Abstract

Background: Tuberculosis (TB) is a global public health problem in children under-five years. Majority of children under-five with TB infection are household contacts of bacteriologically confirmed cases. The World Health Organization has recommended that children under-five that are household contacts of TB cases, should receive isoniazid preventive therapy (IPT) at 10 mg/kg for 6 months. This recommendation has been adopted by the Zimbabwe National TB Programme. IPT is an efficacious chemoprophylaxis that reduces incidence of TB disease in children under-five years however, implementation of the IPT guidelines by healthcare providers in Zimbabwe has been suboptimal. Studies conducted in other countries have reported operational challenges encountered by healthcare providers with implementing IPT guidelines for children under-five years. However, in Zimbabwe there is sparse literature that has explored factors influencing implementation of IPT guidelines for under-five children by health care providers. The purpose of this study is to explore the barriers to and facilitators of implementation of IPT guidelines for under-five children that are household contacts of TB cases by healthcare providers in Harare, Zimbabwe.

Methods: A qualitative study was conducted at four health facilities offering TB services in Harare, Zimbabwe. A total of 18 interviews were carried out amongst healthcare providers working in TB outpatient departments. A semi-structured interview guide patterned along the constructs of the Consolidated Framework for Implementation Research (CFIR) was used for data collection. Framework analysis described by Ritchie and Spencer was used for data analysis.

Results: The main barriers to and facilitators of implementation of the IPT guidelines were categorized into themes. The qualitative themes which emerged were role of opinion leaders, providers' attitude towards IPT, experiences with caregivers, facility factors influencing implementation of the IPT guidelines and use of shorter TB preventive therapy regimens.

Conclusion: The main factors influencing implementation of IPT guidelines were related to implementation practices within the health facilities. More barriers to implementation of the IPT guidelines were identified than facilitators. This highlights the implementation challenges that need to be addressed by the Zimbabwe National TB Programme before IPT uptake in children under-five can be optimized. There is great need for TB policy makers to capacitate health facilities with adequate resources as well as ensure that clinicians are sufficiently trained on the use of childhood IPT guidelines.