the same group to discuss, validate and endorse draft findings, recommendations and action plans. TB survivors and KPs participated fully in these two multi-stakeholder meetings, which were participatory and had opportunities for both presentations and question and answer segments for all the participants.

3.2 Assessment Design

The TB Stigma assessment adopts a mixed methods design, using qualitative and quantitative methods, targeting five categories of respondents. The methods included desk review, interviews using semi-structured questionnaires and a focus group discussion. Key target respondents were people diagnosed with TB (current patients and TB survivors); family members or primary carers of people diagnosed with TB; the community; health care workers; and a multi-stakeholder working group.

3.3 Assessment Methods

The following key data collection methods were utilized in the assessment to collect data to meet the objectives of the assessment:

Desk review

A desk review was conducted to provide data and information to inform the TB Stigma Assessment. The review included scanning the available literature and analysing secondary data. The purpose of

[2] Ministry of Health and Child Care's NTP, lead community-based organization (JHWO), World Health Organization (WHO), National AIDS Council (NAC), TB champion in the Country Coordinating Mechanism, academia (Midlands State University), Prisons ministry, Zimbabwe AIDS Network, Ministry of Justice and a Civil society representative (ZiChire)

the desk review was to understand the country's context in relation to TB stigma, identify key themes, gaps and opportunities by analysing available secondary data, and gather data and information to inform the final report. Desk review helped in contextualizing questions in the tools, ensuring that they are culturally and linguistically appropriate to the Zimbabwe setting.

Semi-structured questionnaires

In total, four interviewer-administered semi-structured questionnaires were used in this assessment. The questionnaires were all reviewed and contextualized by the Core Group to suit the Zimbabwe TB environment. The four types of respondents for these were:

A. **People diagnosed with TB (PWTB):** to understand the levels and dimensions of anticipated stigma, self-stigma, enacted stigma and observed stigma among people diagnosed with TB. The target population was defined as the total number of new and previously treated TB cases registered during the year preceding the assessment as per the NTP TB records (Notification registers and DHIS2). The recruitment considered gender, key population category, TB treatment status, and TB type and people from the current and previous TB cohorts over the last 12 months from available registers were interviewed using a semi-structured questionnaire (Annex 1).
B. **Family members or primary carers of people diagnosed with TB:** to understand the levels and dimensions of secondary stigma, stigma directly experienced, and stigma observed. The household members were individuals who supported the person with TB throughout his or her TB journey. They were interviewed using a semi-structured questionnaire for Family members (Annex 2).
C. **Community members:** To understand the level of perceived TB stigma against people diagnosed with TB in communities and the stigma observed by the community. The community were community members from the same communities where people diagnosed with TB (who were interviewed) resided. They were interviewed using a semi-structured questionnaire for Community members (Annex 3).
D. **Health care workers:** to understand the level and dimensions of perceived TB stigma against people diagnosed with TB and stigma against health care workers. The healthcare workers were the TB nurses linked to people diagnosed with TB who were interviewed. They were interviewed using a semi-structured questionnaire for healthcare workers (Annex 4).

Focus Group Discussion (FGD)

A focus group discussion was held with a multi-stakeholder group involving TB programme staff, representatives from legal, judiciary and civil communities, legislators, media workers, policymakers, funders, and implementing organizations). The discussions shed light on the extent to which any existing laws/policies and the enforcement of those laws and policies and corresponding media coverage could harm or protect people with TB. This multistakeholder group had a discussion using the guide in Annex 5.

3.4 Sampling and Sample Sizes

The assessment was conducted across all ten provinces of Zimbabwe, randomly selecting one district per province based on the TB notifications between January and December 2023. A multistage clustered random approach was used to select districts as follows:

1. There was a total of **19,622 TB notifications** between January and December 2023 across all ten provinces, which was used to calculate notification rates per 100,000 using 2023 ZIMSTAT population data.
2. About 95% of the districts (excluding Harare and Bulawayo) had **TB notification rates of between 41/100,000 and 264/100,000**. The range (223) was divided by 3 to create clusters with low, medium and high rates. There were outliers which were excluded from the sample in the higher end (Nkayi district with 452/100,00) and lower end (Seke, Mbire, Binga and others which had less than 31/100,000).
3. The cluster with the lowest rates (below 115/100,000) had 32 districts, 15 districts were in the cluster with medium rates (116/100,000 to 190/100,000), and nine districts were in the cluster with the highest rates (191/100,000 and above).

4. Harare and Bulawayo were sampled separately due to different population dynamics, population size, service delivery models and dynamics of predominantly urban and periurban settings. The districts with the lowest and highest TB notification rates in both cities were purposively selected to yield four districts in the two Provinces. This is shown in Table 1.
5. The Stat Trek's random number generator was used to randomly select eight districts (1 in each of the eight rural provinces) out of a pool of 56 districts across the three clusters. This together with the four districts purposively selected from the two urban provinces (Harare and Bulawayo) resulted in a total of 12 districts namely Gutu (Masvingo), Makoni (Manicaland), Bulilima (Matabeleland South), Mberengwa (Midlands), Mutoko (Mashonaland East), Bubi (Matabeleland North), Mhondoro (Mashonaland West), Mount Darwin (Mashonaland Central), Emakhandeni and Nkulumane (Bulawayo) and Chitungwiza and Epworth (Harare).

Table 1: Clustering of Districts using TB Notification rates (January to December 2023)

Range of TB Notification rates per 100,000			
Min	**Max**	**Range**	**33.3%**
41	264	223	74
Clusters			
Lowest rates	115	below 115	32 districts
Medium rates	190	116 to 190	15 districts
High rates	264	191 and above	9 districts
Urban Provinces			
Harare (2)	Lowest and Highest rates (2 districts)		
Bulawayo (2)	Lowest and Highest rates (2 districts)		

Sample Sizes

People with TB (PWTB) or TB survivors: The **Kish and Leslie sample size calculator**[3] was used to determine the sample size using a proportion (p) of 56.4%, computed from the total 2023 TB notifications (19,622) compared to the TB disease burden (33,000) according to the WHO data[4], at 5% error margin and 95% confidence level. This yielded 378, which was adjusted upwards by 10% to 416 to take care of selection bias, clustering of stigma and non-response. The total sample size (416) was distributed using probability proportional to size (PPS), using the TB notifications rates per each of the sampled districts. Further disaggregation was done by TB key and vulnerable groups and sex as follows;

- 15% people living with HIV (PLHIV)
- 10% of miners diagnosed with TB
- 10% Diabetic patients diagnosed with TB
- 10% Old Age 65+
- 10% of health workers diagnosed with TB
- 10% of former prisoners diagnosed with TB
- 61% Males and 39% females.

The breakdown of the sample sizes by district is shown in Table 3.

[3] $N = (z^2pq)/d^2$

[4] https://worldhealthorg.shinyapps.io

Table 2: Sample size distribution by district

Cluster (NR/100,000)[5]	District	Province	Total Notifications (Jan – Dec 2023)	District Population	NR per 100 000 (Jan –Dec 2023)	Proportion	Sample Size (PPS)[6]	Carers	Neighbours/Community Leaders	HCWs
Lowest (below 115)	Gutu	Masvingo	97	237,013	41	0.0269	11	3	3	3
	Makoni	Manicaland	252	375,206	67	0.0700	29	3	3	3
	Bulilima	Matabeleland South	108	121,921	89	0.0300	12	3	3	3
Medium (116 to 190)	Mberengwa	Midlands	269	223,345	120	0.0747	31	3	3	3
	Mutoko	Mashonaland East	267	188,184	142	0.0741	31	3	3	3
	Bubi	Matabeleland North	150	92,809	162	0.0416	17	3	3	3
Highest (191 and above)	Mhondoro	Mashonaland West	216	102,307	211	0.0600	25	2	2	2
	Mount Darwin	Mashonaland Central	703	266,115	264	0.1952	81	2	2	2
Urban Provinces	Emakhandeni	Bulawayo	561			0.1557	65	2	2	2
	Nkulumane	Bulawayo	325			0.0902	38	2	2	2
	Chitungwiza	Harare	442			0.1227	51	2	2	2
	Epworth	Harare	212			0.0589	24	2	2	2
TOTAL			**2,077**				**416**	**30**	**30**	**30**

- **Family members or carers:** The guidance set the maximum sample size for family members or carers of PWTB at **30**. These were purposively distributed across the 12 districts, with 2 to 3 being interviewed in each district.
- **Neighbours and Community members:** A total of **30 neighbours or community leaders** were purposively selected, with each district mobilizing 2 to 3 and linked to the PWTB or TB survivors.
- **Healthcare workers (HCWs):** A total of **30 HCWs** linked to the PWTB or TB survivors were conveniently selected across the 12 districts, 2 or 3 per district.
- **Multistakeholder Group:** A focus group discussion with **10 to 12 participants** (TB programme staff, representatives from judiciary and legal communities, legislators, media workers, policymakers, funders and implementing organizations) was convened to review and understand the extent to which any existing laws or policies, their enforcement and media coverage could harm or protect people with TB in Zimbabwe.

[5] NR/100,000 – Notification rate per 100,000
[6] Probability proportional to size

Recruitment of Respondents

Participants will be recruited from the diverse population of people who have been diagnosed with TB, their family members and neighbours, community leaders and health care workers.

- **Recruitment of PWTB or TB survivors**: The research assistants worked closely with the District TB and leprosy coordinators (DTLC) to identify the target population from TB registers at the district hospital and 2 to 3 other facilities depending on the sample size, ensuring that the sample is representative of the **key and vulnerable populations affected by TB**. The recruitment ensured diversity in terms of demographics, gender, key population category, TB treatment status, TB type and TB treatment stages. The sampling frame was constructed from the TB registers, and participants should be randomly selected within each stratum to ensure representativeness. The selected respondents were mobilized to come to a central facility for administering the interviews.
- **Recruitment of family members (carers), Neighbours or community members:** In each district, 2 or 3 of the identified PWTB were requested to provide details of **one main caregiver, one neighbour or community member** linked to them who were contacted and recruited in the study to respond to questions under Annex 2 and 3 respectively.
- **Recruitment of the HCWs**: The PWTB were requested to provide the names of the main HCWs who attended to them during the different stages of their TB journey. A total of 2 to 3 HCWs were interviewed per district linked to 2 or 3 PWTB.
- **Recruitment of members of the Multistakeholder group**: Members of the Core group listed 10 to 12 key participants of the multistakeholder group of the desired composition. The selected individuals were notified by email and phone calls and invited to participate in the FGD.

3.5 Data Collection Team

The data collection was led by the TB Stigma Expert, supervised in the field by members of the NTP and JHWO allocated to each of the sampled districts and a total of 21 research assistants. A total of 6 of the 21 research assistants were TB survivors, and 12 were women, all recruited from the sampled districts. Together with the DTLCs, the data collection team was trained over two days and participated in a pilot assessment before deployment to collect data in their districts of residence. The whole team (project lead and managers, interviewers, field supervisors, and data analysts) were trained on the confidentiality protocol, signed the Confidentiality protocol agreement (Annex 6) and had valid Good Clinical Practice (GCP) certificates.

3.6 Ethical Considerations

This assessment was initiated only after receiving written approval from the local Ethics Review Board (ERB), the Medical Research Council of Zimbabwe (MRCZ) under number MRCZ/A/3162. Those implementing this assessment complied with all policies and procedures of the MRCZ, including administering the informed consent process. The assessment methodology was designed to address the following ethical principles: respect for persons, beneficence, and justice. Efforts were made to protect individual autonomy, minimize harm, maximize benefits and equitably distribute risks and benefits by using procedures which are consistent with sound research designs. The assessment did not pose any physical risks associated with a physical procedure or intervention and recorded no single adverse events.

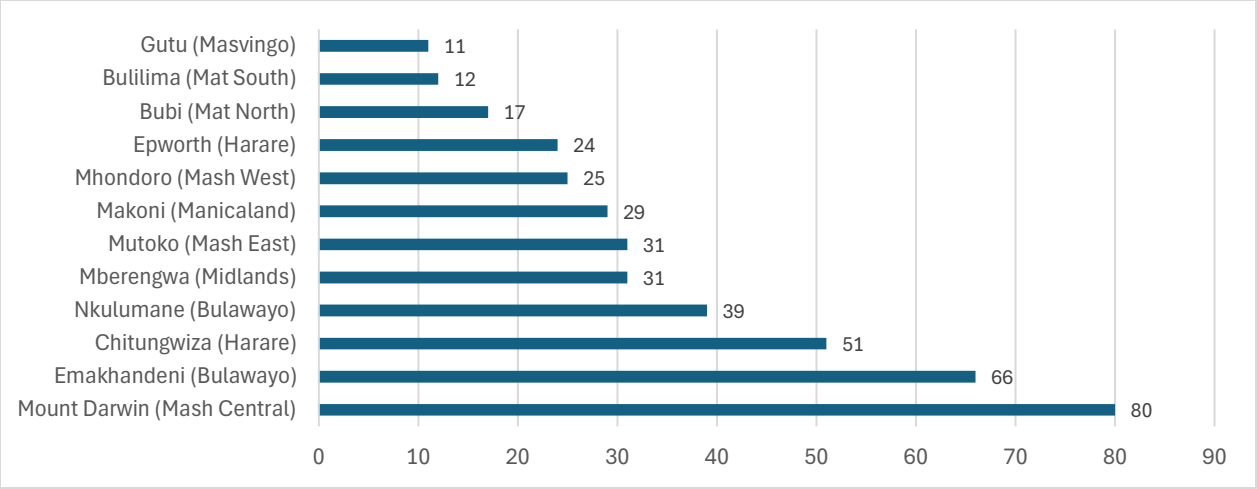
4. Findings

4.1 Demographic Characteristics of Respondents

4.1.1 People diagnosed with TB (PWTB)

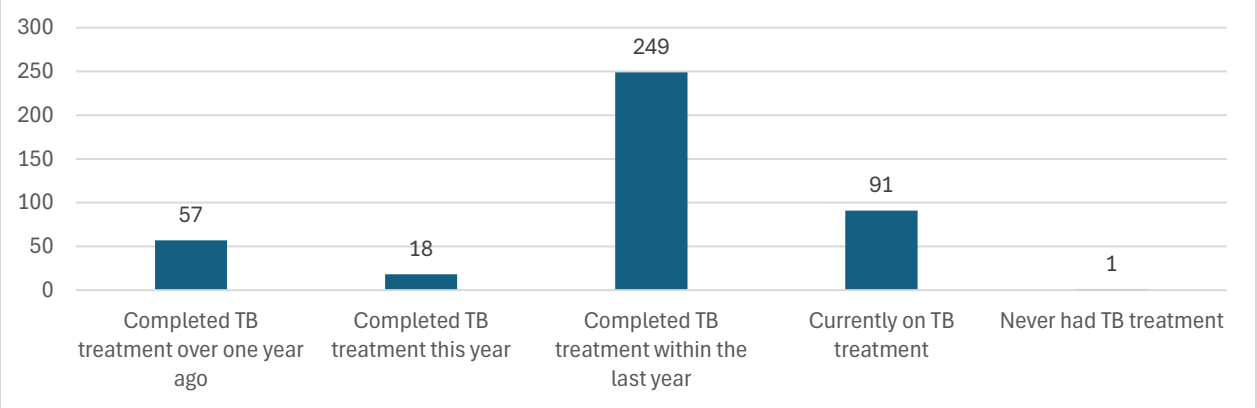
A total of 416 people diagnosed with TB were interviewed across the ten provinces, with the most (80) in Mount Darwin and the least (11) in Gutu based on the sample sizes. The rest of the PWTB interviewed respondents interviewed per district were as shown in Fig 6.

Figure 6: Total number of PWTB interviewed by District (Province), N=416



The data shows that most (59.9%, n=249) of the PWTB had completed treatment within the last 12 months preceding the assessment, while only 0.2% (n=1) had never had treatment, as in Fig 7.

Figure 7: Treatment status of PWTB (N=416)



About 60.1% (n=250) were last diagnosed with drug-sensitive TB, while 32.2% (n-134) did not remember. Female participants constituted 38.7% (n=161), and most of the respondents (51.9%, n=216) were aged between 25 to 44 at the time of the assessment. Persons living with HIV (22.8%, n=95), TB contacts (14.2%, n=59) and miners or ex-miners (11.1%, n=46) were the most common KVP groups that respondents belonged to. A total of 231 (55.5%) of the PWTB belonged to only one KVP, 86 (20.7%) belonged to 2 groups, and 73 (17.5%) belonged to the general population, as shown in Table 3.

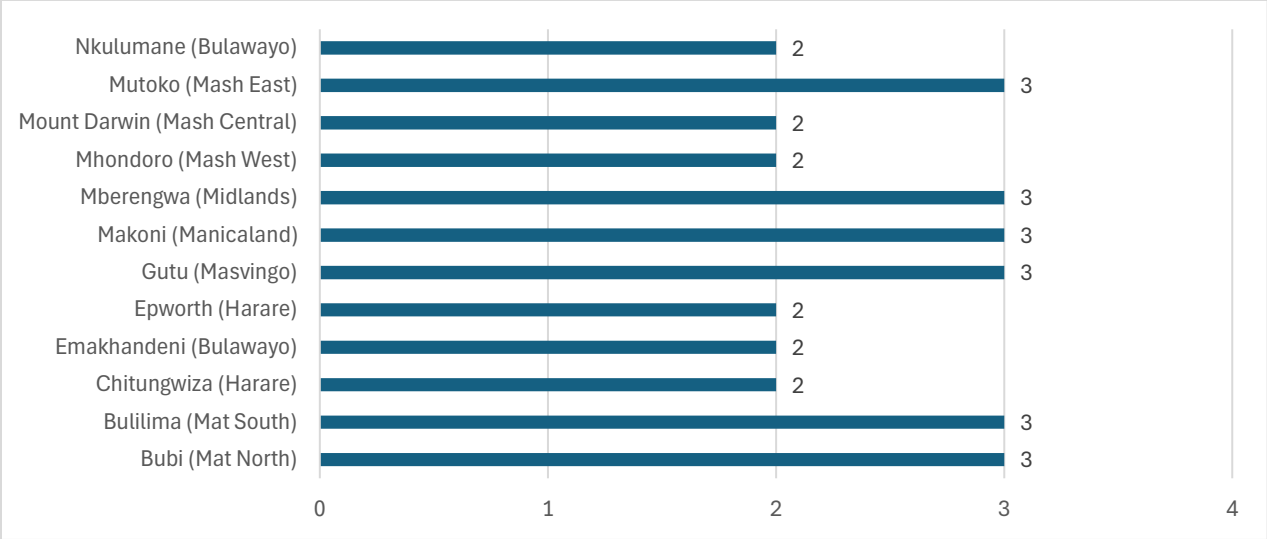
Table 3: PWTB by Treatment Status, Type of TB, Sex, Age and KVP Membership (N=416)

Characteristic	% (n)
Type of TB last diagnosed	
Don`t Know or Don`t remember	32.2 (134)
Drug-Resistant TB	6.7 (28)
Drug-Sensitive TB	60.1 (250)
Extensively Drug-Resistant TB	1.0 (4)
Sex of PWTB	
Female	38.7 (161)
Male	61.3 (255)
Age of PWTB	
18-24	7.5 (31)
25-44	51.9 (216)
45-64	32.0 (133)
65 or older	8.7 (36)
KVP Membership	
Person living with HIV (PLHIV)	22.8 (95)
General Population	17.5 (73)
TB contact	14.2 (59)
Miner or Ex-miner	11.1 (46)
PLHIV/Miner or Ex-miner	6.0 (25)
People in congregate settings (PiCS)	5.0 (21)
PLHIV/TB contact	4.8 (20)
PLHIV/PWUID	1.7 (7)
PLHIV/ PiCS	1.9 (8)
Person who uses and injects drugs (PWUID)	1.0 (4)
PiCS/TB contact	0.7 (3)
PLHIV/Former prisoner	0.7 (3)
Other combinations	16.6 (52)
Number of KVP groups	
General population	17.5 (73)
1	55.5 (231)
2	20.7 (86)
3	4.4 (18)
4+	1.9 (8)

4.1.2 Family members or Carers

A total of 30 carers/family members were interviewed across the 12 districts, with three each in Mutoko, Mberengwa, Makoni, Gutu, Bulilima and Bubi, and the rest had 2 participants each as in Fig 8.

Figure 8: Carers or Family members by District (Province), N=30



A total of 22 (73.3%) interviewed carers were females, most of them were between the ages of 25 and 44 (43.3%, n=13) and mostly other relatives (53.3%, n=16), as in Table 4. About 75% of the other relatives were spouses of the PWTB.

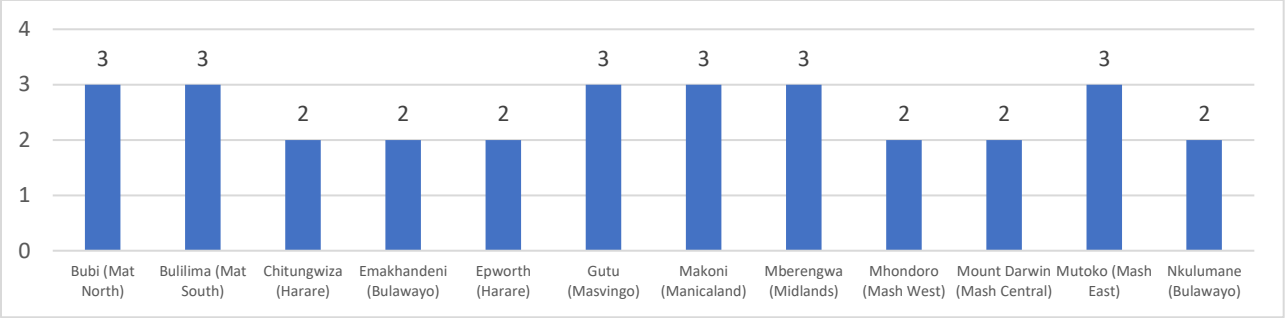
Table 4: Characteristics of interviewed Carers/Family members (N=30)

Characteristic	% (n)
Sex of Carer/Family member	
Female	73.3 (22)
Male	26.7 (8)
Age of Carer/Family member	
18-24	6.7 (2)
25-44	43.3 (13)
45-64	40.0 (12)
65 or older	10.0 (3)
Relationship with PWTB	
Child	16.7 (5)
Sibling	16.7 (5)
Parent	13.3 (4)
Other relative	53.3 (16)

4.1.3 Community members

A total of 30 community members were interviewed across the 12 districts, with three each in Mutoko, Mberengwa, Makoni, Gutu, Bulilima and Bubi, and the rest had 2 participants, as in Fig 9.

Figure 9: Community members interviewed by District (Province), N=30



Regarding the distribution by sex, about two-thirds (n=20) of the community members interviewed were female, while the majority were aged 45-64 years (46.7%, n-14), and 56.7% (n=17) knew two or more people who self-identify that they have or had TB in their communities as shown in Table 4.

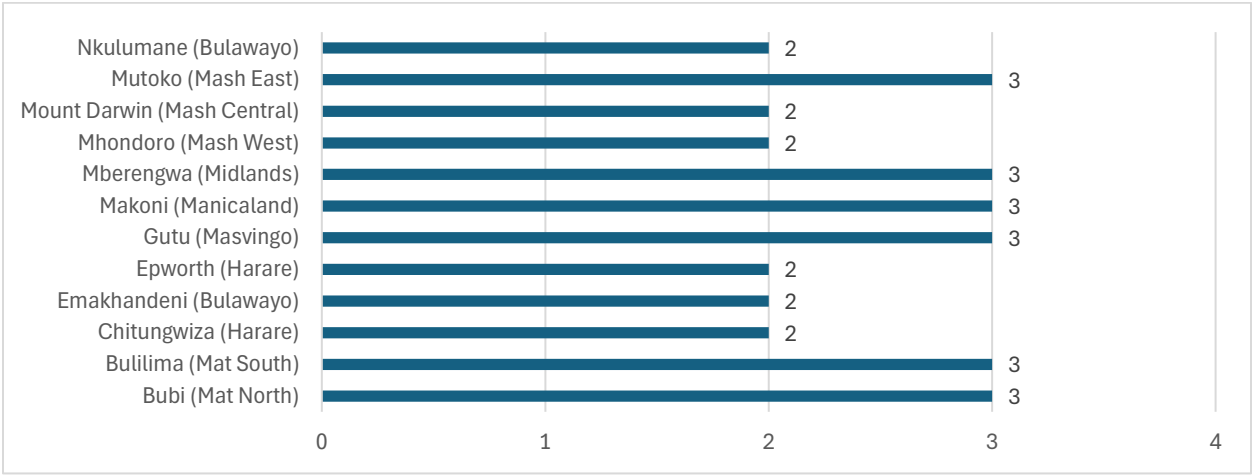
Table 5: Characteristics of Community members interviewed

Characteristic	% (n)
Sex of Community member	
Female	66.7 (20)
Male	33.3 (10)
Age of Community member	
18-24	6.7 (2)
25-44	40.0 (12)
45-64	46.7 (14)
65 or older	6.7 (2)
Number of People they know who self-identify that they have/had TB	
Don`t know	3.3 (1)
None	10.0 (3)
One only	30.0 (9)
Two or more	56.7 (17)

4.1.4 Healthcare workers

Healthcare workers linked to the PWTB were interviewed across the 12 districts, as in Fig 10.

Figure 10: Healthcare workers interviewed by District (Province), N=30



A total of 17 (56.7%) of the HCWs were females, 50% (n=15) between the age of 25-64 years and the remaining 50% (n=15) between the ages of 45-64 years. Almost all (96.7%, n=29) were nurses and had provided services to people diagnosed with TB before, as shown in Table 6.

Table 6: Characteristics of Healthcare workers interviewed (N=30)

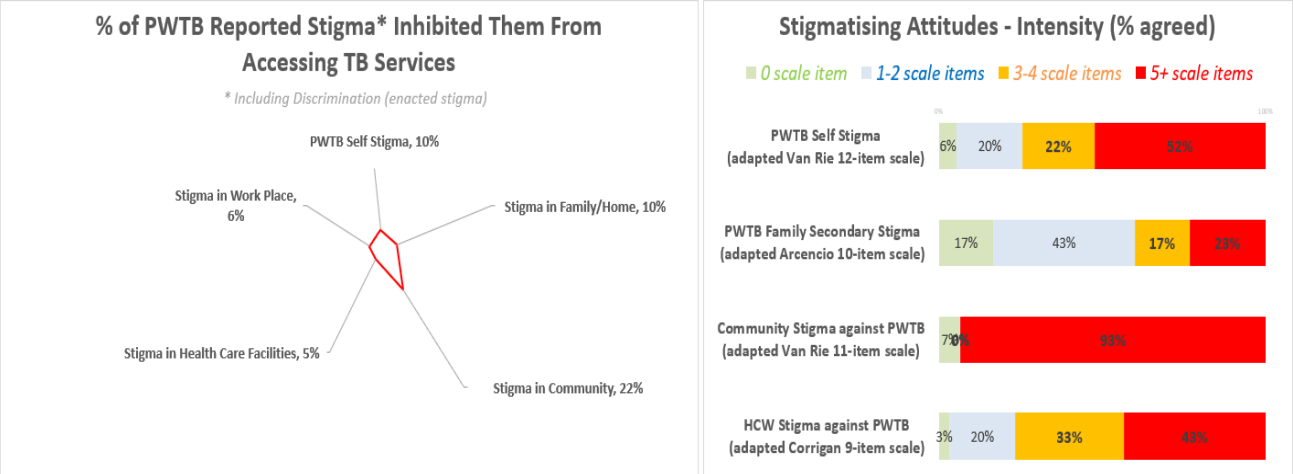
Characteristic	% (n)
Sex of Healthcare worker	
Female	56.7 (17)
Male	43.3 (13)
Age of Healthcare worker	
25-44	50.0 (15)
45-64	50.0 (15)
Type of cadre	
Nurse	96.7 (29)
Other	3.3 (1)
Experience providing services to PWTB	
Yes	96.7 (29)
No	3.3 (1)

4.2 Stigma experienced by PWTB

Stigma Radar and Stigmatising Attitudes – Intensity Results

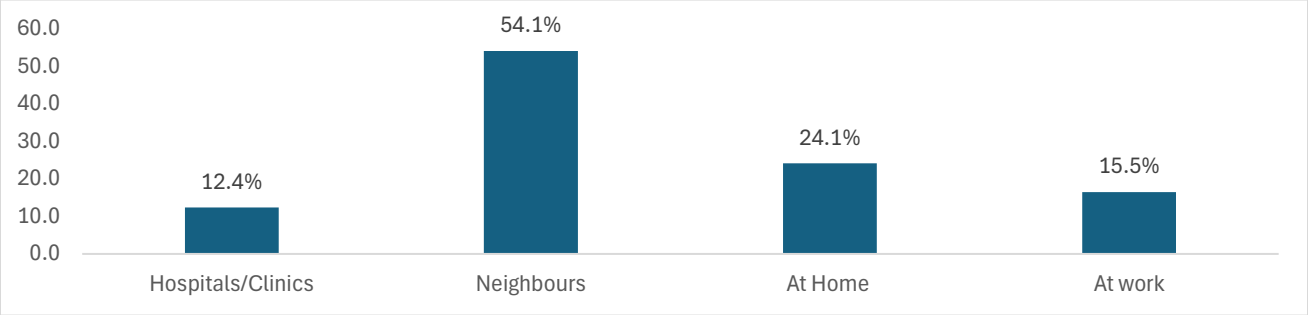
The radar shows that there was 22% stigma in the community, 10% self-stigma by PWTB, 10% stigma in the family or home, 5% for healthcare workers and 6% in the workplace. Regarding stigmatising attitudes, over half (52%, n=220/416) of PWTB reported they agreed to at least five of the 12 items in the self-stigma scale. And almost a quarter (23%, n=7/30) of PWTB family members agreed to 5 or more items of the 10-item family secondary stigma scale. The stimgatising attitdues against PWTB in the community is very high, with 9 out of 10 community respondents (93%, n=28/30) agreeing to 5 or more items in the 11-item community stigma scale. The corresponding stigmatising attitudes against PWTB among HCW were slower still quite high with over two-fifths (43%, n=13/30) agreed to 5 or more items in the 9-item stigma scale. This is shown in Fig 11 – TB service access inhibiting stigma are strongest in the community as reported by both PWTB and the community.

Figure 11: Stigma Radar and Stigmatising Attitudes-Intensity Results



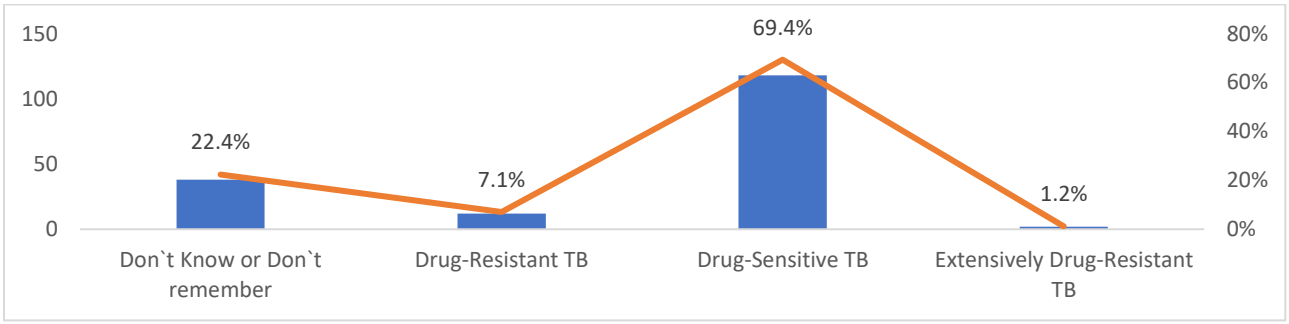
In addition to stigma that inhibited them from accessing TB services reported above, two-fifths (40.9%, n=170/416) PWTB also reported stigma that pose barriers to their daily lives including other non-TB health services. Of these, about 12.4% (n=21) experienced stigma at hospitals/clinics, 54.1% (n=92) from neighbors7, 21.4% (n=) at home and 15.5% (n=) at the workplace, as in Fig 12.

Figure 12: Settings where stigma was experienced by PWTB (N=170)



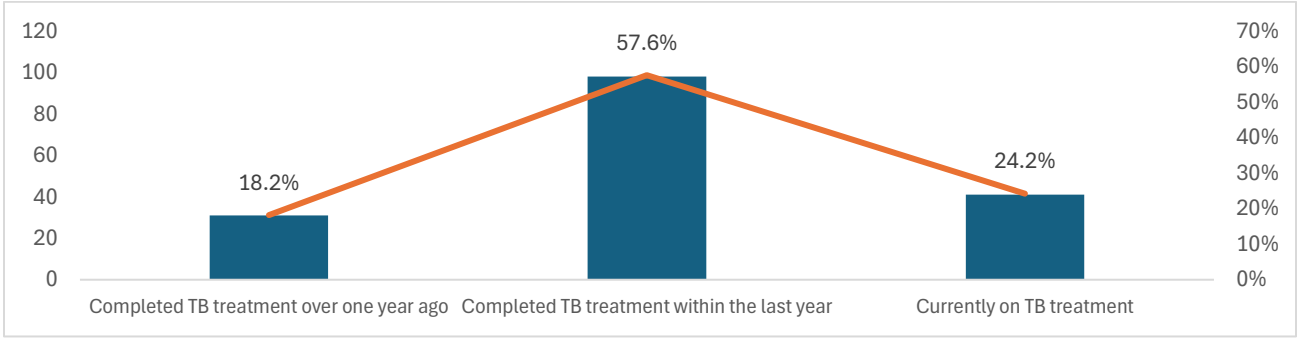
Among different sex groups, more females (44%, n=72/161) reported that they felt more stigmatized than males (38%, n=98/255) and the difference was significant (p<0.001). Disaggregating by TB diagnosis, most of those who felt stigmatized had been last diagnosed with drug-sensitive TB (69.4%, n=118) compared to 52% (n=84) among the non-DR TB, statistically significant at p<0.001, as in Fig 13.

Figure 13: PWTB who felt stigmatized by drug susceptibility (N=170)



Regarding the association between feeling stigmatized and treatment status, more than half (57.6%, n=98) had completed treatment within the last 12 months preceding the survey, followed by those who were currently on treatment (24.2%, n=41), as shown in Fig 14.

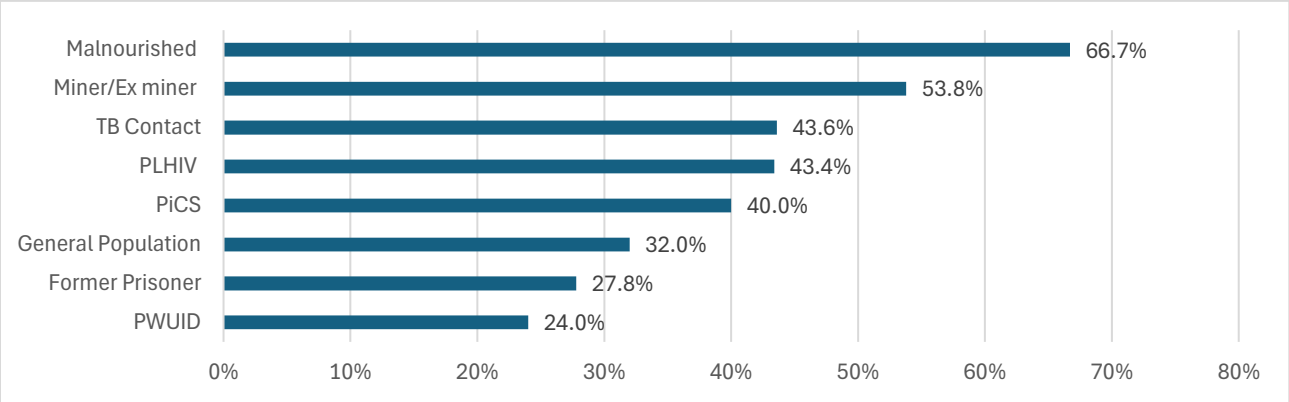
Figure 14: PWTB who felt stigmatized by TB treatment status (N=170).



7 Physical neighbours, friends, roommates, schoolmates, lecturers.

The data shows that among the malnourished PWTB, 66.7% (n=8) felt stigmatized, followed by PWTB who self-identified as miners/ex-miners (53.8%, n=56) and PWTB who use or inject drugs (24%, n=6) felt the least stigmatised as in Fig 15.

Figure 15: PWTB who felt stigmatized by the KVP group (individual responses)



Among the PWTB who did not belong to any KP group, 33% (24/73) felt stigmatized, 20% (n=47/231) felt stigmatized among those who belonged to one KP group 89% (n=99/112) felt stigmatized among those who belonged to two or more KP groups.

4.3 Stigma experienced along the TB Journey stage-setting

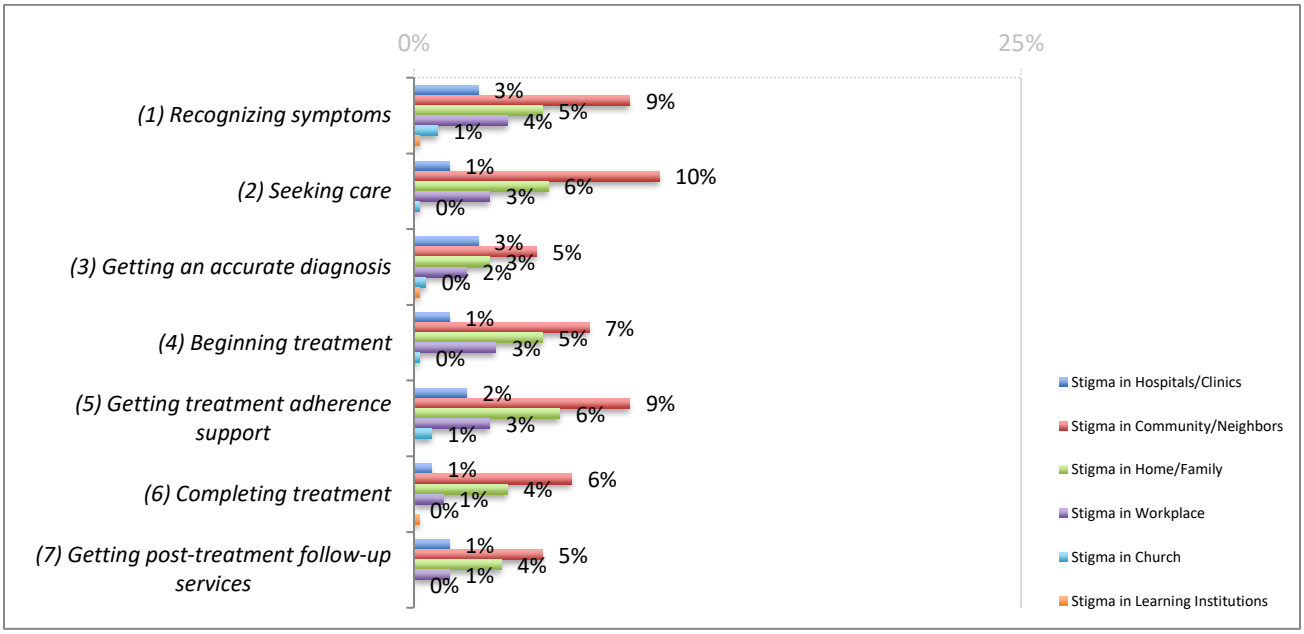
4.3.1 Stigma experienced by PWTB

A total of 416 PWTB were interviewed during the assessment, and among these, 170 (40.9%) had experienced stigma. The top five TB journey stage-setting combos reported by PWTB in Zimbabwe involved stigma experienced at the stage of;

- **recognising symptoms** by community/neighbours, in the home/family, at hospitals/clinics and workplaces (21%, n=36).
- **Seeking care** by community/neighbours, in the home/family, at hospitals/clinics and workplaces (20%, n=34).
- **getting treatment adherence support** from the community/neighbours, in the home/family, at hospitals/clinics and workplaces (20%, n=34).
- **beginning treatment** by community/neighbours, in the home/family, at hospitals/clinics and workplaces (16%, n=27).
- **getting an accurate diagnosis** by community/neighbours, in the home/family, at hospitals/clinics and workplaces (13%, n=22).

The assessment data shows that community/neighbours, home/family, hospitals/clinics and workplaces are the four major settings where stigma against PWTB was experienced in Zimbabwe, as in Fig 16:

Figure 16: Stigma experienced by PWTB on their TB Journey under different settings (N=170)



PWTB mentioned various ways in which they felt stigmatized across the different settings and people surrounding them at family, community and healthcare facility levels. Some of the most common stigmas experienced by people diagnosed with TB impacted their social, emotional, and physical well-being and included:

- **Family Rejection and Isolation**: Many individuals with TB face rejection from their family members, leading to feelings of isolation and abandonment. Family members distanced themselves, forcing some to transfer to different hospitals due to a lack of care home care. One person shared that, *"After I got diagnosed with TB, my family started discriminating against me. My wife refused to sleep on the same bed with me, and she could not even wash my clothes. That made me feel isolated" (PWTB, Mount Darwin 1-26).*
- **Social isolation and community exclusion**: People with TB often experienced social isolation as friends and community members distanced themselves. This led to loneliness and depression. Community members excluded individuals with TB from social events and gatherings. Public gatherings and community events became difficult to attend due to the fear of spreading TB. Patients faced mockery and stigma from neighbors and colleagues, with some even being told they would not survive. One patient experienced mockery and stigma from neighbors and colleagues after being diagnosed with drug resistant TB.resistance
- **Workplace stigma**: Stigma at the workplace was common for those with TB. Colleagues avoided sharing utensils or working closely with them. This often led to feelings of being undervalued and isolated at work. Some were even fired due to their TB status.
- **Healthcare stigma**: Stigma within healthcare settings led to inadequate care. Patients felt neglected or mistreated by healthcare workers, and some reported that they were even isolated within healthcare facilities. Some patients felt that healthcare workers had a negative attitude towards them, treating them with less care and respect. One person mentioned that the nurse attending to them was not kind and that they felt like they were going to infect her. and said, *"I experienced stigma at the hospital, as I fell from the bed and screamed for help, but no one came to help me" (PWTB, Bubi 13)*

- **Self-Stigma**: Self-stigma occurred when individuals internalized negative beliefs about TB. This led to feelings of shame and guilt. This self-imposed isolation often worsened their mental health. Gossip and rumors about a person's TB status spread quickly, leading to social ostracism. This was very damaging to one's reputation and mental health. One respondent indicated that,

  " I lost a lot of friends to the extent that I only have one friend left. At first, people would avoid me until they totally distanced themselves from me. People would gossip about me, and that made me feel bad because I am also HIV positive, so the pressure became too much" (PWTB, Mount Darwin, 1-12)
- **Misconceptions and Myths**: Misconceptions about TB led to fear and avoidance. People believed TB was highly contagious and avoided those diagnosed with it. These misconceptions often led to unnecessary isolation and fear.
- **Blame and Accusations**: Individuals with TB were blamed for their illness and accused of spreading it. This led to further isolation, and this blame often came from both community members and family. One participant mentioned that,

  "People started blaming me for giving them TB every time they had a cough" (PWTB, Mhondoro 6)
- **Loss of Relationships**: TB strained personal relationships, leading to breakups and divorces. This added emotional stress to the physical illness. Some even faced abandonment by their partners. In some cases, TB strained family dynamics, leading to conflicts and changes in relationships. This added to the emotional burden of the illness. The stigma also affected the children of those diagnosed with TB, who faced discrimination and isolation in their communities. One person mentioned that their child was discriminated against in the community and could not play with other children.
- **Discrimination in Public Spaces**: People with TB faced discrimination in public spaces, such as being asked to leave or being avoided. This made it difficult to participate in community life as public spaces became hostile environments.
- **Fear of Disclosure**: Fear of disclosing their TB status led individuals to avoid seeking treatment or support. This worsened their health outcomes as this fear often led to delayed diagnosis and treatment.
- **Loss of Employment**: TB led to job loss or difficulty finding employment. This had severe financial consequences, as some were even fired due to their TB status. One respondent indicated that,

  "I almost lost my job because of TB. The tablets were too strong, they affected my legs, so I couldn't work properly hence, at work, they thought I was no longer useful" (PWTB, Emakhandeni, 3-19)
- **Discrimination in Education**: Students with TB faced discrimination in educational settings, leading to disruptions in their education. This impacted their future as this often led to missed educational opportunities.
- **Impact on Mental Health**: The stigma associated with TB had a significant impact on mental health, leading to depression, anxiety and feelings of loneliness and despair. One respondent indicated that,

  " The stigma I experienced was significant and quite distressing. People who knew of my situation were afraid to be near me. Some people in my community would make offensive comments and sometimes spread rumors about me. They would say things like "she is contagious," which made me feel ashamed and embarrassed. At first, that affected me to a point where I would avoid people, especially when going for treatment" (PWTB, Makoni 2-5)

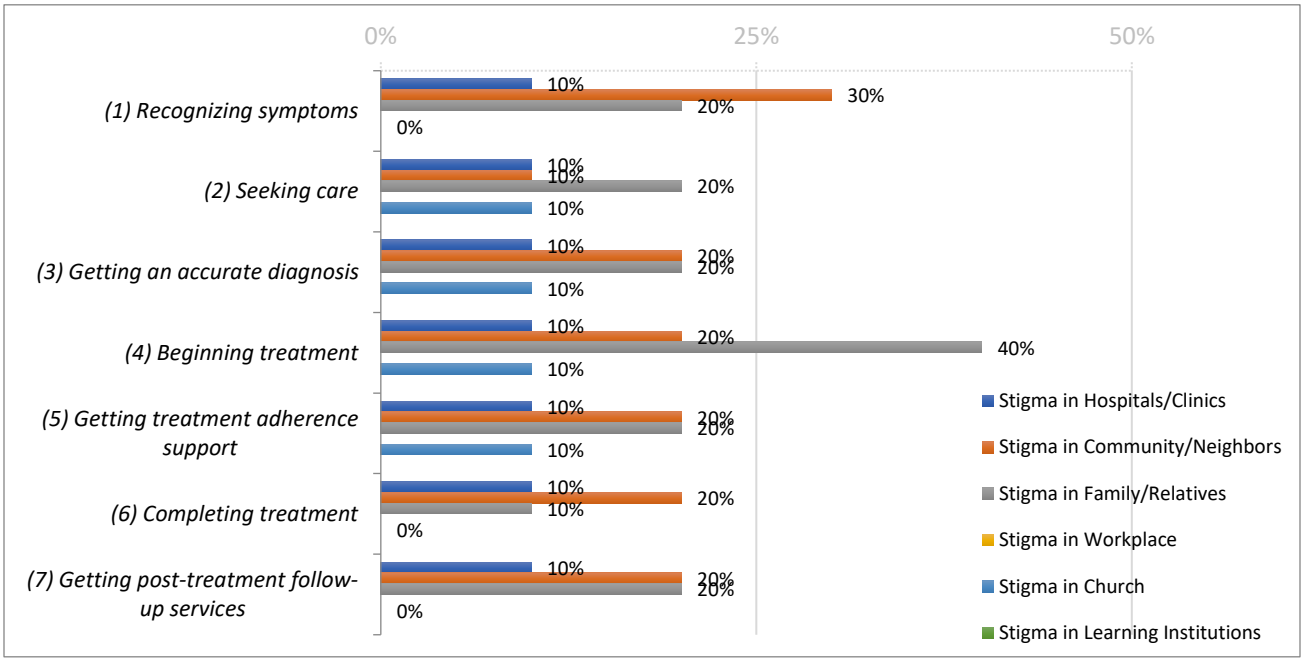
4.3.2 Stigma experienced by Family members

The assessment interviewed 30 family members, and among them, 10 (33.3%) indicated that they had experienced stigma. The top five TB journey stage-setting combos reported by family members or relatives in Zimbabwe involved stigma experienced at the stage of;

- **beginning treatment** by family/relatives, community/neighbours and at hospitals/clinics (80%, n=8).
- **recognising symptoms** by family/relatives, community/neighbours and at hospitals/clinics (60%, n=6).
- **getting treatment adherence support** from family/relatives, community/neighbours and at hospitals/clinics (60%, n=6).
- **getting an accurate diagnosis** by family/relatives, community/neighbours and at hospitals/clinics (60%, n=6).
- **getting treatment adherence support** by family/relatives, community/neighbours and at hospitals/clinics (60%)

The data shows that family/relatives, community/neighbours and hospitals/clinics are the three major settings where stigma has been experienced in Zimbabwe, as in Fig 17:

Figure 17: Stigma experienced by family during the PWTB's TB journey under different settings (N=10)



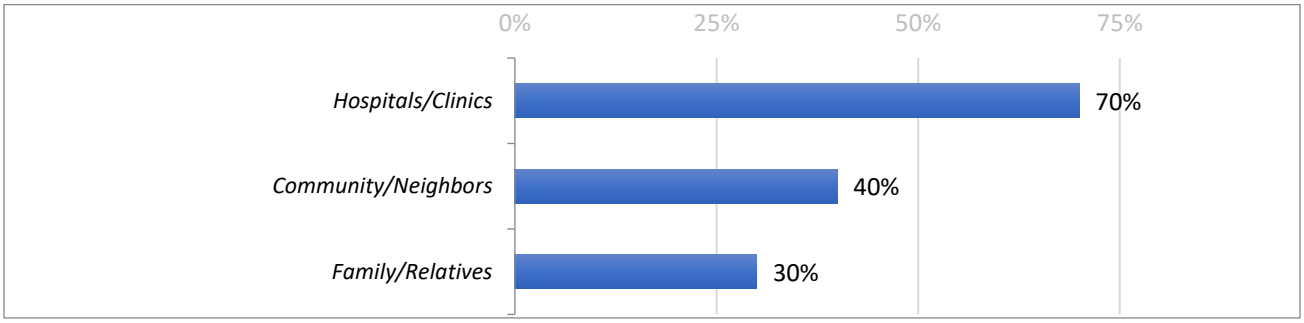
The most common experiences shared by the family members reflect a profound sense of isolation and stigma faced by individuals diagnosed with TB and their carers. In some cases, family members and relatives reportedly distanced themselves, refusing to eat with the patient and excluding them from activities. This led to feelings of loneliness and neglect. The stigma extended beyond the family to the community and church, where TB was perceived as a curse. In another case, the patient and their family were banished from the church after seeking medical treatment, further exacerbating their sense of exclusion and abandonment.

4.3.3 Stigma experienced by Healthcare Workers

A total of 30 healthcare workers were interviewed, and 10 (33.3%) reported that they had felt stigmatized because of their work, which involved interacting with people with or who have had TB.

About 70% (n=7) mentioned that they had experienced stigma at the hospital, 40% (n=4) by community/neighbours and 30% (n=3) by family or relatives, as in Fig 18.

Figure 18: Stigma experienced by health care workers under different settings (N=10)



Healthcare workers faced significant stigma while working with TB patients. They were often warned against spending time with TB patients and were even refused attendance at family gatherings. Some healthcare workers experienced avoidance from others simply because they worked with TB patients. Family members would avoid them if they coughed, and they were expected to take a bath and change clothes immediately upon arriving home. Even minor illnesses like the flu led to discrimination from colleagues. There was a noticeable reluctance among people to associate with TB patients despite the use of personal protective equipment (PPE).

Additionally, some healthcare workers did not want to assist TB patients, especially in the observation room, due to a lack of adequate equipment. This led to some workers going out of their way to ensure their patients received the necessary care. The public stigma was also evident, with some colleagues stigmatizing their peers, causing significant emotional pain. These experiences highlight the pervasive and multifaceted nature of stigma faced by healthcare workers dealing with TB patients.

4.3.4 Findings implications

The four major settings where stigma was experienced are community/neighbours, home/family, hospitals/clinics, and workplaces. Regarding TB journey stages, stigma was experienced mainly at the following stages, particularly in the community setting which is the the most frequently reported across TB journey stages;

- **Recognizing symptoms:** Stigma was reported by PWTB at this stage, particularly from community/neighbours, home/family, hospitals/clinics, and workplaces.
- **Seeking care:** Stigma was experienced by PWTB from community/neighbours, home/family, hospitals/clinics, and workplaces.
- **Getting treatment adherence support:** Stigma was reported by PWTB from community/neighbours, home/family, hospitals/clinics, and workplaces.
- **Beginning treatment:** Stigma was experienced by PWTB from community/neighbours, home/family, hospitals/clinics, and workplaces.
- **Getting an accurate diagnosis:** Stigma was reported by PWTB from community/neighbours, home/family, hospitals/clinics, and workplaces.

Stigma experienced by the different groups of respondents included:

- **People diagnosed with TB:** People diagnosed with TB experienced stigma in various healthcare facilities and community settings. This included clinics, hospitals, and other medical centers where

they sought treatment. The stigma was often related to the fear of infection and misconceptions about TB being a sign of poor hygiene or moral failing.

- **Family members/primary carers of people diagnosed with TB:** Family members or primary carers of people diagnosed with TB also faced stigma in healthcare facilities and community settings. They were perceived as carriers of the disease or blamed for the patient's condition. This secondary stigma led to social isolation and emotional distress.
- **Community members:** Community members observed TB stigma in community settings. This included neighbourhoods, workplaces, and social gatherings where people with TB were often avoided or discriminated against. The stigma was fueled by a lack of awareness and understanding about TB, leading to fear and prejudice.
- **Healthcare workers:** Healthcare workers experienced TB stigma in healthcare facilities. They faced discrimination from colleagues and patients due to their association with TB treatment. This stigma affected their professional relationships and job satisfaction. TB stigma against healthcare workers was also observed by other TB healthcare workers in the same settings. This created a challenging work environment and impacted the quality of care provided to TB patients.

4.4 Stigma observed

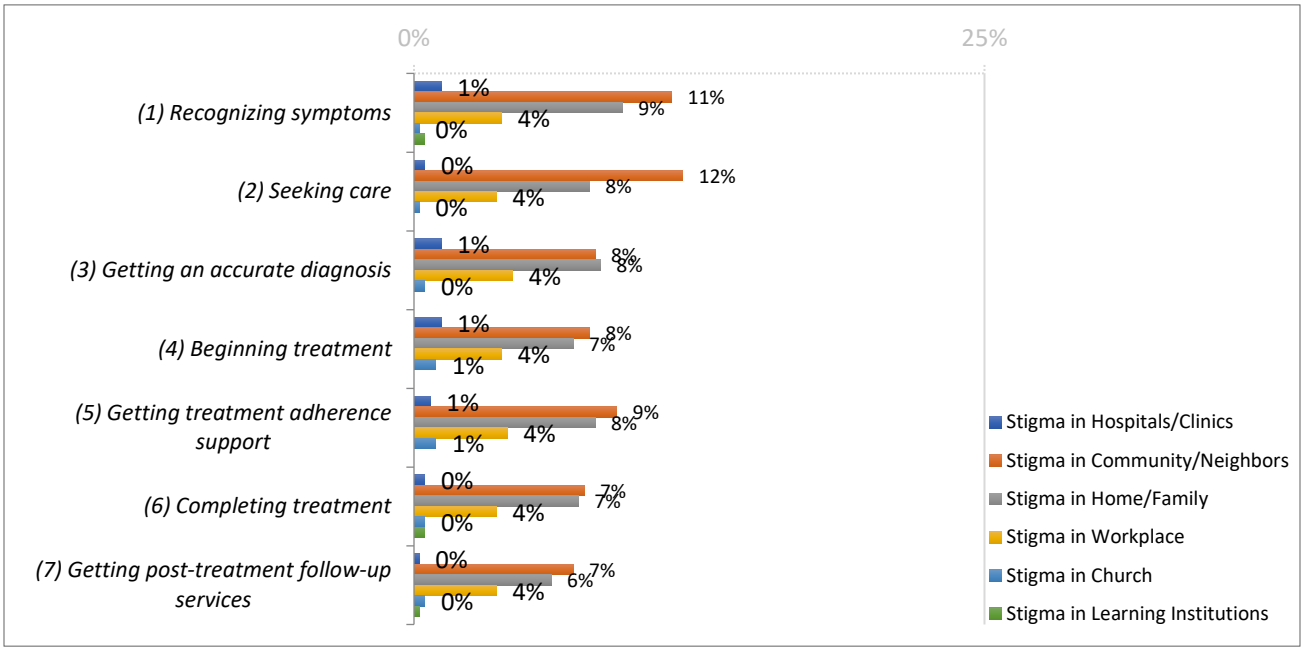
4.4.1 Stigma against other PWTB observed by PWTB

A total of 102 (24.5%) of the PWTB confirmed that they know of other people with or who have had TB being stigmatized because of their TB status. The top five TB journey stage-setting combos reported by PWTB involved stigma that was experienced mostly in community and family settings at the stage of;

- **Recognizing symptoms** by the community/neighbours (11%, n=11), in the home/family (9%, n=9) and at the workplace (4%, n=4).
- **Seeking care** by the community/neighbours (12%, n=12), in the home/family (8%, n=8) and at the workplace (4%, n=4).
- **Getting treatment adherence** support from the community/neighbours (9%, n=9), in the home/family (8%, n=8) and at the workplace (4%, n=4).
- **Getting an accurate diagnosis** by the community/neighbours (8%, n=8), in the home/family (8%, n=8) and at the workplace (4%, n=4).
- **Beginning treatment** by the community/neighbours (8%, n=8), in the home/family (7%, n=7) and at the workplace (4%, n=4).

This is shown in Fig 19.

Figure 19: Know other PWTB being stigmatised during their TB Journey (N=102)



PWTB observed stigma against other PWTB, and the following were some of the most commonly mentioned stigmas that they observed;

- **Family isolation**: Some friends were isolated by their families and given things to use alone because they were afraid of passing TB to others. This isolation extended to not sharing utensils or other items. Some TB patients were neglected by family members, even to the extent of being refused food. This neglect forced them to seek food elsewhere, leading to further humiliation and hardship. The friends felt lonely and rejected, which worsened their emotional well-being.

  "A friend of mine was isolated by his family and given things to use alone and not share with others because they were afraid he might pass TB to others. A woman was sent back to her maternal home by her husband because he did not want to take care of her when she was sick. This rejection led to emotional and financial hardship, as well as a sense of abandonment." (PWTB, Mutoko 2-11)

- **Workplace discrimination**: People at the workplace laughed at individuals with TB, associating it with HIV and AIDS. This led to a hostile work environment where TB patients were mocked and distanced. The stigma made it difficult for them to perform their duties and maintain professional relationships. Colleagues refused to work with a TB patient, forcing them to stop working. This exclusion led to job loss and financial instability, further exacerbating the patient's stress and anxiety. A person was laughed at work due to their TB status, leading them to quit their job. This humiliation caused emotional distress and job loss, further impacting their mental health and financial stability.
- **Public Stigma**: People with TB were often seen as dirty, contagious, or even cursed, leading to suspicion and hostility. This public stigma created a barrier to social interactions and access to community resources. People avoided socializing with TB patients, fearing infection. This social isolation extended to public gatherings and community events, leading to loneliness and a lack of support.

  "People don't want to socialize with anyone who has TB, thinking they will also be infected." (PWTB, Epworth 12)

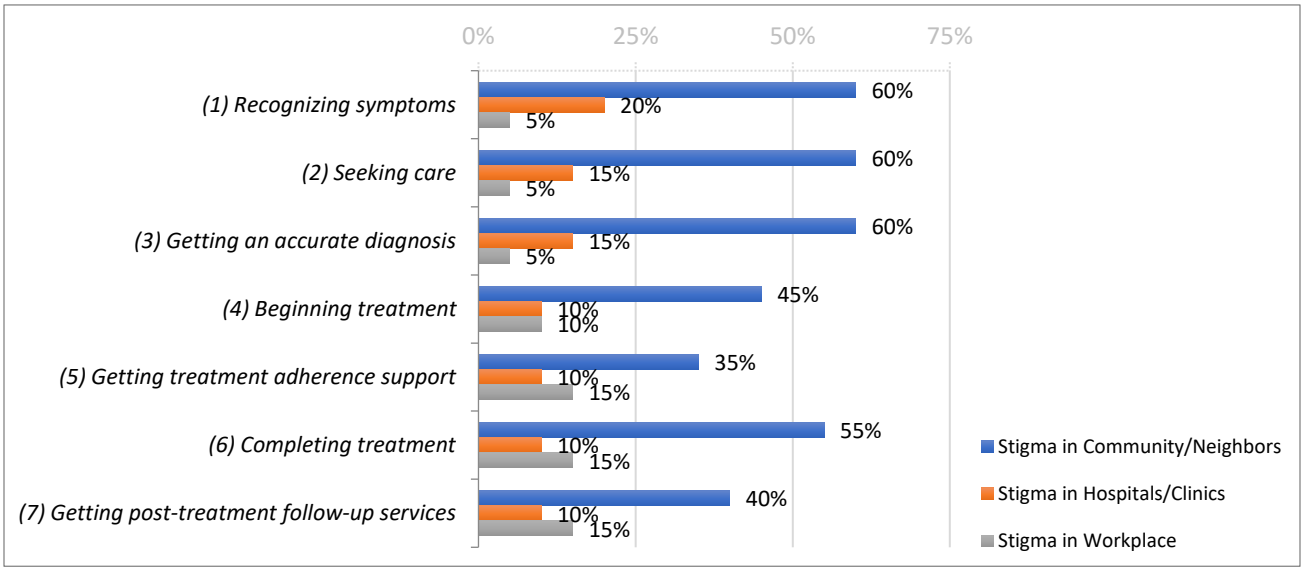
4.4.2 Stigma against other PWTB observed by Community

A total of 66.7% (n=20) of the community respondents indicated that they had seen or heard stigma by the community/neighbors, in hospitals and clinics and at the workplace. The top five journey stage-setting combos observed by the community involved stigma mostly in community setting at the stage of;

- **Recognising symptoms** by the community/neighbors, in hospitals and clinics and at the workplace (85%, n=17),
- **Seeking care** by the community/neighbors, in hospitals and clinics and at the workplace (80%, n=16)
- **Getting an accurate diagnosis** by the community/neighbors, in hospitals and clinics and at the workplace (80%, n=16),
- **Completing treatment** by the community/neighbors, in hospitals and clinics and at the workplace (80% each, n=16).
- **Beginning treatment or getting post-treatment follow-up services** by the community/neighbors, in hospitals and clinics and at the workplace (65%, n=15 - each).

This is shown in Fig 20.

Figure 20: Know PWTB in the community being stigmatised during their TB Journey (N=10)



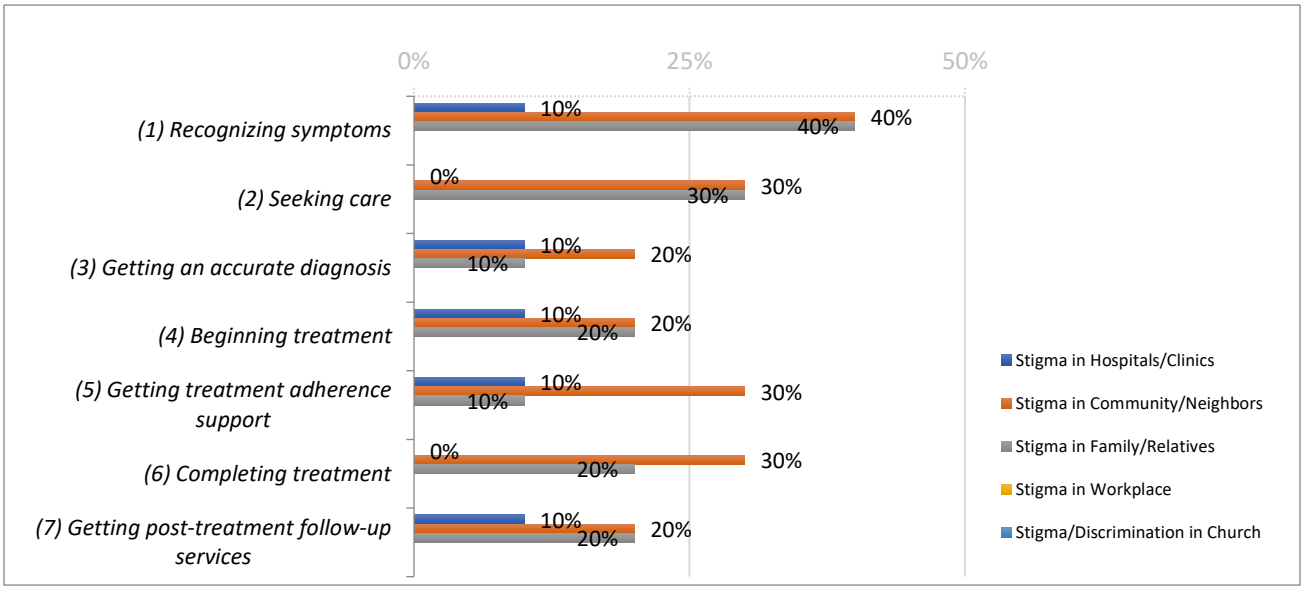
4.4.3 Stigma against other Family observed by Family

One third (33.3%, n=10) of the family members/relatives indicated that they had seen or heard stigma by the family/relatives, by the community/neighbors and at hospitals/clinics. The top five journey stage-setting combos observed by the family involved stigma in the community setting at the stage of;

- **Recognising symptoms** by the family/relatives, by the community/neighbors and at hospitals/clinics (90%, n=9),
- **Seeking care** by the family/relatives and by the community/neighbors (60%, n=6)
- **Beginning treatment, getting treatment adherence support, completing treatment or getting post-treatment to follow-up services** by the family/relatives, by the community/neighbors and at hospitals/clinics (50%, n=5 each),
- **Getting accurate diagnosis** by the family/relatives, by the community/neighbors and at hospitals/clinics (40% each, n=4).

This is shown in Fig 21.

Figure 21: Know of other family members being stigmatised when supporting their family members with TB during their TB Journey under different settings (N=30)

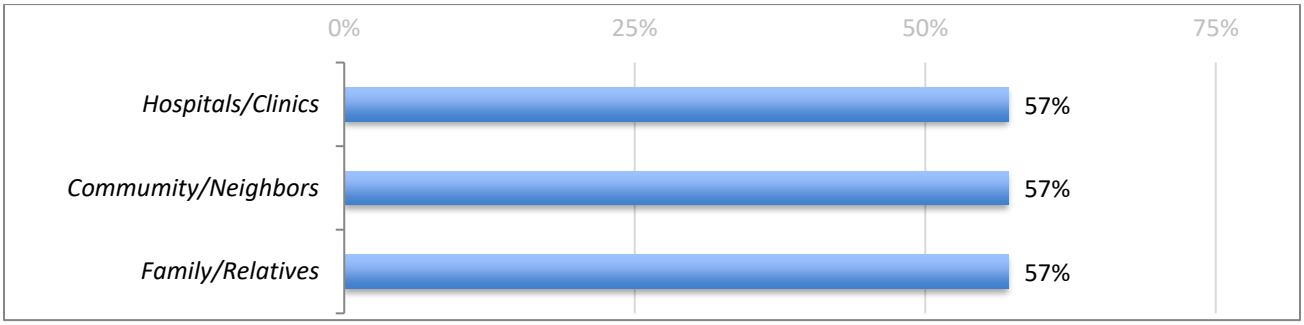


The experiences described by the family members highlight various forms of stigma faced by other family members when supporting their members with TB. One family member was segregated during community meetings and gatherings, while another was stopped from performing duties at work. Harassment of a family member and misconceptions about TB, such as the belief that a person diagnosed with TB is automatically HIV positive, further illustrate the challenges faced. People avoided sharing utensils with TB patients, and name-calling based on TB status and taking care of a TB patient was common. These experiences underscore the severe social and emotional impact of TB-related stigma on family members.

4.4.4 Stigma against other HCWS observed by HCWs

More than a third (35%, n=7) of healthcare workers knew of other healthcare workers being stigmatized in different settings. The top settings reported by HCW where stigma was observed were hospitals/clinics (57%, n=4), by community/neighbours (57%, n=4) and by family/relatives (57%, n=4), as in Fig 22.

Figure 22: Know other healthcare workers being stigmatized under Different Settings (N=7)



Healthcare workers emphasized the importance of treating TB patients with the same level of care and respect as any other patient. They stressed the need for personal protective clothing to be readily available in hospitals to protect themselves while attending to TB patients. Additionally, healthcare workers believed that organizations should intensify public health efforts to ensure that TB patients understood their medication regimen to prevent the spread of the disease and address stigma. They also

advocated for prioritizing TB patients in hospitals and providing them with food hampers and support groups. One healthcare worker stated,

"TB clients are like any of our clients, so we treat them equally," (Healthcare worker, Bubi 3)

Education plays a crucial role in the fight against TB, according to healthcare workers. They suggested that a lot of health education should be given to patients and their relatives to reduce stigma and encourage relatives to get screened as they were TB contacts. Healthcare workers also highlighted the need for close monitoring and empathy training for TB nurses. They believed that educating the community to be alert to TB symptoms could prevent delays in seeking medical attention and reduce the spread of TB. Continuation of TB screening was also encouraged to ensure early detection and treatment. One healthcare worker mentioned,

" A lot of health education to be given to the patients and relatives to reduce stigma against TB. It's important to educate the relatives to be screened as well as they are TB contacts" (Healthcare worker, Emakhandeni, 2-1)

Healthcare workers pointed out several systemic issues that needed to be addressed. They noted that many TB patients were unaware that TB treatment was free, leading some to avoid seeking medical help or pay for consultations unnecessarily. There was also a shortage of TB drugs, which exacerbated the problem. Healthcare workers called for increased domestic funding for TB and regular screening for TB among healthcare workers themselves, with compensation for those who contracted TB at work. They also emphasized the need for community awareness to reduce transmission and increase precautionary measures.

4.4.5 Findings implications

The observations by the different categories of observations show that most of the stigma observed (by PWTB, family and community) were stigma in the community setting as follows;

- **PWTB observations**: PWTB observed stigma against other PWTB at various stages of their TB journey. When recognizing symptoms, seeking care, getting treatment adherence support and getting an accurate diagnosis, stigma was observed by the community/neighbors, in the home/family, and at the workplace.
- **Community observations**: The community also reported observing stigma against PWTB at different stages of the TB journey. When recognizing symptoms, seeking care, getting an accurate diagnosis and completing treatment, stigma towards PWTB was observed from the community/neighbors, in hospitals and clinics, and at the workplace.
- **Family observations**: Family members/relatives also observed stigma against PWTB at various stages of the TB journey. When recognizing symptoms, seeking care, beginning treatment, getting treatment adherence support, completing treatment, or getting post-treatment follow-up services, stigma was observed from family/relatives, by the community/neighbors, and at hospitals/clinics.
- **HCWs observations**: Healthcare workers also reported observing stigma against other HCWs in different settings. Stigma was observed in hospitals/clinics, by community/neighbors, and by family/relatives. HCWs emphasized the importance of treating TB patients with the same level of care and respect as any other patients. They stressed the need for personal protective clothing to be readily available in hospitals to protect themselves while attending to TB patients. They also advocated for prioritizing TB patients in hospitals and providing them with food hampers and support groups.

Implications for recommendations:

- **Addressing stigma**: The stigma experienced by PWTB women, specific key populations (KPs), and those with a drug-resistant TB diagnosis highlights the need for targeted interventions to reduce stigma. This includes community education programs to dispel myths and misconceptions about TB, as well as campaigns to promote empathy and support for TB patients.
- **Support systems**: The emotional and financial hardships faced by PWTB women, such as being sent back to their maternal homes or being isolated by their families, underscore the importance of providing robust support systems. Recommendations could include establishing support groups, providing financial assistance, and ensuring access to mental health services for TB patients and their families.
- **Workplace policies**: The discrimination and hostile work environments faced by TB patients at their workplaces suggest the need for stronger workplace policies. Employers should be encouraged to implement policies that protect TB patients from discrimination, provide reasonable accommodations, and promote a supportive work environment.
- **Healthcare access**: The stigma associated with seeking care, getting an accurate diagnosis, and beginning treatment indicates a need for improving healthcare access and patient experience. Recommendations could include training healthcare workers to provide non-judgmental care, ensuring confidentiality, and making TB treatment more accessible and patient-friendly.
- **Public awareness**: The public stigma and misconceptions about TB being contagious or cursed highlight the need for public awareness campaigns. These campaigns should aim to educate the public about TB transmission, prevention, and treatment and encourage community support for TB patients.

4.5 Stigmatizing attitudes

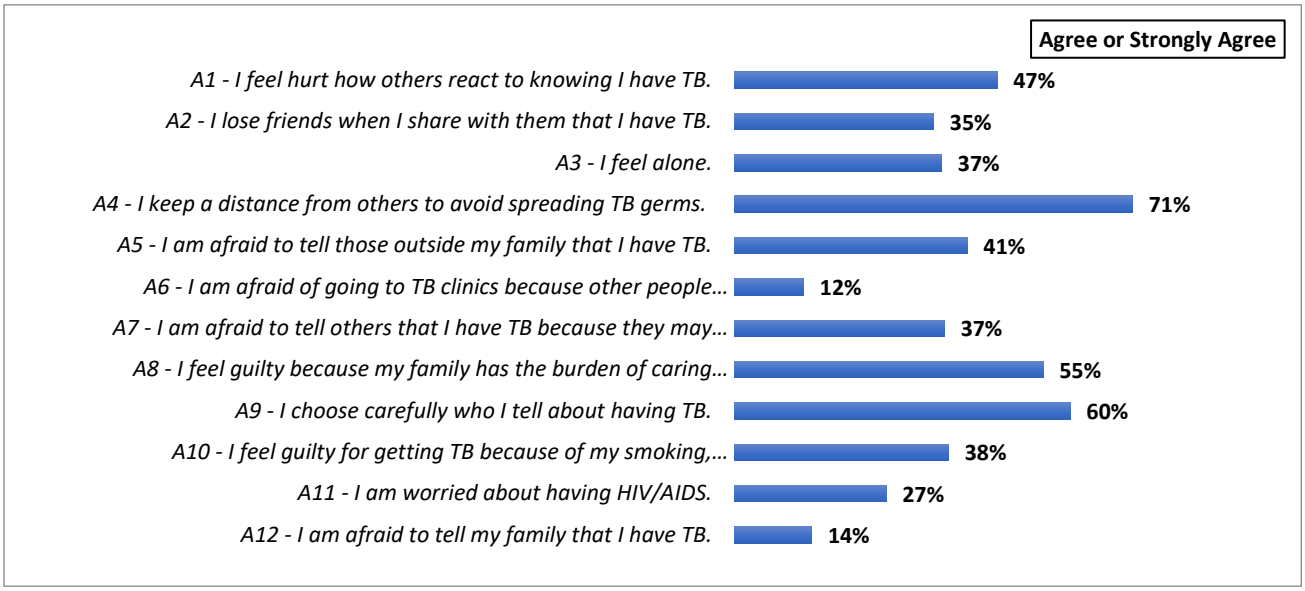
4.5.1 PWTB self-stigma

Regarding self-stigma among PWTB, the following were the top 3 scale items where the respondents (N=416) agreed or strongly agreed;

- *A4: I keep a distance from others to avoid spreading TB germs (71%, n=295)*
- *A9: I choose carefully who I tell about having TB (60%, n=249).*
- *A8: I feel guilty because my family has the burden of caring for me (55%, n=187).*

The scale item with the least proportion (12%, n=50) was A6 (I am afraid of going to TB clinics because other people might see me there) and A12 (I am afraid to tell my family that I have TB, 14%, n=58) as shown in Fig 23.

Figure 23: People with or had TB Self-Stigma (N=416)



About 70.9% (n=295) of the PWTB indicated that at least one of the 12 statements above described how they felt about TB themselves, while only 13.9% (n=41) of these mentioned that these feelings about TB inhibited them from seeking and accessing TB services.

Those with drug-sensitive TB and those who did not remember the type of TB they were last diagnosed with had the highest proportions contributing to the 3 top scale items, while more females than males and those aged 25-44 years had higher proportions than the rest of the age groups ($p<0.01$). Among the specific KVPs, the malnourished, TB contacts, PLHIV and the miners/ex-miners had higher proportions compared to the rest of the groups ($p<0.001$), and those who belonged to 2 or more KVP groups contributed more to the 3 top scale items than those who belonged to only one or none KVP group ($p<0.01$).

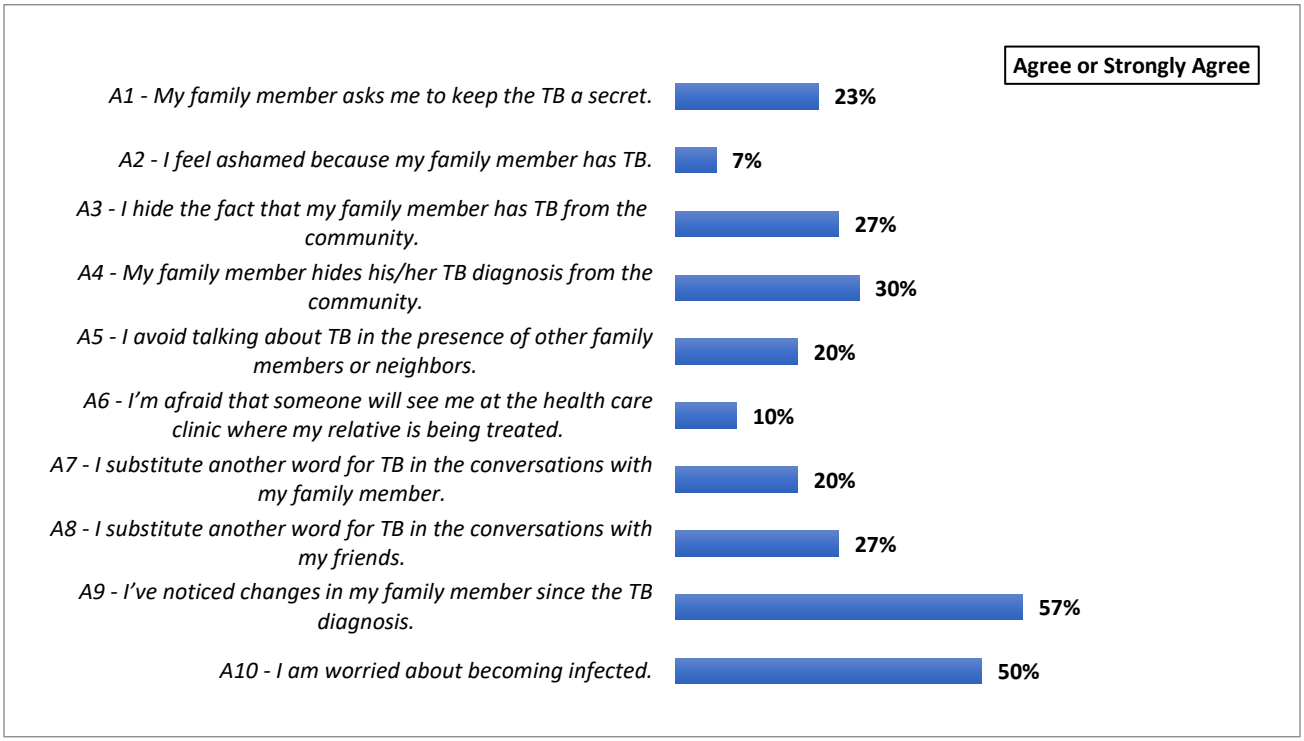
4.5.2 Family secondary stigma

Regarding secondary stigma among family members/relatives, the following were the top 3 scale items where the respondents (N=30) agreed or strongly agreed;

- *A9: I have noticed changes in my family members since the TB diagnosis (57%, n=17)*
- *A10: I am worried about becoming infected (50%, n=15).*
- *A4: My family member hides his/her TB diagnosis from the community (30%, n=9).*

The scale item with the least proportion was A2 (I feel ashamed because my family member has TB) at 7% (n=2) and A6 (I am afraid that someone will see me at the health care clinic where my relative is being treated) at 10% (n=3) as shown in Fig 24.

Figure 24: Family Secondary Stigma (N=30)



Those with drug-sensitive TB had the highest proportions contributing to the 3 top scale items compared to those with non-DR TB ($p<0.01$), while more females than males and those aged 25-44 years had higher proportions than the rest of the age groups ($p<0.001$, for both differences). Among the specific KVPs, the malnourished, PLHIV and the miners/ex-miners had higher proportions than the rest, and those who belonged to 2 or more KVP groups contributed more to the 3 top scale items than those who belonged to only one or none of the groups ($p<0.01$).

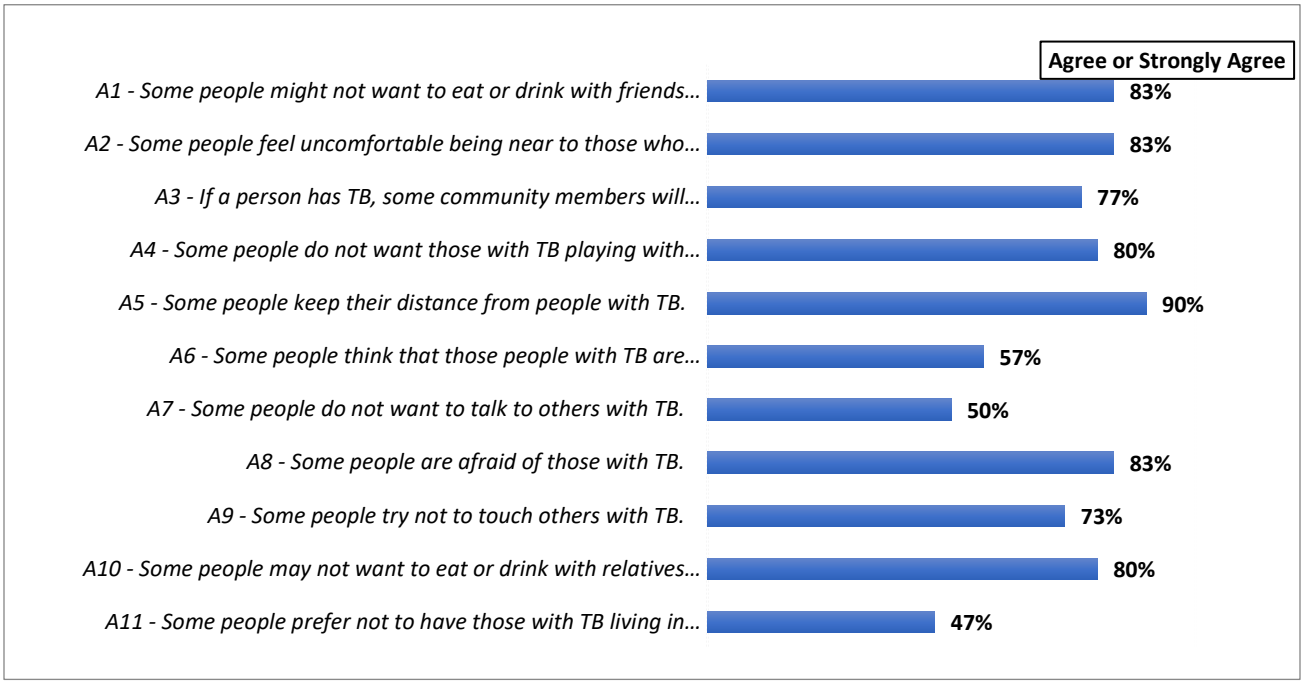
4.5.3 Community stigmatising attitudes against PWTB

Regarding community stigmatising attitudes against PWTB, the following were the top 3 scale items where the respondents (N=30) agreed or strongly agreed with;

- *A5: Some people keep their distance from people with TB (90%, n=27)*
- *A1: Some people might not want to drink or eat with friends who have TB (83%, n=25).*
- *A2: Some people feel uncomfortable being near those who have TB (83%, n=25).*
- *A8: Some people are afraid of those with TB (83%, n=25).*

The scale item with the least proportion was A11 (Some people prefer not to have those with TB living in their community) at 47% (n=14) and A7 (Some people do not want to talk to others with TB) at 50% (n=15) as shown in Fig 25.

Figure 25: Stigma towards people with or who had TB by Community (N=30)



For the top 4 scale items in this category, more females than males agreed or strongly agreed ($p<0.001$), while for A1, A2 and A8, those aged 25-44 years contributed the highest proportions to the items A1, A2 and A8 while the 45–64-year-olds contributed the highest to scale item A5.

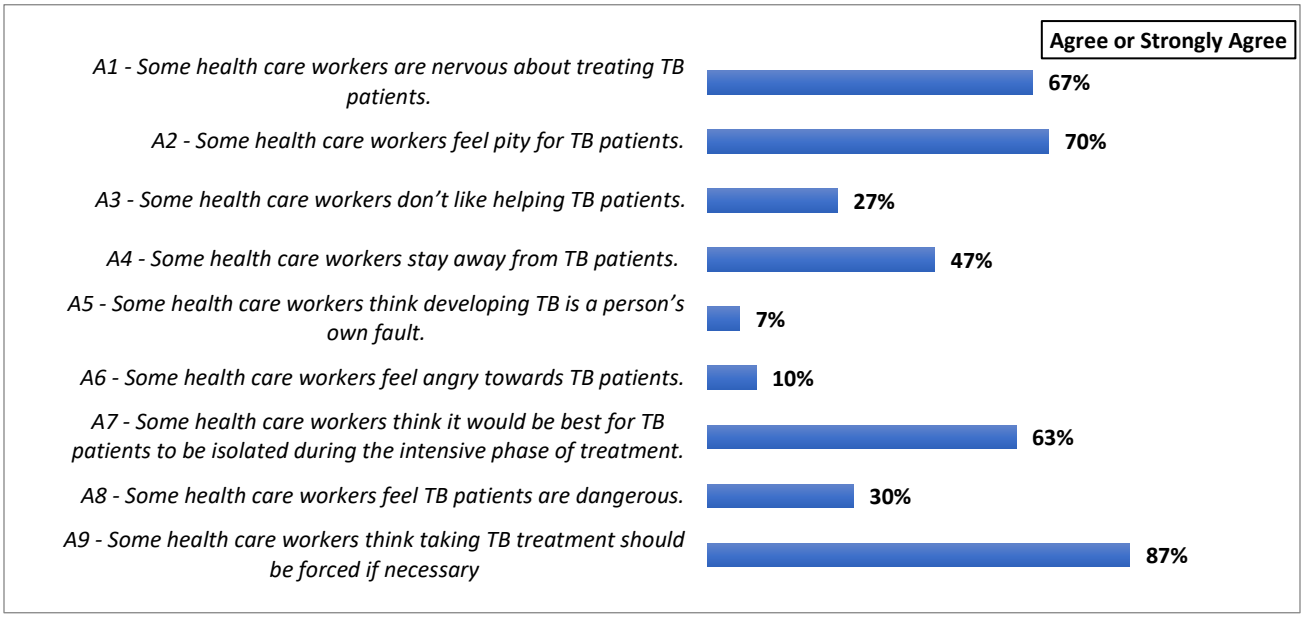
4.5.4 HCW stigmatising attitudes against PWTB

Regarding stigmatising attitudes towards PWTB by healthcare workers, the following were the top 3 scale items where the respondents (N=30) agreed or strongly agreed with;

- *A9: Some healthcare workers think taking TB treatment should be forced if necessary (87%, n=26)*
- *A2: Some healthcare workers feel pity for TB patients (70%, n=21).*
- *A1: Some healthcare workers are nervous about treating TB patients (67%, n=20).*

The scale item with the least proportion was A5 (Some health care workers think developing TB is the person's fault) at 7% (n=2) and A6 (Some health care workers feel angry towards TB patients) at 10% (n=3) as shown in Fig 26.

Figure 26: Stigma Towards People With or Had TB by Health Care Workers (N=30)



For all the top 3 scale items (A1, A2 and A9), females had a higher proportion than males ($p<0.001$), and those aged 25-44 and 45 – 64 had equal contribution to the top 3 scale times.

4.5.5 Findings implications

Self-stigma among PWTB was a significant issue, where individuals often feared spreading TB germs and thus kept a distance from others. This fear led to selective disclosure, where they were cautious about whom they informed about their condition. Additionally, many individuals with TB experienced feelings of guilt and burden, as they felt responsible for the care their families had to provide. These feelings of guilt could be overwhelming, as they worried about the impact of their illness on their loved ones' lives and well-being.

Family secondary stigma was another critical aspect, where family members noticed changes in their dynamics due to the TB diagnosis. They often feared infection themselves and went to lengths to hide the diagnosis from the community. This fear led to significant stress and anxiety within the family as they navigated the challenges of supporting their loved ones while protecting themselves. Community stigmatizing attitudes further exacerbated the issue, with social distancing, discomfort, and fear being common reactions. Some community members even preferred not to have those with TB living in their vicinity. Healthcare workers were not immune to stigmatizing attitudes either; some believed in forced treatment, felt pity and nervousness, and a small proportion even blamed TB patients for their condition8. These attitudes negatively impacted the quality of care that TB patients received, further isolating them and reinforcing the stigma associated with the disease.

Implications for recommendations:

- **Education and awareness**: Implementing educational programs to reduce fear and misinformation about TB can help mitigate self-stigma and community stigmatizing attitudes especially issues around community attitudes A1, A2, A5 and A8.
- **Support systems**: Establishing support systems for both individuals with TB and their families can alleviate feelings of guilt and burden and reduce secondary stigma.

- **Community engagement**: Engaging community leaders and members in stigma reduction initiatives can foster a more supportive environment for individuals with TB to take care of attitudes A1, A2, A5 and A8.
- **Training for healthcare workers**: Providing training for healthcare workers on stigma reduction and empathetic care can improve the quality of care and support for TB patients to reduce attitudes A1, A2 and A9 under healthcare worker stigmatizing attitudes.

4.6 Structural Stigma

The Zimbabwe TB scorecard produced by the Step Up for TB provides a comprehensive overview of the policy environment for tuberculosis (TB) care and prevention in Zimbabwe. The report evaluates the country's adoption of 14 key policies that are internationally recommended for effective TB control. Zimbabwe has implemented Rapid Molecular Diagnostic (RMD) testing as the initial test for TB, which is crucial for early and accurate diagnosis. The country also conducts drug resistance testing for rifampicin (RIF) and isoniazid (INH) for all individuals starting treatment and at least fluoroquinolone (FLQ) resistance testing for all people with rifampicin-resistant TB (RR-TB).

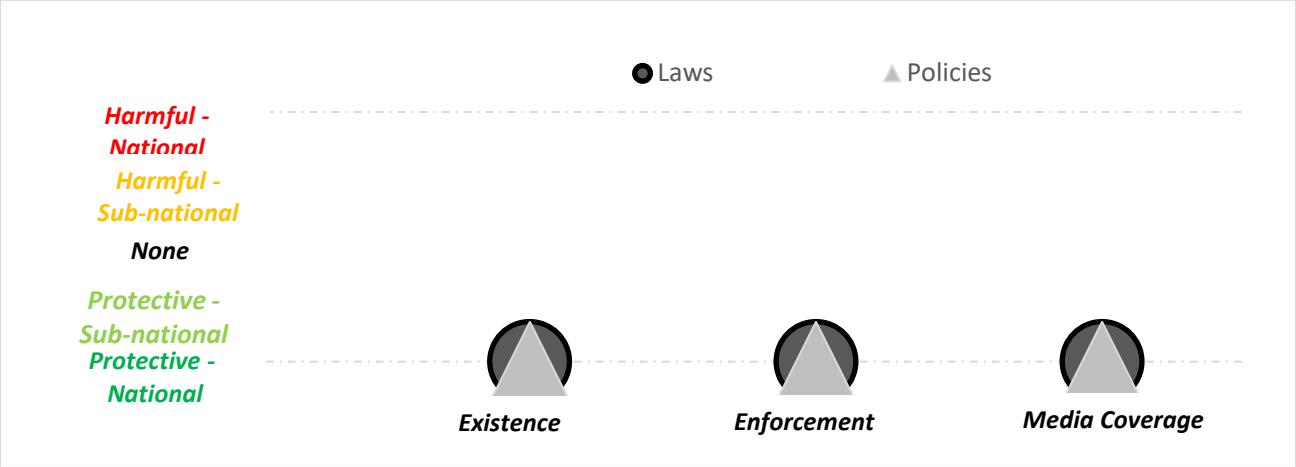
Treatment for drug-resistant TB (DR-TB) is decentralized to primary healthcare facilities and can be administered at home. For children with uncomplicated DR-TB, injectable-free regimens are used routinely, and a modified shorter all-oral regimen is available for eligible adults with DR-TB. Zimbabwe offers shorter TB Preventive Treatment (TPT) regimens and investigates household contacts of a person with bacteriologically confirmed DS-TB and DR-TB for signs and symptoms of TB.

The country is enrolled in the WHO Collaborative Registration Procedure (CRP) and requires stringent regulatory authority (SRA) approval and/or WHO Prequalification (PQ) for the importation of TB medicines purchased with domestic funding. Partners are enhancing integrated COVID-19, HIV, TB, and MDR-TB case finding and management training to include uniform forces and private practitioners. The development of a national Public-Private Mix (PPM) operational plan for the provision of TB services in the private sector is underway.

The National TB Program (NTP) and partners are working closely to strengthen and expand access to the TB diagnostic network and optimizing the use of GeneXpert machines to reach underserved, vulnerable communities. TB education and screening are being integrated at all healthcare service points, and private pharmacies are involved in screening and referring people with presumptive TB. The NTP and partners continue to work with in-country partners and stakeholders to monitor and mitigate the impact of subsequent waves of COVID-19 resurgences on TB programming in real-time.

These policies reflect Zimbabwe's commitment to combating TB and providing care for those affected by the disease. The legal framework is geared towards ensuring access to diagnosis, treatment, and prevention while also addressing the challenges posed by drug-resistant TB. The country's approach is in line with international recommendations and aims to create a TB-free Zimbabwe by 2035. The multistakeholder group conducted a focus group discussion and reviewed the laws and policies in line with the objectives of the assessment, which revealed that all the rights and freedoms were covered by the existing laws and policies, with some areas requiring improvement on enforcement and media coverage. The outcome of Core Group and stakeholders' discussion on the country's current laws and policies, law or policy enforcement and corresponding media coverage about protecting individuals against TB-related stigma. The scores for both laws and policies are shown in Fig 27.

Figure 27: Law and Policy Environment (average of 8 rights)



The existence of laws/policies, enforcement of the laws/policies and media coverage of enforcement of the laws and policies were rated separately for laws and policies based on the following criteria;

- ***Existence of Laws/Policies:*** 0 – Laws/Policies that harm people with TB exist at the national level. 1 - Laws/Policies that harm people with TB exist only at the sub-national level. 2 - No Laws/Policies relevant to people with TB exist. 3 - Laws/Policies that protect people with TB exist only at the sub-national level. 4 - Laws/Policies that protect people with TB exist at the national level.
- ***Enforcement of Laws/Policies:*** 0 - Laws/Policies that harm people with TB are enforced at the national level. 1 - Laws/Policies that harm people with TB are enforced only at the sub-national level. 2 - No Laws/Policies relevant to people with TB. 3 - Laws/Policies that protect people with TB are enforced only at the sub-national level. 4 - Laws/Policies that protect people with TB are enforced at the national level.

- ***Media Coverage of Law/Policy Enforcement:*** 0 - Enforcement of Laws/Policies that harm people with TB is supported in national media coverage. 1 - Enforcement of Laws/Policies that harm people with TB is supported only in sub-national media coverage. 2 - No media coverage. 3 - Enforcement of I Laws/Policies that protect people with TB is supported only in sub-national media. 4 - Enforcement of Laws/Policies that protect people with TB is supported in national media coverage.

Table 7: The Law Matrix

Law Matrix	*L1*	*L2*	*L3*	Comments & Key Recommendations
	Existence of Laws	***Enforcement of Laws***	***Media Coverage of Law Enforcement***	
Rights to Freedom from Discrimination (enacted stigma)	**4**	**4**	**4**	**Existence:** - ***Section 56: Equality and Non-Discrimination Subsection (1):*** This right entails among other things the right to equal protection and benefit of the law. Persons who are living with TB and who are affected or impacted by TB have the right to equal treatment as any other person in the country. - **The Public Health Act (PHA) - 2018** indicates that there should be no discrimination against all patients seeking health services. **Enforcement:** - For all rights, the existence of the Constitutional Court of Zimbabwe (CCZ) is there to address violations of all rights, and decisions of the CCZ are binding and enforceable. **Media Coverage:** - Right is covered faily across all media and there have been limited reports on stigma and discrimination. **Recommendations:** 1. Implementation of existing laws needs to be strengthened 2. Public knowledge on their rights is limited, including rights for PWTB.
Rights to Access Information	**4**	**4**	**4**	**Existence:** - ***Section 62: Access to Information:*** Section 62(2) provides for the right of every person (including the media) to information held by any person including the State, in so far as that information is required for the exercise or protection of a right. This accords people living with HIV, TB and vulnerable and key populations the right to access relevant information regarding protection, treatment, care, reproductive health and related matters. - Section 34 of the PHA (2018): User to have full knowledge of services available **Enforcement:** - For all rights, the existence of the Constitutional Court of Zimbabwe (CCZ) is there to address violations of all rights, and decisions of the CCZ are binding and enforceable. - Limited knowledge on the part of the patients and service providers on the rights to access information. **Media Coverage:** - Coverage is done in an unstructured way depending on epidemic trends - TB information and news are traditionally covered intensively during the World TB Day and sporadically thereafter. **Recommendations:** 1. The Government to declare a month of awarness and information sharing about TB instead of just a single day. That campaign can learn from the Breast Cancer Awareness month.

				2. Improve healthcare workers capacityto provide detailed, accurate and real time TB information.
Rights to Access Services	**4**	**4**	**4**	**Existence:** - ***Section 76: Right to Health Care Section 76 (1):*** Every citizen and every permanent resident have the right to access to basic health care services including reproductive health care services. Section 76 (2): While people living with TB are accorded the right to access basic health care services in the broad general provision that is applicable to every citizen, they are further specifically protected under Subsection 76 (2) which provides access to basic health care services for people with chronic illness. - Section 37 of the PHA (2018): Duty to disseminate information **Enforcement:** - The Government has various programmes to promote access to health services including TB services through campaigns, mobile services and partnering with other organizations nationally. **Media Coverage:** - Active in sharing schedules which notify populations of where to access services. **Recommendations:** 1. Actively engage and consider working with social media influencers and using all channels available to reach all types of patients with tailored TB messages.
Rights to Privacy	**4**	**4**	**4**	**Existence:** - ***Section 57: Right to Privacy:*** This includes the right not to have one's health condition not to be disclosed. Although this provision does not specifically mention people with TB, it ensures that everyone, including those with TB, has the right to confidentiality regarding their health status. This protection helps prevent stigma and discrimination by safeguarding individuals' right to keep their diagnosis private. - Section 39 of the PHA (2018): Confidentiality **Enforcement:** - Promoted at all service delivery points. **Media Coverage:** - Accidental disclosures of TB patients have happened through the media channels. **Recommendations:** 1. Media to be sensitized on privacy and confidentiality issues with respect to TB patients or survivors
Rights to Informed Consent	**4**	**4**	**4**	**Existence:** - Section 52: Right to personal security: Every person has the right to bodily and psychological integrity, which includes the right (a) to freedom from all forms of violence from public or private sources; (b) subject to any other provision of this Constitution, to make decisions concerning reproduction; (c) not to be subjected to medical or scientific experiments, or to the extraction or use of their bodily tissue, without their informed consent. - Section 35 of the PHA (2018): Consent of user

				Enforcement: - Implementation of the PHA and the supportive policies ensures the enforecement of the rights to informed consent. **Media Coverage:** - Limited media coverage **Recommendations:** 1. Recommend measures to minimize accidental disclosures and assumed consent.
Rights to Freedom from Arbitrary Arrest/Detention and Involuntary Isolation	**4**	**4**	**4**	**Existence:** - **Section 49: Right to personal liberty.** (1) Every person has the right to personal liberty, which includes the right (a) not to be detained without trial; and (b)not to be deprived of their liberty arbitrarily or without just cause. (2) No person may be imprisoned merely on the ground of inability to fulfil a contractual obligation. - **Section 52 of the PHA (2018):** Provision of isolation hospitals, mortuaries, disinfecting stations and ambulances by local authorities **Enforcement:** - Implementation of the PHA and the CCZ to redress any violations. - TB patients have been allowed to continue on treatment even when arrested, improving adherence. **Media Coverage:** - Community media has sometimes protrayed cases of TB patients negatively **Recommendations:** 1. Strengthen the capacity of media personnel on positive media reporting of TB cases/issues.
Rights to Safe Workplace	**4**	**4**	**4**	***Existence:*** - ***Section 65: Labour Rights:*** Section 65 (1) provides for the right to fair and safe labour practices and standards, and section 65 (4) ensures just, equitable and satisfactory conditions of work. Therefore, employees living with TB, as well as other vulnerable and key populations, have the right to fair and safe labour standards and to be treated equitably and in a justice manner notwithstanding their TB status. **Section 28:01 of the Labour Act in Zimbabwe, outlines;** - Fundamental Rights of Employees: The Act declares and defines the fundamental rights of employees, which include the right to fair labor practices and safe working conditions, - Unfair Labour Practices: It defines unfair labor practices and provides mechanisms to address them. This includes protection against forced labor, violence, harassment, and unfair retrenchments, - Regulation of Conditions of Employment: The Act regulates conditions of employment to ensure that workplaces are safe and healthy for employees. This includes the establishment of workers' committees and trade unions to represent employees' interests. - International Obligations: The Act gives effect to the international obligations of Zimbabwe as a member state of the International Labour Organisation (ILO) and other international agreements governing conditions of employment.

				Enforcement: - Labour Court: The establishment and functions of the Labour Court are outlined to handle disputes related to employment, including those concerning workplace safety. **Media Coverage:** - Media has been actively highlighting the dangerous working envirnments especially of artisanal miners and those involved in informal sectors. **Recommendations:** 1. Advocate for safe mining practices especialy among artisanal miners 2. Align the current Labor Act to the prevailing largely informalized job market and industries.
Rights to compensation and redress	**4**	**4**	**4**	***Existence:*** - ***Section 65: Labour Rights:*** Section 65 (1) provides for the right to fair and safe labour practices and standards, and section 65 (4) ensures just, equitable and satisfactory conditions of work. Therefore, employees living with TB, as well as other vulnerable and key populations, have the right to fair and safe labour standards and to be treated equitably and in a justice manner notwithstanding their TB status. - **Section 28.01 of the Labour Act in Zimbabwe** outlines several provisions regarding the rights to compensation and redress for employees such as Compensation for Unfair Dismissal: Employees who are unfairly dismissed are entitled to compensation. The Labour Court has the authority to order reinstatement or compensation for the loss of employment, Retrenchment Compensation: The Act provides for compensation in cases of retrenchment. Employers are required to follow a specific procedure and provide fair compensation to employees who are retrenched, Workplace Injuries and Diseases: Employees who suffer injuries or contract diseases in the course of their employment are entitled to compensation. The Act mandates employers to provide compensation for medical expenses and loss of earnings. **Enforcement:** - Redress Mechanisms: The Labour Court and other designated bodies handle disputes related to compensation and redress. Employees can seek redress through these mechanisms if they believe their rights have been violated. **Media Coverage:** - Media has extensively reported on givernment efforts to compensate affected workers and former miners and their families affected by closure of mines or diseases. **Recommendations:** 1. Align the labor law to ensure that employees'contracts are not terminated once they are diagnosed with TB and that they can return to work post treatment in a stigma free and supportive environment.

Table 8: The Policy Matrix

Policy Matrix	*P1* *Existence of Policies*	*P2* *Enforcement of Policies*	*P3* *Media Coverage of Policy Enforcement*	Comments & Key Recommendations
Rights to Freedom from Discrimination (enacted stigma)	**4**	**4**	**4**	**Existence:** - **Policies supporting the Public Health Act (PHA) and supportive policies.** **Enforcement:** - For all rights, the existence of the Constitutional Court of Zimbabwe (CCZ) is there to address violations of all rights, and decisions of the CCZ are binding and enforceable. **Media Coverage:** - Coverage is fair across all media channels. **Recommendations:** 1. Public knowledge on their rights is limited, including rights for PWTB and the knowledge about existing policies is even more limited.
Rights to Access Information	**4**	**4**	**4**	**Existence:** - **Policies supporting Section 34 of the PHA (2018)**: User to have full knowledge of services available **Enforcement:** - Enforced through the open-door policy. **Media Coverage:** - Limited coverage **Recommendations:** 1. The Government through the relevant Ministry should concientise the public, including PWTB, about their rights to access information.
Rights to Access Services	**4**	**4**	**4**	**Existence:** - Policies supporting Section 37 of the PHA (2018): Duty to disseminate information **Enforcement:** - Done through budgeting and ensuring that there are adequate resources mobilized internally and externally. **Media Coverage:** - Adequate coverage. **Recommendations:** 1. Ensure adequate local funding of health services, including those required by key and vulnerable populations.
Rights to Privacy	**4**	**4**	**4**	**Existence:** - Policies supporting Section 39 of the PHA (2018): Confidentiality **Enforcement:**

				- Promoted at all service delivery points. **Media Coverage:** - Accidental disclosures of TB patients have happened through the media channels. **Recommendations:** 1. Media to be sensitized on privacy and confidentiality issues with respect to TB patients or survivors
Rights to Informed Consent	**4**	**4**	**4**	**Existence:** - Policies supporting Section 35 of the PHA (2018): Consent of user **Enforcement:** - Implementation of the PHA and the supportive policies ensures the enforecement of the rights to informed consent. **Media Coverage:** - Limited media coverage
Rights to Freedom from Arbitrary Arrest/Detention and Involuntary Isolation	**4**	**4**	**4**	**Existence:** - **Policies supporting Section 52 of the PHA (2018):** Provision of isolation hospitals, mortuaries, disinfecting stations and ambulances by local authorities **Enforcement:** - Implementation of the PHA and the CCZ to redress any violations. - TB patients have been allowed to continue treatment even when arrested, improving adherence. **Media Coverage:** - Community media has sometimes protrayed cases of TB patients negatively
Rights to Safe Workplace	**4**	**4**	**4**	***Existence:*** - **Policies supporting Section 28:01 of the Labour Act** **Enforcement:** - safe working environment is a requirement for all companies and workplaces. **Media Coverage:** - Media has been actively highlighting the dangerous working envirnments especially of artisanal miners and those involved in informal sectors.
Rights to compensation and redress	**4**	**4**	**4**	***Existence:*** - **Policies supporting Section 28.01 of the Labour Act** **Enforcement:** - Employees can seek redress through these mechanisms if they believe their rights have been violated. **Media Coverage:** - Moderate coverage

Despite having a protective law and policy environment at the national level, there is room for enhancement to address stigma effectively. Laws and policies need to be reformed to promote awareness, education, and support for affected individuals. Firstly, comprehensive awareness campaigns should be mandated by law to educate the public about diseases like TB. These campaigns should focus on how TB is transmitted, treated, and prevented, thereby dispelling myths and misconceptions that contribute to stigma. For instance, community engagement through awareness programs can help eradicate stigma by informing people about the realities of TB and encouraging supportive behaviors. As one participant mentioned,

"I think at clinics TB patients are treated nicely, but there is a need for community engagement through awareness so that stigma can be eradicated" (Family member, Harare).

Secondly, policies should be implemented to ensure that healthcare facilities provide adequate support and counselling services for TB patients and their families. Post-treatment counselling services can help patients reintegrate into society and reduce the stigma associated with the disease. Moreover, healthcare providers should be required to give caregivers detailed information on how to care for TB patients, which can help alleviate fears and misconceptions within families. One suggestion was,

"If a TB patient comes to the clinic with a caregiver, please give them enough information as to how a TB patient is supposed to be taken care of. We need things like fliers which have enough information on Tuberculosis and how we must treat our relatives with TB" (Family member, Harare)

Lastly, laws should be enacted to provide financial and social support to TB patients. This could include provisions for nutritious food, transportation to healthcare facilities, and financial assistance for those unable to work due to their illness. By addressing the socio-economic challenges faced by TB patients, these policies can help reduce the stigma associated with the disease and improve the overall quality of life for affected individuals. Additionally, encouraging family members of TB patients to get tested and providing them with the necessary support can help prevent the spread of the disease and further reduce stigma.

5. Recommendations

5.1 Recommendations

The assessment makes the following recommendations and are categorised into short-term and long-term recommendations.

A. Short-term recommendations

1. Community Education Programs

Finding: High levels of anticipated, self, enacted, and observed stigma among people diagnosed with TB. Many respondents diagnosed with TB reported experiencing discrimination from family members, communities, co-workers, and healthcare workers.

Recommendation: Develop and implement community education programs to raise awareness about TB, its transmission, and treatment. These programs should aim to dispel myths and misconceptions about TB, reduce fear, and promote supportive behaviors towards people diagnosed with TB in the community addressing community stigmatizing attitudes A1, A2, A5 and A8. Utilize local media, community leaders, and educational institutions to disseminate information effectively.

2. Healthcare Worker Training

Finding: Perceived stigma against people diagnosed with TB was common in healthcare settings, leading to delays in seeking diagnosis and treatment. The stigma was particularly common among key populations on healthcare worker stigmatizing attitudes A1, A2 and A9. Healthcare workers also reported feeling stigmatized because of their work with TB patients, with 33.3% experiencing stigma in hospitals, from neighbors, and from family members.

Recommendation: Provide comprehensive training for healthcare workers on TB stigma, its impact on patients, and strategies to provide non-discriminatory care. This training should include sensitivity training, communication skills, and the use of standardized protocols to ensure respectful and supportive interactions with TB patients and manage the stigma against themselves.

3. Improve the presence and coverage of Support Groups for TB Patients

Finding: Secondary stigma was prevalent among family members and primary carers of people diagnosed with TB, affecting their willingness to seek care and support for their loved ones. Among those who reported experiencing stigma, 60.8% were female, 37.3% were male, and 1.8% preferred not to disclose their gender.

Recommendation: Increase the presence and coverage of support groups for TB patients and their families to provide a safe space for sharing experiences, receiving emotional support, and accessing information about TB treatment and care. These groups can be facilitated by trained counsellors and healthcare workers.

4. Media Campaigns to Reduce Stigma

Finding: Perceived stigma against people diagnosed with TB was common in communities and healthcare settings, leading to delays in seeking diagnosis and treatment.

Recommendation: Launch media campaigns to reduce public TB stigma by promoting positive stories of TB survivors, educating the public about TB, and encouraging supportive attitudes towards people diagnosed with TB. These should cover all the top stigmatizing attitudes across the PWTB, family, community and among healthcare workers. Utilize various media platforms, including social media, radio, and television, to reach a wide audience.

B. Long-term recommendations

7. Legal Protections for TB Patients

Finding: Structural stigma, including limited implementation, enforcement and media coverage of laws and policies, further exacerbated the challenges faced by people diagnosed with TB. The lack of robust legal protections for people living with TB and key populations contributed to their vulnerability and marginalization.

Recommendation: Advocate for the implementation and enforcement of legal protections for TB patients to prevent discrimination and ensure that all their rights are upheld, especially rights to access information, confidentiality and to be free from discrimination. Advocate for policy reforms to address structural stigma by ensuring that laws and policies are inclusive, non-discriminatory, and supportive of TB patients' rights. Engage policymakers, legal experts, and civil society organizations in the advocacy efforts.

8. Strengthening Social Support Systems

Finding: Secondary stigma was prevalent among family members and primary carers of people diagnosed with TB.

Recommendation: Strengthen social support systems for TB patients and their families by providing financial assistance, counseling services, and access to social services to alleviate the burden of TB. Collaborate with social service agencies and non-governmental organizations to provide comprehensive support.

9. Collaboration with Civil Society Organizations

Finding: Stigma was prevalent among family members and primary carers of people diagnosed with TB.

Recommendation: Collaborate with civil society organizations to implement stigma reduction programs, provide support to TB patients, and advocate for their rights. Partner with organizations that have experience in addressing stigma and discrimination.

10. Monitoring and Evaluation of Stigma Reduction Programs

Finding: Structural stigma, including limited implementation of some laws and policies, further exacerbated the challenges faced by people diagnosed with TB.

Recommendation: Establish monitoring and evaluation mechanisms to assess the effectiveness of stigma reduction programs and make necessary adjustments to improve their impact. Use data from these evaluations to inform future interventions and policies.

11. Research on TB Stigma

Finding: High levels of anticipated, self, enacted, and observed stigma among people diagnosed with TB.

Recommendation: Strengthen ongoing research on TB stigma reduction to better understand its dimensions, impact, and effective strategies for reduction. This research should inform the development of evidence-based interventions to address TB stigma and could be implemented by strengthening and institutionalising TB stigma surveillance through digital platforms such as One Impact. Collaborate with academic institutions and research organizations to conduct studies and disseminate findings.

12. Key Populations and Stigma

Finding: People diagnosed with TB who belonged to one key population group felt less stigmatized compared to those who belonged to two or more groups (58%).

Recommendation: Tailor stigma reduction interventions to address the unique challenges faced by people diagnosed with TB belonging to multiple key population groups and those not belonging to any key population groups.

A draft action plan developed and validated preliminarily by the Multistakeholder group is in Annex 1. The plan will be developed further and finalized through a follow up workshop coordinated by NTP and JHWO.

6. Conclusion

The Tuberculosis Stigma Assessment in Zimbabwe has provided critical insights into the multifaceted nature of TB stigma and its profound impact on individuals and communities. This assessment underscores the urgent need for comprehensive strategies to address TB stigma at multiple levels, including community education, healthcare worker training, policy reforms, and legal protections. The findings reveal that TB stigma is a significant barrier to accessing and providing TB services in Zimbabwe.

High levels of anticipated, self, enacted, and observed stigma were reported among people diagnosed with TB, with 40.9% of respondents experiencing TB-related stigma. This stigma was prevalent in various settings, including family, community, workplace, and healthcare environments, leading to delays in seeking diagnosis and treatment. The stigma was particularly common among key populations such as the malnourished, miners or ex-miners, PLHIV and TB contacts.

Secondary stigma was also prevalent among family members and primary carers of people diagnosed with TB, affecting their willingness to seek care and support for their loved ones. This secondary stigma further exacerbates the challenges faced by TB patients and their families, leading to social isolation and reduced access to essential support services.

Structural stigma, including the limited enforcement and media coverage of some laws and policies, further exacerbated the challenges faced by people diagnosed with TB. The lack of robust legal protections for people living with TB and key populations contributed to their vulnerability and marginalization. This structural stigma not only hinders access to TB services but also perpetuates the cycle of discrimination and exclusion, making it difficult for TB patients to seek and receive the care they need. This was reinforced by limited knowledge about all the rights that the PWTB have due to a lack of comprehensive health education and information.

The impact of TB stigma on treatment and care is profound. Stigma disrupted essential life aspects such as resources, social relationships, and coping behaviors, ultimately impacting the health of populations. This stigma is a fundamental cause of health inequality, as it creates barriers to accessing quality, affordable, and equitable TB services and care. The findings underscore the need for comprehensive strategies to address TB stigma at multiple levels, including community education, healthcare worker training, and policy reforms.

The assessment also highlights the importance of community involvement in addressing TB stigma. Engaging community leaders, influencers, and local organizations in stigma reduction initiatives can help create a supportive environment for TB patients. Community education programs can raise awareness about TB, dispel myths and misconceptions, and promote supportive behaviors towards people diagnosed with TB.

Healthcare worker training is another critical component in addressing TB stigma. Providing comprehensive training for healthcare workers on TB stigma, its impact on patients, and strategies to provide non-discriminatory care can improve the quality of care for TB patients and reduce stigma in healthcare settings. This training should include sensitivity training, communication skills, and the use of standardized protocols to ensure respectful and supportive interactions with TB patients.

Legal protections for TB patients are essential to prevent discrimination and ensure their rights are upheld. Advocating for the implementation and enforcement of legal protections for TB patients can help eliminate discriminatory practices and ensure that TB patients have access to legal support services4. This includes revising existing laws and policies to eliminate discriminatory practices and ensuring that TB patients have access to legal support services.

Media campaigns can also play a significant role in reducing TB stigma. Promoting positive stories of TB survivors, educating the public about TB, and encouraging supportive attitudes towards people diagnosed with TB can help change public perceptions and reduce stigma2. Utilizing various media platforms, including social media, radio, and television, can help reach a wide audience and create a more supportive environment for TB patients.

In conclusion, addressing TB stigma is crucial to improving access to TB services, enhancing treatment outcomes, and supporting the right to health for all individuals affected by TB. By implementing comprehensive strategies to tackle stigma, Zimbabwe can make significant strides towards reducing TB stigma and achieving the goal of ending TB by 2030.

Annexes:

Annex 1: Action Plan

Zimbabwe			Action Plan to Address TB-related Stigma																	
Date Action Plan Endorsed: 26-Nov-24																				
Implementation Period of the Action Plan: January 2025 to Dec 2028																				
Endorsed by: Multistakeholder Group (Government, CSOs, TB affected community, CBOs,)																				
Objectives	***Interventions***	**Priority** 1=short term (implementation within 2 years) 2=longer term, (implelmentation 3-5 years)	(A) **Target settings for this intervention?** (select ✓ if Yes)						(B) **Which of the stages of the TB Journey would this intervention contribute towards reducing stigma?** (select ✓ if Yes)							(C) **Details of Interventions**		(D) **Alignment with National Strategic Plan** (specify which NSP goals the proposed intervention would contribute towards)	(E) **Which key findings and recommendations of the stigma assessment do this intervention address?**	(F) **Costs** (estimates in local currency, based on country's existing similar programme unit costs)	(G) **Focal Point** (person/ organisation)
			PWTB	Family of PWTB	Community	Health Care	Law and Policy	Media	(1) Recognizing symptoms	(2) Seeking care	(3) Getting an accurate diagnosis	(4) Beginning treatment	(5) Getting treatment adherence support	(6) Completing treatment	(7) Getting post-treatment follow-up services	How would the intervention be gender- and KPs-responsive?	Who, when, where and how many? What are the source and unit costs of existing or similar programmes in the country?				
1. To reduce stigma in the community	Increase Awareness and Education (Target various stakeholders; dispel various myths)	Short term	X	X	X	X			X	X	X	X	X	X	X	All			Community Stigma		
	Train and capacitate Community Health Workers on issues related to TB	Short term			X				X	X	X	X	X	X		All			Community Stigma		
	Provide psycho-social support		X	X	X	X			X	X	X	X	X	X	X	All			Community Stigma		
	Offer training & support to familiy members on how to provide emotional support to individuals with TB		X	X	X	X	X	X								All			Community Stigma		

	Establish family support groups/ counseling services where relatives of TB patients can share experiences, receive mental health support, and learn how to combat stigma		X	X	X	X	X	X								All			Community Stigma		
	Recognise TB survivor support groups		X	X	X	X	X	X								All			Community Stigma		
	Train them to publicly speak out against TB related stigma and promote acceptance and understanding of the disease	Short term	X	X	X	X	X	X													
	Train influencers to address and challenge stigma in their communities and support people affected by TB	Short term	X	X	X	X	X	X													
2. To implement MAF	Stakeholder engagement																				
	Adopt a holistic approach to MAF implementation																				
3.Reduction of stigma within the community	Sensitization of the community on the prevention and treatment of TB, Awareness campaigns, social media, IEC, Family dialogues	Short term,ongoing	X	X	X			X	X	X		X	X	X	X						
4. Reduction of burden in males between 25-44	Targeted community screenings (mines, beerhalls, shopping areas)	Short term	X	X	X			X	X	X	X										
5.Reduction of stigma among health care workers	Counselling, training in Infection Prevention Control	Long term, Ongoing				X			X	X	X	X	X	X	X						
6.Reduction of stigma in the household	Conscentisation of directly observed treatment support	Short term,		X					X	X	X	X	X	X	X						

		Ongoing																		
7.Reduction of self stigma	Counselling, training in Infection Prevention Control	Long term, Ongoing	X	X	X	X			X	X	X	X	X	X	X					
8.Reduction of stigma within the community	1.Sensitization of the community on the prevention and treatment of TB,Awareness campaigns,social media,IEC,Family dialogues	Short term,ongoing	X	X	X			X	X	X		X	X	X	X					

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