THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

NATIONAL OPERATIONAL GUIDELINE FOR COMMUNITY - BASED TUBERCULOSIS AND LEPROSY INTERVENTIONS

National TB and Leprosy Programme (NTLP)

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TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

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Dr Catherine Joachim

Head of Programs and Health systems strengthening

FOREWORD

The Government has been committed to improve access to quality health services including primary health care since the 1960s. Over the last 5 years, the Ministry of Health (MoH) had embarked on strengthening linkages between health facilities and the community in the provision of health services at community level.

For the last two centuries, Tuberculosis (TB) has been the deadliest infectious disease globally. Leprosy continues to be a disease of concern with a slow decline in the incidences in the last decade despite availability of appropriate chemotherapy. These two diseases present a challenge to the health of Tanzanians as they cause suffering, economic losses, disability and even deaths. Currently, the health system is detecting and treating only 59% of the estimated TB cases, with the remaining 41% going undiagnosed in the community. One of the challenges for TB and Leprosy control in the country is that several TB and Leprosy cases are not reached by the current health system and program interventions. In addition, COVID-19 has had a negative effect on TB and Leprosy prevention and care. The other challenges include inadequate community awareness on TB and Leprosy and its control measures, long distances to diagnostic facilities, and ultimately delayed medical seeking behaviour.

In order to address the identified challenges, the MoH through the National TB and Leprosy Programme (NTLP) adapted the ENGAGE TB approach to sensitize and encourage a wider range of stakeholders to involve themselves in community-based activities. These include Non-Governmental Organizations (NGOs), Civil Society Organizations (CSOs) and other Non-State Actors (NSAs) who are actively involved in community-based activities. This strategy has been a success, where currently there are over 20 CSOs that have engaged in TB control activities. Based on this positive experience, the country is therefore expecting more CSOs to work in this area, a fact that calls for a clear guidance on community TB service provision.

The MoH has therefore developed these National Operational Guidelines for TB and Leprosy interventions to provide guidance to implementers. This document is translating the overarching policy guidelines for community health and will strengthen collaboration between implementers and linkage between the community and health facilities providing TB and Leprosy services.

Prof. Tumaini Nagu

Chief Medical Officer

ACRONYMS

ACF	Active Case Finding
AIDS	Acquired immune deficiency syndrome
ARVs	Anti-Retro Viral
CBOs	Community Based Organizations
CHMT	Council Health Management Team
CCHP	Comprehensive Council Health Plans
CHP	Community Health Programme
CHW	Community Health Worker
CI	Contact investigation
CORPs	Community Owned Resource Persons
CSO	Civil Society Organization
CSW	Commercial Sex Worker
CTC	Care and Treatment Centre
DMO	District Medical Officer
DOT	Directly Observed Treatment
DRS	Drug Resistance Surveillance
DR TB	Drug Resistant Tuberculosis
DTLC	District Tuberculosis and Leprosy Coordinator
EQA	External Quality Assurance
GBV	Gender Based Violence
HB-DOT	Home Based DOT
HIV	Human immunodeficiency virus
HTC	HIV Testing and Counselling
IDP	Internally Displaced Persons
IDU	Intravenous Drug Users
IEC	Information Education and Communication
IGAs	Income Generating Activities
IPC	Infection prevention and control
KVPs	Key Vulnerable Populations
LTBI	Latent Tuberculosis Infection
M&E	Monitoring & Evaluation
MDR	Multi Drug Resistant

MKUTA	Mwitikio wa Kudhibiti Kifua Kikuu na UKIMWI Tanzania
MSM	Men having Sex with Men
MoH	Ministry of Health
MVCs	Most Vulnerable Children
NGOs	Non-Governmental organizations
NTLP	National Tuberculosis and Leprosy Programme
OVC	Orphan and Vulnerable Children
PCT	Patient Centered Treatment
PHDP	Positive Health, Dignity and Prevention
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with Human Immune Virus
PORALG	President's Office Regional Administration and Local Government
PWIDs	People Who Inject Drugs
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
RMO	Regional Medical officer
RTLC	Regional Tuberculosis and Leprosy Coordinator
SACCOs	Savings and Credit Co-operatives
STIs	Sexually Transmitted Infections
SBC	Social Behavior Change
STP	Stop TB Partnership
TB	Tuberculosis
TBHIV	Tuberculosis and Human Immune Deficiency Virus
TFNC	Tanzania Food and Nutrition Centre
TSQ	Tuberculosis screening questionnaires
VAC	Violence against Children
VDCs	Village Development Committees
VEO	Village Executive Officer
VICOBA	Village Community Banks
WEO	Ward Executive Officer
WHO	World Health Organization

DEFINITION OF TERMS

Advocacy: Is a set of coordinated activities for creating political and social will and influencing decision makers to take actions to support an achievable policy goal.

Community: Is a group of people, based on common values and norms, who live within a geographically defined area and who share a common language, culture or values.

Community-based TB activities: These cover a wide range of activities that contribute to detection, referral and treatment of people with drug-susceptible, drug-resistant and HIV-associated TB. They are conducted outside the premises of formal health facilities (e.g. hospitals, health centres and clinics), in communities and community-based structures (e.g. schools, places of worship, congregate settings, markets) and homesteads[1].

Community Involvement: The process whereby a community takes responsibility for identifying, analyzing, prioritizing and addressing its problems. The community should have authority and control over its resources, management and ownership for health and development activities.

Community Health Worker: Female and/or male individuals chosen by the community and trained to address health issues of individuals and communities in their respective localities, working in close relationship with health facilities. A CHW acts as a catalyst and a change agent to enable people to take control and responsibility for their own effort achievement in the health[2].

Community volunteers: These are people who have been systematically sensitized about TB prevention and care, either through a short, specific training scheme or through repeated, regular contact sessions with professional health workers. Their profile, roles and responsibilities vary greatly between projects/interventions, and their time is often compensated by incentives in kind or in cash[1].

Contact investigation (CI): This is a systematic process intended to identify previously undiagnosed cases of TB among the contacts of an index case[3].

[1] Global TB report 2015, WHO
[2] National Community Based Health Program Policy Guidelines (MOHSW, 2014)
[3] Recommendations for investigating contacts of persons with infectious tuberculosis in low- and middle-income countries, WHO, 2012

Direct Observed Treatment (DOT): Means that a trained health care provider or other designated individual, including family members observe the patient swallow all the tablets.

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health Promotion: Defined by the World Health Organization's (WHO) 2005 Bangkok Charter in a Globalized World as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health".

Health Education: Is defined as any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.

Health service integration: Refers to combine health care services and components of health care services that are currently delivered and/or managed separately, for the purpose of optimizing the use of scarce resources, maximizing coverage of services, and improving health outcomes.

Influential person: This can be any person generally respected and trusted by the community and are ready to engage with community to effect positive change.

Initial lost to follow-up: Refers to TB patients who not yet started treatment or have missed treatment for less than two months consecutively.

Linkage: Means a network to enhance patients to receive continuum of care of different services.

Lost to follow up TB cases: Is a TB patient who did not start treatment or whose treatment was interrupted for two consecutive months or more. Such a patient should be traced and brought back to DOT clinic to start or re-start treatment.

Primary Health Care: As stated at Alma Ata Conference: "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."

EXECUTIVE SUMMARY

Tanzania is among the 30 highest TB burden countries which contribute to 90% of the global TB burden. The most recent WHO modeled estimates in 2019 show that the incidence of all forms of TB is 237 per 100,000 and case detection rates determined at 36%[4]. According to 2019 data Tanzania notified a total of 82,166 cases of all forms of TB[5]. WHO Global TB report of 2020 estimated that, Tanzania is missing approximately 54,166 TB cases of all forms in 2019. The number of Leprosy cases has steadily declined from 3,500 in 2006 to 1,535 in 2018 making a case detection of 2.8 per 100,000 population.

Community based activities in the control of TB and Leprosy is among the main pillar in the End TB strategy, National TB Laboratory Strategic Plan 2018-2022, National Operational Guideline for Community Based Health Care Services, 2020 and the sixth NTLP strategic plan. The engagement of the different community-based organizations such as CSOs and other NGOs, Former TB patient groups, Communities is a main approach in realizing this important pillar. In this regard a guideline on how to implement the activities is needed to provide guidance, coordination and leadership to all the mentioned stakeholders.

This operational guideline offers a coordinative and integrative framework to provide guidance to all community-based TB and Leprosy stakeholders in the planning, implementation, and scale up of community-based TB and Leprosy prevention, diagnosis, treatment, and care activities. The motivation that led to the development of these guidelines was to enhance efficient provision of quality and systematic community-based TB and Leprosy interventions.

The guideline describes key community-based TB and Leprosy interventions; roles and responsibilities for different levels of care provision; and monitoring and evaluation for community-based TB and Leprosy interventions.

The guideline will be used by anyone who needs to implement TB and Leprosy control activities in the community.

[4]Global Tuberculosis Report (WHO, 2015)
[5]Annual report 2019

CHAPTER 1
INTRODUCTION

1.1 Why revise guidelines

This operational guideline offers a coordinative and integrative framework to provide guidance to all community-based TB and Leprosy stakeholders in the planning, implementation, and scale up of community-based TB and Leprosy prevention, diagnosis, treatment, and care activities. The motivation that led to the development of these guidelines was to enhance efficient provision of quality and systematic community-based TB and Leprosy interventions.

Community based activities in the control of TB and Leprosy is among the main Pillar in the End TB strategy, the fourth National Health strategic Plan and the sixth NTLP strategic plan. The country has been missing TB cases which is contributed by several barriers to access TB services. The main barriers include low community engagement, gender and human rights related barriers[6]. Engagement of NGO and other CSOs, former TB and Leprosy patient groups and communities and other implementing partners is a main approach in realizing this important pillar. In this regard a guideline on how to implement the activities is needed to provide guidance, coordination and leadership to all stakeholders on Community TB considering Community, Rights and Gender implementations for TB and Leprosy responses.

1.2 Community-based health care

Communities in Tanzania continue to face challenges in accessing quality health care services. In responding to these challenges, approaches such as expanding health care interventions to outside clinic and hospital settings have been implemented for over a decade – this is termed Community-based health care. The main objective is to decentralize TB and leprosy services beyond health facilities and into the communities. The approach does not replace health-facility TB and leprosy control services, but embraces Primary Health Care (PHC) approach of community engagement on TB and Leprosy control, which makes health care more accessible to patients and their families.

[6] The National CRG Operational Plan (2020)

1.3 Community-based TB care

Community-based TB Care has been implemented in the country since 2003 to complement Directly Observed Treatment (DOT) coverage has the national wide and has demonstrated high treatment success rates. Community members have been trained and supervised to provide DOT to TB patients at home. Through community-based TB care, communities have been empowered to participate in TB control activities. As of 2020, there are over 400 TB survivor patient groups supporting the country TB control efforts. TB survivor patient groups contribution is noted by increasing TB case notification from 10% (2016) to 26% (2019) of all TB cases notified in the country[7]. Furthermore, 82% of the TB patients received treatment through home-based DOT in 2019[8] and their treatment success was 91.0%.

Despite of the national DOTs coverage and higher proportion of home-based DOT, several challenges still exist in the control and prevention of TB in Tanzania which include:

- Delays by patients in seeking care contributing to persistent transmission of TB in the community,
- Fewer community-led organization in TB care and control,
- Community, rights and gender related barriers to seeking TB services.

To address these challenges, the government and implementing partners, need to build and strengthen community systems for early TB case detection, services delivery and treatment success.

1.4 Community-based leprosy care

The leprosy control strategy in Tanzania includes the following:

i) Strengthening community health systems to support promotion of the use of community-based rehabilitation to improve the quality of life of persons and families affected by leprosy, and

ii) Application of cost-effective methods to improve community awareness, acceptance, and involvement to combat stigma and discrimination against persons and families affected by leprosy. Community awareness on leprosy can increased through health education especially at the community levels.

[7]NTLP Annual report, 2019, NSP 6
[8]NTLP data, 2019

1.5 Community, Rights and Gender in relation to TB and Leprosy services

TB and Leprosy, throughout its long history, have disproportionately affected people marginalized by poverty and social exclusion. The marginalized people are most affected because of the unrealized human rights and gender issues which hinder availability, accessibility, acceptability and affordability of TB and Leprosy services.

The Government of Tanzania (GoT) has continued to put attention on broad aspects of human rights and gender in its health sector priorities[9]. To initiate the implementation of Community, Rights and Gender (CRG), the Country has developed the National CRG Operational Plan (2020) which defines priority interventions to address CRG issues. CRG promotes societal inclusion through addressing all forms of discrimination and stigma.

- Empowering persons affected by TB and leprosy and strengthen their capacity to participate actively in TB and leprosy services.
- Involving communities in actions for improvement of TB and leprosy services.
- Promoting coalition-building among persons affected by TB and leprosy and encourage the integration of these coalitions and or their members with other community-based organizations.
- Promoting access to social and financial support services, e.g. to facilitate income generation, for persons affected by TB and leprosy and their families.
- Supporting community-based rehabilitation for people with leprosy-related disabilities.
- Working towards abolishing discriminatory laws and promote policies facilitating inclusion of persons affected by TB and leprosy.

1.6 TB and Leprosy situation in Tanzania

1.6.1 Situation of Tuberculosis

Tanzania is among the 30 highest TB burden countries which contribute to 90% of the global TB burden. The most recent WHO modeled estimates in 2020 show that the incidence of all forms of TB is 237 per 100,000 and

[9]National TB and Leprosy Strategic Operational Plan for 2020-2025

case detection rates determined at 36%[10]. According to 2019 data Tanzania notified a total of 82,166 cases of all forms of TB[11]. WHO Global TB report of 2020 estimated that, Tanzania is missing approximately 54,166 TB cases of all forms in 2019.

The estimated population mortality rate has been decreasing since the 1990s and in 2019 was estimated at 35/100,000 population. TB-related mortality of HIV-infected TB cases specifically is 20/100,000. TB cases mortality rates are higher among males than females in the age range 40-54 years and increased in adults aged 65 years and above. The notified death rate has progressively been declining since 2015 from 6% to 4% in 2019 (NTLP report, 2019).

TB/HIV: HIV remains a major driver of the TB epidemic. In Tanzania Mainland, HIV/TB co- infection has decreased to 24% in 2019 as compared to 36% in 2014. In the year 2019, 82,166 TB cases were notified, among the notified cases 81,548 (99.2%) were counseled and tested for HIV. The testing results shows that 19,490 (24%) cases were found to be co-infected with HIV which is less by 4% compared to the co-infection rate in 2018. Out of those tested HIV positive, 19,343(99%) were started on ART and out of them 18,603(95%) received CPT[12]. Overall TB treatment success rate was 93%[12].

The inter-related epidemiological patterns of HIV and TB present opportunities for joint programming and response at all levels including community level. This will lead into efficient use of resources for the high impact results.

Drug resistant TB: According to the National Drug Resistance Survey (2016/17), MDR prevalence in Tanzania is 1.2%, whereby the prevalence among new and previous cases is 0.96% and 4.7% respectively. From 2015 to 2019 the number of laboratories confirmed DR-TB patients has been increasing significantly from 194 to 534 respectively (an increase of 160%), although the enrollment gap has been decreasing from 62% in 2015 to 85% in 201912

Major drivers of MDR-TB include; poor patient follow-up of drug sensitive TB and poor adherence to treatment by some of patients of which community engagement is potential to reduce the faults.

[10]Global Tuberculosis Report (WHO, 2015)
[11] Annual report 2019
[12]NTLP Data 2019

1.6.2 Situation of Leprosy

Over the past three decades the mode for leprosy control strategies has been detection of all cases and prompt treatment with multidrug therapy (MDT). The global elimination target has been reached, but leprosy remains in isolated endemic foci or districts in a few countries. WHO defines elimination of leprosy as the reduction of leprosy prevalence to a level of less than 1 case per 10,000 population. WHO's Global Leprosy Strategy 2016–2020 indicates a shift from "elimination of leprosy as a public health problem" to reduction of the disease burden, measured as a reduction in grade-2 disabilities (G2D) among new cases, including children.

In 2018 there were 208,619 new cases reported globally from 159 countries, and the rate of detection of new cases was 2.74 per 100,000 population. About 95% of these cases were notified from the 23 leprosy high priority countries, including Tanzania. The number of registered leprosy cases on MDT treatment has gradually declined from nearly 3,500 cases in 2006 to 1,535 in 2018 with significant change of newly notified cases (as shown in Figure 1) with case detection rate of new cases of 2.8 per 100 000 population. In 2020 there has been a further decline in Leprosy cases to 1,208 new cases.

Figure 1. New and registered leprosy cases in Tanzania from 2006 to 2018.

1.7 Scope of the guideline

The principles in this guideline are aligned with the National strategic plan for TB and Leprosy 2020-2025 in line with Global End TB strategy 2016-2035 and are complementary to existing guidelines to engage NGOs and other CSOs and communities in TB prevention and care at community level. This guidance also emphasizes that CSOs providing facility-based TB services like hospitals, health centres or clinics integrate community-based TB services.

The guidelines are intended to provide guidance to community TB stakeholders at all level of health from national, regional, district and community to implement quality, accessible and safe community-based TB, TB/HIV, and DR-TB care and treatment support services.

These guidelines are intended for five main sets of actors:

i. Ministry of Health (MoH), President's Office Regional Administration and Local Government (PORALG) through National Tuberculosis and Leprosy Programme (NTLP) and National AIDS Control Programme (NACP) for coordination and monitoring of Community Based TB, TB/HIV, DR TB and Leprosy interventions in the country.

ii. RHMTs, CHMTs, for coordination and monitoring of Community Based TB, TB/HIV DR TB and Leprosy services in their localities.

iii. NGOs and other CSOs working on HIV, TB, TB/HIV, DR-TB, Leprosy and other development initiatives (e.g. advocacy, education, agriculture or income generation schemes) that intend to integrate TB prevention and care services in their field work.

iv. Funding agencies, academia and research stakeholders (especially those with interest and expertise in operational and implementation research) can also benefit from this guidance to support community-based TB interventions.

v. Community Based TB service providers and community members at large.

1.8 Process of developing guidelines

The National Guidelines for Community Based TB and Leprosy interventions have been developed by the MoH through NTLP in collaboration with

implementing partners and other stakeholders in TB and Leprosy control. Relevant content has been drawn from various documents in line with the National Community Based Health Programme Policy Guidelines including; WHO ENGAGE-TB guidelines, National ENGAGE TB operational Guidelines, NTLP manual, NTLP implementation reports, National Guidelines for Community Based HIV and AIDS services, Adaptation and Implementation Guide for Recommendations for Investigating Contacts of Persons with Infectious Tuberculosis in Low- and Middle-income Countries by USAID.

The Guideline was first reviewed by MoH staffs, NTLP, NGOs and other stakeholders in collaboration with the National Consultant. Participants built on the first guideline during the workshop held on May 2021, in Morogoro, Tanzania. Finally, the document was shared in the meeting which involved various stakeholders including community members, civil society organizations and government officials for them to buy in the guidelines before printing.

Through this process the guidelines have improved in framework and material content.

1.9 Overall goal of the guidelines

The overall goal of this guidance document is to enhance efficient provision of quality and systematic community-based TB and Leprosy interventions.

The **specific objectives** of the document are to:

1) Describe community-based TB and Leprosy services and approaches in Tanzania;
2) Provide guidance for implementation of community-based TB and Leprosy control interventions in line with right-based and gender-responsive approach;
3) Describe roles and responsibilities of different stakeholders in the provision of community TB and Leprosy interventions; and to;
4) Provide guidance for monitoring and evaluation of community-based TB and Leprosy control interventions.
5) Mitigation measures of COVID-19 for TB and Leprosy

1.10 Guiding principles

The following are considered essential for designing, implementing, recording, and reporting of Community TB care programs, which should target all people in need of these services. Community TB and Leprosy service programs should be *comprehensive.* They should include medical and nursing care, legal advice, referrals, emotional, socioeconomic, and spiritual support. Cooperation at all levels including involving all key players i.e., MoH, POLARG and TFNC is of paramount importance.

- **Using a continuum of care approach**: Community TB and Leprosy programs should be *provided along a continuum of care* which provides comprehensive care and support; and links health-facility services with services at home and in the community.
- **Using holistic approach**: Community TB and Leprosy programs should be *integrated with appropriate prevention activities*. These include cough hygiene and infection control measures; provision of Positive Health, Dignity and Prevention packages (PHDP) for TB and Leprosy care services for orphans, vulnerable children and key populations in TB control including Elderly, Prison, Children and other populations in congregate settings.
- **Family/Patient Centered:** Community TB and Leprosy programs should be provided in *family/ Patients-centered approach.* TB Patients, Family or household members are key actors to support the Programme.
- **Community Ownership**: Community TB and Leprosy programs should be *owned by communities*.
- **Community Involvement:** Community members should be involved in the programs and participate fully in planning, implementation and monitoring.
- **Using a Social behavior change (SBC) approach**: Community TB and Leprosy programs should use communication to promote and facilitate behavior change and support the requisite social change for the purpose of improving health outcomes. Thus, it works at one or more levels: the behavior of individual, collective actions taken by groups, social and cultural structures and the enabling environment.

- **Focusing on Sustainability**: Community TB and Leprosy programs during planning and implementation should focus on sustainability.
- **Gender equity centered**: Community TB and Leprosy service model requires fair distribution of gender roles and responsibilities. Families and communities should address the gender issues in supporting TB and Leprosy patients, PLHIVs, key populations and other vulnerable groups.
- **Right centered approach**: Human rights-based TB services should include non-discrimination, transparency and accountability in the design, implementation, monitoring, and evaluation of programs. TB based human rights-related activities should be informed through assessment and analysis of where human rights barriers and gender inequality exist and whom they affect. These can help ensure that users of health services and those most affected by TB are brought together in non-threatening and meaningful consultation with government, service providers, community leaders and others in civil society.

CHAPTER 2
COMMUNITY-BASED APPROACHES

2.1 Community-based Care Approaches

Community TB and Leprosy care covers a wide range of activities and services that contribute to the detection, referral, and treatment support of people with TB, DR-TB, TB/HIV and Leprosy. These are conducted outside the premises of formal health facilities in communities and community-based structure for example schools, places of worship, congregate settings, markets, factories and homesteads.

For better implementation of community TB and Leprosy care in Tanzania, four approaches are employed as shown in Figure 2.

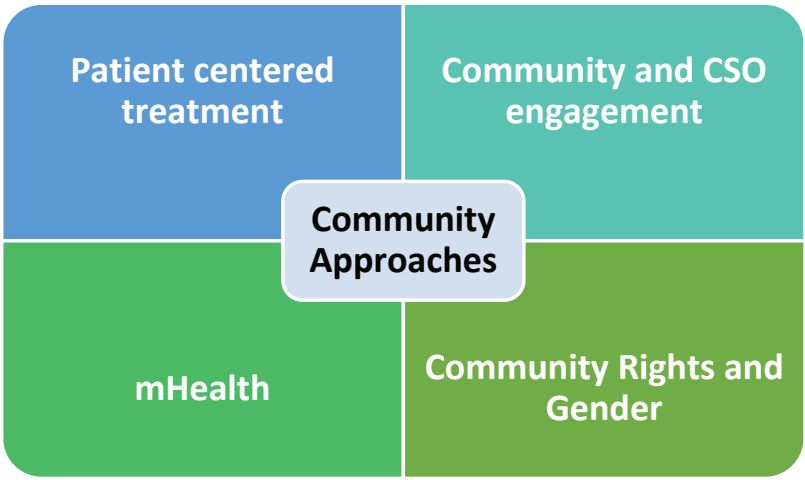

Figure 2. Approaches of Community TB and Leprosy Care in Tanzania

2.1.1 Patient Centered Treatment (PCT)

In PCT, TB patients are given an option to choose where they would like to be supervised during their daily treatment either in health facility or at home. A patient who chooses to be supervised at a health facility will receive their daily treatment under the supervision of a health care worker (HCWs). A patient who chooses to take daily treatment at home will be

supervised by a treatment supporter of his/her own choice who has been trained in directly observed treatment (DOT) and how to record daily medication[13]. PCT makes easier for patients to complete their treatment without compromising the principles of directly observed treatment. It has been recognized that health facility directly observed treatment puts too much demand on patients and health care workers.

HCWs should provide patients and families with basic information on TB, including reassurance that TB is curable; the treatment process and duration; drug side effects, including how to identify them and what to do if they occur; and the importance of adhering to and completing treatment. Explain the necessity of directly observed treatment either in a facility or at home and communicate with patients and their families in a supportive manner and be ready to answer their questions.

- Short-course chemotherapy has a very high success rate if properly administered to a TB patient. The duration of treatment is six months for all new and previously treated patients.
- The initial phase should consist of two months of isoniazid, rifampicin, pyrazinamide, and ethambutol (RHZE). The continuation phase should consist of four months of isoniazid and rifampicin (RH).
- All patients with drug-susceptible TB and TB patients who have been treated previously with anti-TB medicines should receive a first-line treatment regimen using DOT. A patient should therefore be given time to decide whether to use Home-based DOT (HBD) or Health facility-based DOT (HFD) as per TB Manual, 2020.

On the other hand, leprosy patients use home-based DOT, unless admitted for any reason will then be on HFD. Clinical review and medicines refill are done on monthly basis. A patient with challenges is encouraged to attend the health facility at any time as per need.

Note: For details, refer to *How to Provide Patient-Centered TB Treatment,* 2005. Should refer National TB Manual 2020.

2.1.2 Engagement of communities

Community engagement is defined as a process of working collaboratively with and through communities to address issues affecting their wellbeing. It is critical to improve the reach and sustainability of TB interventions,

[13]Patient Centred Treatment Guidelines, MOHSW, 2005

helping save lives of this top infectious killer disease. The fight to End TB epidemic by 2030 can only be won with community engagement as a heart of the TB response. Various community TB care approaches lay out the path to make enhanced community engagement a reality and expand the base for the global TB response.

On the other hand, WHO's Global Leprosy Strategy 2021–2030 indicates a shift from "elimination of leprosy as a public health problem" to "elimination" through interruption of transmission and ensuring there is absence of disease in autochthonous population. There are four strategic pillars which will lead us towards zero leprosy;

i. Implement integrated, country owned zero leprosy roadmaps in all endemic countries

ii. Scale up leprosy prevention alongside integrated active case finding/ detection

iii. Manage leprosy and its complications and prevent new disability

iv. Combat stigma and ensure human rights are respected

Thus, a set of community leprosy interventions as highlighted in this guideline have an important role in achieving this global strategy.

For the purpose of this guideline, the following groups/ individuals have been identified as key stakeholders on this response:

- TB, TB/HIV, DR TB and Leprosy patients
- Community health workers (CHW) including TB survivors' groups, HUWANYU, PLHIV groups
- Community Owned Resource Persons (CORPs) including Traditional healers, traditional birth attendants, local community leaders, religious leaders and other influential people.
- Drug dispensers of Accredited Drug Dispensing Outlets (ADDO) and Pharmacies.
- Sample transporters (including sputum specimen)

2.1.2.2TB, TB/HIV, DR-TB and Leprosy patients

These are people confirmed to have TB, TB/HIV, DR-TB or Leprosy and receiving treatment. They should adhere to the treatment and by doing so, they contribute in TB and Leprosy control as they stop more TB/Leprosy transmission in the community.

2.1.2.3 Community health workers

CHWs are people who have some formal education and are given training to contribute to community-based health services, including TB and leprosy prevention as well as patient care and support (TB manual, 2020). These people include employees, volunteers, TB survivors groups, HUWANYU and PLHIV support groups. Unemployed CHWs are often supported through incentives in-kind or in cash provided by the community they serve or by the health program. They are usually motivated for being useful to their communities and recognition of the need to do something. They are also proud to help others (Their roles and responsibilities are discussed in CHAPTER 5).

The work and services rendered by the CHWs actualize their full potential in the presence of effective support from the health system and of the possibility of a two-way referral between health facilities or public health services and the community. Such referral systems require a regular link. CHWs can serve as important links between the health system and the communities they serve. NGOs/CSOs working on community-related TB and Leprosy should have an active and cooperative working relationship with them.

2.1.2.4 Community Owned Resource Persons (CORPs)

A Community Owned Resource Person is an individual identified by the community to promote health services at community level. A wide range of community members, including traditional healers, traditional birth attendants, local community leaders, religious leaders and other influential people should be encouraged to participate in TB and Leprosy care and control. These people should be consulted when defining the roles that they should play in the community TB care and control effort. A top-down approach should be avoided. A consultative process with consensus-building around roles and responsibilities of the community vis-à-vis those of the health care system is likely to result in a stronger partnership between

the health care system and the community and enhanced community ownership of the program. The tasks that may be undertaken by this group are highlighted above.

Qualities of a CORP

A Community Owned Resource person should be an: -

- Effective communicator who understands what to say and to whom with accuracy.
- Resourceful by being able to identify human and financial resources for the community's problems and concerns.
- Empathetic – Able to understand and experience another person's feelings and respond in a sincere and sympathetic manner.
- Patient – calm and able to let people move at their preferred pace, not overly anxious.
- Trustworthy/honest – able to be trusted with individual and family confidential matters. Anything a man or woman says to a CORP should be kept confidential.
- Able to be respected and accepted by the community and also to respect the individual/families despite their problems, or social status.

2.1.2.5 Drug dispensers from ADDOs and Pharmacies

Drug dispensers are people trained and employed to dispense medicines in ADDOs and Pharmacies based on doctor's prescriptions.

Key Steps in drug dispensers' involvement:

- Mapping and identification of ADDOs and Pharmacies in intervention area
- Mapping of TB and Leprosy diagnostic centers available in the intervention area
- Consultative meetings and stakeholder consensus building including owners
- Assessment of knowledge and practice related to TB and Leprosy
- Distribution of tools for screening, referral and registration of presumptive TB and Leprosy cases
- Train drug dispensers and owners on TB and Leprosy screening, use of tools, recording and reporting
- Sensitization of HCWs in the intervention area

2.1.2.6 Sample Transporters

Sample transporters are people who have received basic training for specimen collection, packaging and transportation from non-TB diagnostic health facility to TB diagnostic facility for either smear microscopy or GeneXpert examination. The means of transportation include motorcycles, bicycles, boats or any other means that suit specific environment/setting.

Selection for specimen transporters

The following are the attributes of sputum specimen transporters fixers:

Attributes

- Living in areas with limited access to TB diagnostic centres
- Should be a member and resident of the communities they are going to serve
- Accepted and trusted by community members/specific target group including PLHIV, Pregnant women, adolescent and youth, MSM, SW and PWID
- Ability to read and write (Standard seven, form four or form six will be an added advantage)
- Good communication and interpersonal relationship skills.
- Willing to volunteer in community TB initiatives with minimal incentives.
- Honest and reliable (trustworthy).
- Non-discriminative with respect to gender, tribe, job, skin color, political affiliation and any other form of discrimination as defined by the community
- Energetic and with ability to work
- Ability and willingness to work in challenging environment and conditions

NOTE:All personnel responsible for specimen collection, packaging and transportation shall receive basic training to ensure their competency and safety (National procedure manual for comprehensive sample referral system, 2020).

2.1.3 Engagement of NGOs and other CSOs (ENGAGE-TB)

2.1.3.1 Concept of ENGAGE TB

The ENGAGE-TB approach aims to integrate community-based TB activities into the work of CSOs. CSOs working in communities are in a unique position to contribute to community health. They usually easily penetrate in communities including people in isolated or neglected parts of the community when the formal health system cannot reach them. They are familiar with the community's culture and language, they can communicate about the community's needs, and they can mobilize people in the community to influence decisions for the community.

CSO refers broadly to the organizations and institutions that operate outside the state and the private sector. They include:

- **NGOs** that are usually registered and have legal status;
- **Community-based organizations (CBOs)** that are usually local and run by community members; they may not be registered;
- **Faith-based organizations (FBOs)** that are connected with and supported by a religious group; larger ones may be registered as NGOs but smaller ones are often similar to CBOs;
- **Networks and associations of people or organizations** working on issues such as TB, HIV infection or diabetes are membership organizations. They provide support to members and engage in advocacy and education on the issues they are concerned with. Some take the form of coalitions or consortia. Larger ones may be registered as NGOs[14]. (ENGAGE TB implementation Manual, WHO 2013)

In this guideline, the term used to include all the organizations and groups in the above list is "NGOs and other CSOs", or "NGOs/CSOs". NGOs/CSOs can use the ENGAGE-TB approach to support their work with communities on TB, by:

[14]National ENGAGE TB Operational Guidelines, MOHSW, 2013

- Finding more people who might have TB and linking them to TB services;
- Supporting people to start and complete TB treatment and client needs
- Raising community awareness on prevention and increasing demand for TB testing, treatment and support;
- Advocating for better access to TB diagnostics, treatment and care; and
- Advocating for policy changes to facilitate greater access to services, e.g., task-shifting that allows nurses, CHWs or CVs to do sputum collection and provide DOT in the community.

The NTLP is responsible for the whole programme, including activities at community level. It should form partnerships with NGOs and CSOs and help them to carry out community-based TB activities in a way that contributes to national efforts. It has a key role in encouraging NGOs/CSOs that do not work on TB to integrate TB into their activities, by providing resources, facilitating support and responding to their needs. This helps to improve national outcomes in TB case detection, notification and treatment success.

2.1.3.2 Six ENGAGE-TB components

The six ENGAGE-TB components provide a systematic framework for establishing partnerships between the NTLP and NGOs/CSOs for NGOs/CSOs to integrate TB activities. Not all components of the framework have to be addressed by every NGO if there are capacity constraints. The most important priorities are to find a way to select the TB tasks that will be implemented and to ensure that the outcomes are monitored and reported. The other components support these two main priorities.

The following are the six ENGAGE TB components (see Figure 3):

- Creating an Enabling environment
- Developing New tools
- Gathering information
- Assessing tasks
- Getting the evidence
- Enhancing capacity

Figure 3. Six components of ENGAGE-TB

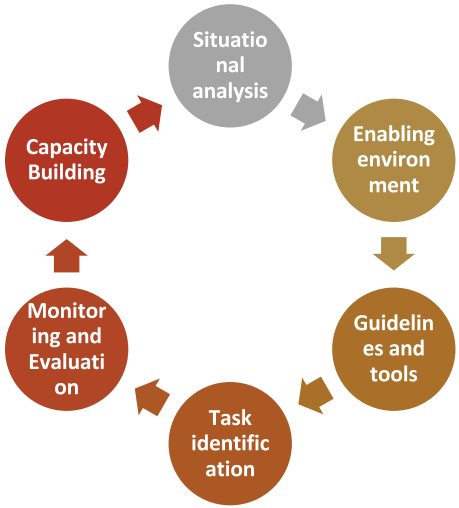

Table 1. Elaboration of six components of ENGAGE-TB

Component	Description
Situation analysis	• CSOs should conduct a situation analysis to identify the specific needs and tasks that will be undertaken to integrate community TB control activities into their plans for implementation. • The analysis should involve information-gathering at the respective level of their jurisdiction to analyze and understand the existing situation before implementation of TB control activities.
Enabling environment	• The MOHSW has established ENGAGE-TB policies and operational guidelines to enable effective engagement of CSOs in TB control activities. • Regions and districts must ensure a good environment for ENGAGE-TB implementation in their respective areas according to national policies. • The established National CSOs Coordinating Body, which represents the interests of CSOs, should systematically share and disseminate lessons learned by individual member organizations.

Guidelines and tools	• National operational guidelines for ENGAGE-TB, a handbook for CHWs to use in complement with other NTLP guidelines, should be used by CSOs to implement TB control activities at the community level.
TB task identification	• TB is intricately linked with HIV and is also closely related to social determinants of health and non-communicable diseases such as poverty, crowding, malnutrition, drug and alcohol use, and diabetes mellitus. • Therefore, the task identification needs to consider the opportunities, capacities, and comparative advantages of the CSOs working in such areas and decide how best to address TB in their target populations and areas of work.
Monitoring and evaluation	• Engagement of CSOs in delivery of community-based TB activities should be routinely monitored to inform their contribution in TB control and to ensure quality and effectiveness of their involvement. • CSOs should ensure that planned activities are aligned with MOHSW policies and guidelines. • Existing standardized TB forms and registers linked with the national TB monitoring and evaluation system must be used to allow the system to determine the contribution of community-based TB activities to national TB control efforts.
Capacity-building	· CSOs engaged in TB and Leprosy activities should conduct needs assessments to identify the capacity of and skills needed by health care workers, CHWs, and volunteers to implement identified community-based TB and Leprosy control activities.

Mechanism which NGOs and other CSOs work on TB in communities

NGO/CSO community projects and programmes can use community systems to contribute to TB control through three main types of activity:

- ***Providing TB and Leprosy services in the community:*** This includes TB and Leprosy awareness and prevention, TB and Leprosy screening, sample collection and transport, treatment support, home-based care (HB-DOT) and TB &leprosy education.
- ***Providing support for people needing or using TB and leprosy services,*** including reducing TB and Leprosy stigmatization in families and health facilities, helping people to access TB and Leprosy services for instance sputum fixing at remote located DOT centres, providing transport, psychological, economic and legal support to TB patients and communities on TB control issues.
- **Enabling environment for TB and Leprosy activities by:**
    - **mobilizing communities** to act on stigma, basic rights and access to health services and basic standards of housing, nutrition, water, sanitation and hygiene;
    - **linking community services** with the formal health system and its personnel and institutions; and
    - **Engaging in local level advocacy** to ensure responsiveness to needs such as for TB laboratory equipment or Anti TB/Leprosy medicines at health facilities.

NGOs/CSOs needs in order to work effectively on TB

NGOs/CSOs to identify and provide a set of TB and Leprosy services in collaboration with the NTLP and the health system.

Larger NGOs may already have sufficient funding and other support that enables them to integrate community-based TB and Leprosy activities into their existing portfolio of work. Some smaller organizations may not have enough resources or capacity to do this. However, they may have potential to develop their capacity.

The resources and support needed include:

- **Funding** to ensure their stability as organizations (core funding) while they implement their activities;
- **Technical support, mentoring and resources** to assist them in delivering services, documenting activities and engaging in advocacy;
- **Training and capacity-building** for running their organization or group and for implementing their TB activities, including mentorship and technical support;
- **Linkages and partnerships** may be established to support their contributions to community health.

2.1.3.3 Collaboration between NTLP and NGOs/CSOs

NTLP operates at national, regional, district and health facility levels. At national level, the NTLP is responsible for development of TB strategy, policy and for overall programme management. TB service deliveries are supervised by a regional and district TB coordinators. The NTLP basic management unit (BMU) is at district level which is responsible for all community TB programmes/interventions in its catchment area. Services are usually provided through hospitals, health centres and dispensaries.

NGOs/CSOs need to link with the NTLP at any of these levels depending on the NGOs/CSOs size, resources and the type of work they do. Based on the WHO recommendations, the following are the best ways of linking that will also bring in other organizations and groups that are not already engaged:

- Through CSOs coordinating body (NCB) that brings NGOs and other CSOs together as a coalition or network. NCB should be set up and independently managed by the NGOs/CSOs, who can then more systematically engage in partnership with government but also act as advocates.
- The NCB should act as an "umbrella" body for NGOs/CSOs to develop a working relationship and engage with the NTLP at all levels, health providers and each other. This provides the NTLP with a clear contact point for active and systematic collaboration and for hearing about the needs, constraints and lessons learnt by NGOs/CSOs in planning, resourcing and implementing community-based TB and Leprosy activities.

- The NCB is a structure that aimed at serving to attract more and more NGOs and CSOs that have not been aware of or involved in TB and Leprosy activities on a continuing basis. This has the potential to extend TB and Leprosy activities to more communities and to neglected parts of the population.

In Tanzania NTLP has supported the start-up and development of the NCB since 2012. The NGOs/CSOs, with NTLP support, can work together to monitor progress, address bottlenecks and highlight new ideas and approaches. The partnership can also be used to establish the basic ENGAGE-TB components to support their activities.

2.1.3.4 Integration of community-based TB activities into other programmes

Integration of community-based TB and Leprosy activities into health and other development programmes is the heart of the ENGAGE-TB approach. Almost any health or development programme could integrate one or more of TB and Leprosy activities listed below into their on-going community-based works:

2.1.3.4.1 Integrating TB into RCH

The continuum of RCH care includes the period before conception through pregnancy, childbirth and infancy. It includes care at home, in the community, and in the health system. Community-based TB and Leprosy activities can be integrated into different stages of the RCH continuum of care. This can include the routine activities of community midwives and RCH community workers or CHWs before and during pregnancy and after the baby is born. TB activities can take place during:

- Household visits,
- Health promotion at community level,
- Maternity outreach services and when linking pregnant women,
- Mothers and their children to health facilities.

RCH community workers can play a key role in identifying and supporting those who also need or use TB and Leprosy services (Annex 1: Community TB activities which can be integrated into RCH programmes).

Table 2. Integration of community-based TB and Leprosy activities into other programmes[15]

Theme	Possible activities
Prevention	Awareness-raising, information, education, communication (IEC), behaviour change communication (BCC), infection control, training providers
Detection	Screening, contact tracing, sputum collection, sputum transport, training providers
Referral	Linking with clinics, transport support and facilitation, accompaniment, referral forms, training providers
Treatment adherence support	HB DOT support, adherence counselling, stigma reduction, pill counting, training providers, home-based care and support
Social and livelihood support	Cash transfers, insurance schemes, nutrition support and supplementation, voluntary savings and loans, inclusive markets, training providers, income generation
Advocacy (cross-cutting)	Ensure availability of supplies, equipment and services, training providers, governance and policy issues, working with community leaders
Stigma reduction (Cross-cutting)	Community theatre/drama groups, testimonials, patient/peer support groups, community champions, sensitizing and training facility and CHWs and leaders

2.1.3.4.2 Integrating TB and HIV activities at community level

The MoH through NTLP and NACP have been implementing TB and HIV collaborative activities within health systems since 2008. However, these activities are mostly not integrated at community level. It is important to target everyone at risk from TB in communities as well as everyone at risk from HIV infection.

[15]Engage TB Implementation Manual (WHO, 2013)

Although TB and HIV epidemics often affect the same people, not everybody in an affected community has both diseases. Some people will need both HIV and TB care, support and treatment; others may need them only for TB or only for HIV infection. It is important that communities and CHWs understand that HIV infection and TB are separate diseases and need different treatments and different methods of prevention. However, there are large numbers of people with undiagnosed TB and/or undiagnosed HIV infection. Hence, increased screening, case-finding and early treatment are priorities for both diseases.

- All PLHIV should be screened for TB, and those confirmed not having TB should receive IPT, which can prevent latent TB from becoming active TB.
- TB screening and treatment (IPT) should be integrated into all HIV programmes.
- Similarly, HIV counselling and testing should be integrated into all TB programmes.
- All people who have presumptive or confirmed TB should be offered an HIV test.
- Anyone with TB disease who tests positive for HIV should be linked to HIV treatment and care services (Annex 2: Community TB activities which can be integrated into HIV programmes).

2.1.3.5.3 Integrating TB and Leprosy within PHC

Primary Health Care (PHC) reaches across many different sectors "multi-sectoral" and it includes everything affecting health in communities. It is involving several different sectors. It also includes the activities of different types of health care providers, such as CHWs, mobile clinics and outreach teams from health facilities (Annex 3: Community TB activities which can be integrated into PHC programmes).

NGOs, CSOs and FBOs should therefore engage with PHC providers to support and increase the integration of TB activities into their work. Depending on the local context and needs, PHC programmes could, for example, work with CHWs and outreach or mobile teams to integrate TB activities into the following range of PHC activities:

- education on common community health problems and methods of preventing and controlling them;

- appropriate treatment of common diseases and injuries;
- promotion of food supply and healthy nutrition;
- adequate supply of safe water, basic sanitation and hygiene;
- RCH care, including family planning;
- vaccination against the major infectious diseases; and
- Provision of essential drugs.

2.1.3.5.4 Integrating TB and Leprosy into agriculture programmes

Most agriculture programmes supported by NGOs use group approaches for their work. These can include "farmer field and livelihood schools" for adults and young people, farmers' clubs, associations and cooperatives. Group members meet regularly throughout an agricultural season or cycle to improve farmers' decision-making capacity, life skills and agricultural practices by sharing their experience and knowledge.

The structured learning provided by farmer field and livelihood schools and other group approaches is adaptable to local situations and priorities. Learning about TB and Leprosy prevention and improving social and livelihood support for those affected can therefore be easily integrated into group activities. Screening and referrals for TB and Leprosy diagnosis can also be included. It is important to have a reliable health system to receive and support such referrals and to ensure that confidentiality is protected, especially for people in small, close-knit rural communities (Annex 4: Community TB activities which can be integrated into Agricultural programmes).

2.1.3.5.5 Integrating TB and Leprosy into a livelihood development programme

Livelihood development programmes are aimed at improving the quality of life of people and communities who are marginalized, vulnerable or stigmatized. The objective is to create opportunities for people to move out of poverty and powerlessness.

Health is an integral part of livelihood programmes, along with food and nutrition, water and sanitation, education and shelter. Community-based TB activities should therefore fit naturally into the activities of livelihoods programmes. Livelihood programme officers like Community Development Officers working closely with their communities and community structures, such as village development committees can also link with CHWs

and volunteers, midwives, water and sanitation and agriculture workers for integration of community TB activities (Annex 5: Community TB activities which can be integrated into Livelihood programmes).

2.1.3.5.6 Integrating TB and Leprosy into education

The education sector has a vital role to play in supporting community efforts against TB and Leprosy. Lack of knowledge about TB and Leprosy contributes to myths and stigmatization and hence increased spread of TB and likewise for Leprosy.

Recently, NTLP discovered TB cases (bacteriological confirmed) among pupils and students in the country. Education on TB and Leprosy should therefore be included in school curricula and it should be known that education on TB prevention is one contribution that the education sector can make quite easily. Schools can teach children on TB and Leprosy signs and symptoms and what measures to take once signs and symptoms are detected (Annex 6: Community TB activities which can be integrated into education programmes).

2.1.3.5.7 Integrating TB into water, sanitation and hygiene (WASH) programmes

Water, sanitation and hygiene (WASH) are essential for maintaining health and preventing disease. Sputum is body waste that can infect other people and must be safely disposed of, just like urine or faeces. WASH programmes can therefore integrate TB into disease prevention by promoting better hygiene (Annex 7: Community TB activities which can be integrated into WASH programmes).

2.1.4 Mobile Health (mHealth) approach

Mobile health (mHealth) is a component of health through use of electronic platform where provision of health services and information is done using mobile technologies such as mobile phones, tablet computers and personal digital assistants such as Tambua TB or One Impact TB Janja.

2.1.4.1 Tambua TB

Tambua TB is an mHealth approach using mobile phones for TB self-screening, general TB knowledge as well as treatment adherence to the public. It has two modules;

i) one for educational messages and self-screening and
ii) Another for treatment adherence among TB patients. The Tambua TB approach has the following features/steps:

- Individuals using the USSD self-screening application subscribe to*152*05#, then select number 6 from the menu and follow the instructions.
- At the end of the screening questions, the application classifies the individual as presumptive TB or not.
- If one is presumed with TB (presumptive TB), messages are sent to encourage the individual to go to the health facility for testing;
- And if not presumptive TB, the individual will receive TB educational messages.
- In addition, CHWs may use their mobile phones to screen community members for TB through the same application.

2.1.4.2 One Impact

One impact is a digital solution that enables people with TB to connect with peers, access TB services and information, and report TB treatment challenges. It empowers people with information on TB creating virtual spaces for TB actors to connect and share information and facilitating community-based monitoring of TB services. One Impact empowers people with TB and supports the national programme to engage civil society and ensure patient-centered care in TB.

Key features of One Impact:

i. **Get knowledge:** TB treatment adherence support, TB science and messages from the TB-affected community
ii. **Get access:** Find and access the nearest TB health facilities
iii. **Get connected:** Connect to TB peers, support groups and TB Actors
iv. **Get involved:** Report challenges with TB services, access, and quality; provide evidence; and remain anonymous
v. **Reporting and trends:** Generate downloadable reports against project indicators; design and circulate surveys
vi. **Interactive dashboards:** Track challenges being reported; develop feedback loops and accountability mechanisms; map frequency and locations of challenges reported

Note: For more information, refer "TB Manual, 2020" and chapter three of this guideline.

2.1.5 Community Rights and Gender (CRG)

TB and Leprosy are the diseases of poverty and inequality. Unfortunately, some individuals lack access to TB and leprosy services due to many factors related to community issues, right and gender inequality that hinder the effectiveness, accessibility and sustainability of TB program and services. CRG agendas should therefore be addressed throughout community-based service delivery.

CRG agendas include:

- Underlying poverty and economic inequality
- People in state custody and people who use drugs
- Migrants, refugees, nomad and misplaced persons
- Traditional norms and believes
- Stigma and discrimination

Note: For further information refer National community gender and rights implementation guide for TB response, 2021

CHAPTER 3
COMMUNITY INTERVENTIONS

Community-based actions are essential in a country's efforts against TB and Leprosy. It is also important to link community action on TB and Leprosy with efforts of the health system to extend and reach as many people as possible.

The following are the key community TB and Leprosy interventions:

- Community Active TB/Leprosy Case Finding (ACF):
- Tracing Lost to follow up
- Health education and Counselling
- Infection Prevention and Control
- Linking community and health facilities
- Sputum transportation
- Treatment support
- Community lead monitoring (CLM application)
- Community Based Rehabilitative (CBR) and support services for TB and Leprosy.
- TB and Leprosy screening campaigns
- mHealth initiatives

3.1 Community Active TB Case Finding (ACF)

Active TB case finding (ACF) from the community, is a systematic searching for people presumed to have TB/Leprosy, who would not spontaneously present to health facilities due to many factors such as lack of awareness and competing priorities for time and money and bringing them into care. It focuses in improving early TB/Leprosy case detection by reducing delays in presentation to a health facility and hence reduces TB/Leprosy transmission in the community.

3.1.1 Contact investigation

Contact investigation is a systematic process intended to identify TB/Leprosy cases among contacts of an index case. This will result in earlier identification of TB/Leprosy cases, possibly leading to decreased disease severity and reduction in transmission of the two diseases in general community.

Contacts of TB/Leprosy patients are at higher risk of developing TB/Leprosy disease, this also include HCWs and other health facility staff who come into contact with person with active TB pulmonary disease and Leprosy. PLHIV also are at particular risk of rapid progression to TB disease if they become infected or re-infected with *Mycobacterium tuberculosis*. The definition of contacts are shown in (Table 3)

Table 3. Definitions of Contact investigations[16]

Term	Definition
Index case (TB patient)	An identified case of new or re-treatment/previous treated TB or DR TB.
Contact	Any person who has been exposed to an index case.
Household contact	A person who shared the same enclosed living space with an index case.
Other contact	A person who is not household contact but shared an enclosed space, such as a social gathering place, workplace or facility, for extended time periods during the day with the index case.

Contact investigation consists of two components: i) Contact identification and prioritization and ii) contact clinical evaluation.

3.1.1.3 Contact identification and prioritization

This is a systematic process to identify contacts with or at increased risk for development of TB. Definition of contact identification and prioritization includes an interview with the index case to obtain the names and ages of contacts and an assessment of contacts' risk for having TB/Leprosy (generally based on the presence of symptoms compatible with TB/Leprosy or developing TB/Leprosy and to determine those for whom clinical evaluation is indicated.

[16]Recommendations for Investigating Contacts of Persons with Infectious Tuberculosis in Low- and Middle-Income Countries by WHO, 2012

The screening of both TB and Leprosy is done using TB/LEP 12 and if an individual with one or more of the symptoms should be referred to the health facility using TB/LEP 15.

TB: The assessment of close contacts will be done using community TB screening questionnaires (TSQ):

- Cough of any duration
- Weight loss
- Fever,
- Excessive night sweats
- History of living with a TB patient

Leprosy: The assessment of close contacts will be done using community Leprosy screening questionnaires:

- One or more pale or reddish, hypo-pigmented patch(es) on the skin with diminished or loss of sensation,
- Painless swelling or lumps in the face especially the nose and/or earlobes,
- Enlarged and/or tender nerves,
- Burning sensation of the skin
- Weakness of eyelids, hands, and/or feet, and
- Painless wounds or burns on the hands and/or feet.

3.1.1.2 Model for Contact Investigation

There are two ways of conducting contact investigation (CI):

Active contact investigation - Contact visitation.

Contact visitation (active contact investigation) is the most useful approach. A contact visit provides a check on the information obtained from the index case regarding the numbers of persons in close contacts including physical and social structure of the house or working place. It also serves to build a stronger connection between the clinic staff, the family, and the community. In this approach the person conducting the contact investigation should visit contacts of index patient to, conduct interviews and develop a priority list of contacts for clinical evaluation.

Passive contact investigation—Contact invitation

If contact visitation is not possible, a less-desirable approach is "contact invitation," (passive contact investigation) in which contacts are invited to visit the clinic by the index case for evaluation. A modification of this approach is to instruct the index case to tell close contacts to visit the clinic for investigations.

Note: Steps for conducting TB/Leprosy contact investigation

1. Obtain list and particulars of confirmed TB/Leprosy clients from the HF.
2. Perform elicitation of contacts to index case.
3. Inform and get consent to visit households from community and village leaders
4. Schedule visits with contacts and screen for TB/Leprosy.
5. Registers all contacts in community TB/LEP screening form (TB/LEP 12).
6. Collect quality sputum to all TB presumptive clients and referrer those in needs.
7. Register all presumptive TB/Leprosy clients in TB/LEP 12.
8. Follow up sputum examination results.
9. Ensure all confirmed TB/Leprosy cases have been initiated on TB/Leprosy treatment.
10. Update relevant information in TB/LEP 12.
11. Encourage diagnosed TB/Leprosy patients to join the patient support group

Steps for contact invitation

1. Repeat steps 1 to 3 above (contact investigation)
2. Invite the close contacts to the facility

3.1.1.3 Contact clinical evaluation

This is a systematic process for the diagnosis or exclusion of active TB and Leprosy among contacts. Clinical evaluation is undertaken if the results of contact identification and prioritization indicate a risk for having or developing TB/Leprosy. Definition of contact clinical evaluation includes, at a minimum, a more extensive assessment of symptoms compatible with TB and Leprosy.

Additional components may include:

- A more detailed medical history
- A physical examination
- Microbiological assessment of specimens from sites of suspected involvement
- Radiographic examinations for TB

1.1.1.4 House to house TB screening

CHWs/volunteers might need to conduct Active TB/Leprosy case finding at the household level. This involves house to house search of household members with TB/Leprosy related signs and symptoms. The following are steps to be followed:

Steps

1. Identify high TB risk areas.
2. List the particulars of all household members.
3. Conduct TB/Leprosy screening to all household members using community TB/Leprosy screening form.
4. Collect sputum among TB presumptive clients and refer those in needs for investigations.
5. Register all presumptive TB cases in TB/LEP 12
6. Follow up sputum examination results and update relevant information to community presumptive TB register.

Ensure all confirmed TB cases are initiated on TB treatment.

Note: House to house TB screening is recommended in high TB risk areas i.e. KVPs, elderly homes, mining communities

3.1.2 Other active TB/Leprosy case finding at community level

Several other community TB interventions are in place for the purpose of increase TB case detection from the community level. This includes:

3.1.2.1 ADDO

This is the community intervention that focus on involvement of the ADDO in identification of presumptive TB/Leprosy clients. For presumptive TB clients, sputum should be collected and transported to GeneXpert testing site using an integrated system of CHWs and health facility. For

presumptive Leprosy clients, they should be referred to health facility for further investigation.

3.1.2.2 Tambua TB (mHaelth)

Tambua TB is an innovation in digital health specifically for TB to support TB self-screening using mobile SMS application (*150*66#).

3.1.2.3 Traditional healers

This is the community intervention that focus on involvement of the traditional healers in identification of presumptive TB/Leprosy clients and referral of sputum for TB testing using an integrated system of CHWs and health facility.

3.1.2.4 Sputum referral and transportation

This involves collection and transportation of sputum from the community level for the purpose of increasing access to TB diagnosis using either CHWs or health workers. The point of collection should be at the household or where the TB screening is done. The sputum transporters should then transport directly either to the either TB diagnosis site or sputum collection site.

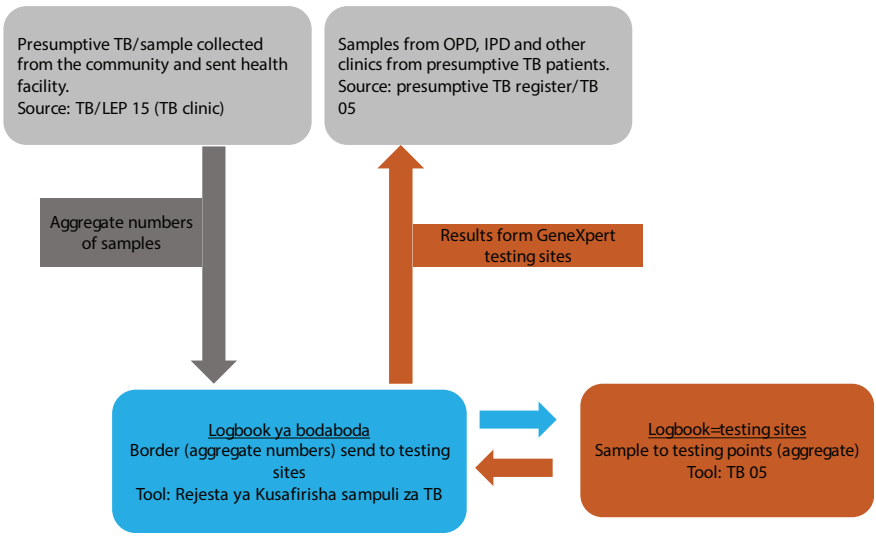

Figure 4. Sample transportation flow from the community to TB diagnostic sites and results feedback pathway.

Non-diagnostic sites/Sites with no GeneXpert

Key steps

- The samples from the community and other entry points are collated and then sent to the GeneXpert diagnostic site. The referral forms TB/LEP 15 and presumptive registers are the source of patient data to be entered into the presumptive TB register at the health facility.
- The samples, request forms are given to the sputum transporter for transportation to the GeneXpert sites.
- A chain of custodian is ensured through handover signing in the Logbook ya bodaboda and sample transportation register.

GeneXpert testing sites

- The samples are handled to the laboratory manager and the results are given to the sample transporter.
- The laboratory technician to ensure chain of custody of samples and results through the designated logbook.

3.1.2.2 School health programs and community TB/Leprosy sensitization and screening campaign among general population and KVP

This is the integration of TB agenda into the existing school health programs and increasing general knowledge on TB through different campaigns and sensitization forum.

3.2 Community leprosy interventions

3.2.1 Contact screening

Contact screening has been recommended worldwide as one of the most effective modalities of community intervention in leprosy high risk groups. It involves examining many potential skin lesions in healthy people and so a range of other skin lesion will be detected as well as potential early leprosy cases. This can be done passively or actively with the aim of early case detection of the disease. In active case finding, the index case who present to the facility for treatment, will provide particulars of his/her household contacts. The contacts are followed up in their homes and screened. Pa-

tients presumed with leprosy are immediately referred to the health facility for diagnosis and further management. In passive means, the contacts will be asked to attend at the facility for investigations. This is mainly done by the community volunteers and community health workers.

Note: Chemoprophylaxis

- Household contacts who screened leprosy negative are then given a single dose Rifampicin (SDR) as a drug to prevent the development of the disease. The effectiveness of SDR is likely to require the programmes to ensure high coverage of contact screening in use a broad definition of contacts, including social contacts.
- In Tanzania it has been implemented as a study (LPEP study) since the year 2016 in 3 districts and later on scaled up to 6 districts (Kilombero, Nanyumbu, Liwale, Chato, Muheza and Mkinga) with over 10% increase of new leprosy cases.

3.2.2 CBR services for people affected by leprosy

Beneficiaries will be identified by health workers/DTLCs or by using the Prevention of Disabilities (POD) Register (LEP 06):

- Assess the disability and need for rehabilitation by discussing the issue with other health workers, community members, social workers, and disabled people about their experiences, interests, expectations, frustrations, challenges, and ideas to improve the situation.
    - Provide basic services like drugs, protective footwear, counselling, and training in self-care.
- Provide guidance in procuring appropriate protective devices.
- Encourage the practice of self-care, discuss problems, find feasible solutions, and refer to other organizations providing services.
- Encourage people with disabilities to join or form a self-help group.
- Coordinate with various agencies/organizations and help in dissemination of information to potential beneficiaries/users.
- Facilitate accessibility to socioeconomic rehabilitation services through the social welfare department.
- Advocate for CBR activities to be incorporated into other sectoral ministries (education, justice, labour, home affairs).

Advantages of CBR

Organization of self-help groups:

- Provides visibility to the group members.
- Provides support for individual members.
- Helps groups solve problems.
- Enhances mainstreaming of leprosy disability services within general disability services and involvement of general disability issues into development projects.
- Provides identity to members and to the group within the community so that the members of the group act as a resource to the community.

Empowerment of the disabled: People with disabilities and their families are provided updated information and training so that they are able to take responsibility for their development within the context of general community development.

Behavior change: CBR promotes the change in mind-set of disabled people so that people affected by leprosy do not remain passive recipients but become active contributors and participate in family and community life.

Empowerment of the community: The community becomes responsible for ensuring that all of its members, including those with disabilities, achieve equal access to all of the resources that are available to that community and that people with disabilities are enabled to participate fully in the social, economic, and political life of the community.

Stigma and discrimination reduction: Reduce the perceived fear of infection and misconceptions related to leprosy.

Socioeconomic rehabilitation: Increases accessibility to socioeconomic rehabilitation services for people affected by leprosy by establishing linkages.

Legislative measures: Promotes implementation of the Disabled Peoples Act at all levels.

3.2.3 CBR for MDR-TB Patients

Community Health Workers, TB survivor: In community-based programs should conduct home visits to check adherence, social situation, health of

family members, address fears or doubts and other barriers to treatment for DR-TB contacts.

3.2.4 Lost to follow up tracing

Lost to follow up leprosy case should be traced and brought back to TB/ Leprosy clinic to start or re-start treatment. A health care provider at the facility will identify and provide a list of missed appointment and other lost to follow up leprosy patients with their physical contact address to the CHWs for tracing as early as possible to avoid drug resistance.

3.2.5 Health education

Health education in leprosy focuses on awareness, early diagnosis, proper treatment, and prevention and CBR component. Promoting societal inclusion by addressing all forms of discrimination and stigma.

CBR involves communities in action for improvement of leprosy services through.

- **Community sensitization:** is the process of providing the community with accurate information about the diseases affecting them and availability of services that can be used to manage the disease. It encourages community members who have the disease to report themselves to the available services, enable the patient to understand the disease, promote patient adherence to treatment to reduce lost to follow ups, reduce stigmatization and discrimination against patient and their families, and educate patients about their rights and the rights of their families. This can be done through campaigns, distribution of IEC materials and mass media.
- **Empowering persons affected by leprosy** and strengthening their capacity to participate actively in leprosy services.
- **Coalition-building** among persons affected by leprosy and encouraging the integration of these coalitions and/or their members with other community-based organizations.
    - o Promoting access to social and financial support services, for example to facilitate income generation, for persons affected by leprosy and their families.
- **Supporting** community-based rehabilitation for people with leprosy-related disabilities.

3.3 Leprosy elimination campaigns

These campaigns need to be planned and implemented in a collective way with multiple partners from the community level to council level. Leprosy elimination campaigns are designated campaigns intended for the purpose of elimination of Leprosy in high burden areas. It comprises a series of provision of health education, screening of people and initiation of anti-Leprosy treatment at the community level.

3.4 Treatment support

The aim of TB treatment is to cure TB patients and restore quality of life, prevent death, avoid relapse, prevent emergence of drug-resistant organisms, and prevent transmission of TB to others. In order to achieve favourable treatment outcomes, close follow up and support of a patient are highly emphasized.

3.4.1 Direct Observed Treatment (DOT)

This is a modal of treatment whereby a trained health care provider or other designated individual (selected by patient) including family member observe when patient swallow ant-TB. This ensures that a TB patient takes the right drugs, in the right doses and at the right intervals. DOT can either be health facility based or home-based or combined health facility/home based. In a health facility-based DOT, a facility health worker supervises the patient at DOT clinic while home-based DOT, TB dose is observed by a treatment supporter selected by patient.

Note: A combined facility/community-based DOT may be employed according to the nature and regimen used by TB patient.

In order to facilitate community-based DOT, community members, including CBOs, religious groups, and current/former TB patient groups should be encouraged to participate in TB care and control. For good outcome under community-based DOT, health care provider should:

- Supervise TB patients under home based DOT
- Facilitate establishment and empowerment of treatment support groups
- Inform TB/DR TB patient the importance of drug compliance and adherence (DOT)
- Remind the family members on importance of drug compliance and

adherence Inform TB patient, family and community members on effects of poor compliance and adherence (DOT) including drug resistant TB.

- Involve community leaders and other influential people in difficult situations

3.4.2 Managing side effect

Side effects are the most important reason why patients default from treatment. These can occur at any time during treatment. In most cases they are mild, but occasionally they can be severe. It is important to detect and resolve them quickly:

Symptoms based approach to manage side effects of anti-TB drugs

Minor side effects

- These include: Anorexia, nausea or abdominal pain, Drowsiness, Flu syndrome (fever, chills, malaise, headache, arthralgia), Orange/red urine

Action: reassure the patient that there will be self - limitation and closely monitor the patient

Major side effects

- These include: Skin rash with or without itching, impaired hearing, dizziness, Joint pain, burning, numbness or tingling sensation in the hands or feet, jaundice, confusion, decrease urine output, shock and oedema of lower limbs

Action: stop the medications then refer the patient to health facility immediately

Daily DOT is an opportunity for early detection of side effects. The TB Community health service provider and the TB Supporter should be conversant with the potential side effects that could be produced by the regimen that the patient is receiving. The Supporter should have an easy mode of communication with a HCW.

3.4.3 Referral and Linkages to services

An effective and functioning referral system is important to assist TB patients to continue receiving appropriate services of care, treatment and support within their respective communities. TB patients require oth-

er support services like nutrition, socio-economic and psychosocial and therefore should be linked to respective services such as:

- **Community nutrition services**: TB patient need proper nutrition counselling services in order to have favorable treatment outcome. The nutrition service comprises of nutritional education, provision of IEC materials, identification and referrals for all clients with nutritional needs, nutritional counselling and linkage to support groups (chronic diseases) replacement and therapeutic feeds.
- **Socio-economic support**: TB patients may require socio – economic support. In order to obtain these services, patients need to be linked to:
    - Income generating groups such as VICOBA, SACCOS etc.
    - Social support groups such as TB survivor group, MKUTA etc.

3.4.4 Lost to follow up tracing

Lost to follow up TB case is a TB patient who did not start treatment or whose treatment was interrupted for two consecutive months or more. Such a patient should be traced and brought back to DOT for appropriate management.

Note:

"Initial lost to follow up" are those not initiated with anti-TB treatment after diagnosis.

A health care provider at the facility will identify and provide a list of missed appointment and lost to follow up TB patients with their physical contact address to the CHWs for tracing as early as possible to avoid drug resistance development. During tracing of lost to follow up and missed appointments, tracing of their contacts is very crucial.

3.5 Health education and Counselling

Counselling of TB patients and their families is essential and therefore quality training to health workers and CHWs, with regular supervision and mentorship must be properly done. Components of counselling in the context of community health include;

- Psycho-social support: Psycho-social support should be provided to

TB/Leprosy patients, their families and community members, when necessary, TB/Leprosy patients should be linked to spiritual support.

- TB and HIV related counselling and testing to families of index TB/Leprosy patient.

Health Education is a critical component of fight against TB/Leprosy. Health education has a goal of changing health related behaviour of the community. Intervention under health education may facilitate or empower community gathering, political and financial support and address the challenges of individual and socio-behavioural change. These challenges include:

- Delayed health seeking behavior
- Inadequate access to TB, TB/HIV, DR-TB and Leprosy diagnostic health facilities
- Inadequate knowledge of TB, TB/HIV and Leprosy symptoms and signs
- Stigma and discrimination
- Misconception and myths surrounding TB, TB/HIV and Leprosy
- Poor adherence to TB, TB/HIV, DR-TB and Leprosy treatment
- Insufficient resources allocation to TB, TB/HIV, DR-TB and Leprosy control

3.5.1 Awareness creation on TB and Leprosy

Awareness creation in TB and Leprosy control aims at increased case identification and stigma reduction of both diseases and it includes the following activities:

- Conduct house to house visits including marginalized families and communities.
- Participate in community gathering and special events at village and ward levels.
- Distribution of IEC materials to community members.
- Provide testimonies.
- Conduct health talks at health facilities and community level.
- Conduct TB and Leprosy sensitization campaign in schools, learning institutions, orphanage centers, prison, mining and mining communities.
- Using existing groups in communities such as cultural troops, choirs, drama groups to convey messages on TB and Leprosy.

Key messages should focus on TB and Leprosy transmission, signs and symptoms, treatment and duration, prevention including infection control plan formulation.

3.5.2 Advocacy at community level

Advocacy influences policy makers, funders and decision makers at international, national, regional, district and local levels through variety of channels to change or enhance policy and allocate necessary funding and resources to achieve TB and Leprosy control activities. Advocacy is the tool with its primary work for behavioural change of public leaders and decision makers.

At community level advocacy activities for TB and Leprosy includes:

- Advocacy meeting with community leaders (Councilors, Ward Executive Officer, Village Executive officer, religious leaders, CORPs, traditional healers, CSOs and patient organizations) to highlight them on issues relating to TB and Leprosy control in order to gather support.
- Resource mobilization activities (meeting with various partners including NGOs, CBOs, local Government authorities).
- Advocating for support from media to educate communities on sign and symptoms of TB and Leprosy including prevention and control
- Advocating for inclusion of former/current TB and Leprosy patients in planning, design, implementation and evaluation of TB and Leprosy interventions

3.6 Infection Prevention and Control

Three levels of TB/Leprosy Infection control at community level

3.6.1 Administrative control measures

This is the most important level of control measures addressing the reduction of exposure of community, patients and family members to *Mycobacterium tuberculosis or Mycobacterium leprae*. Unfortunately, the risk usually cannot be eliminated, but it can be significantly reduced with proper administrative control measures. The most important administrative control measures include:

- Assessment of the risk of transmission in community
- Early TB/Leprosy screening and referral of presumptive clients for early TB/Leprosy diagnosis

- Prompt initiation of appropriate anti-tuberculosis or Leprosy treatment.

Administrative measure can be agreed and applied by community members under village/ward leaders' guidance and supervision.

3.6.2 Environmental control measures

This reduces the concentration of infectious droplet nuclei by a person who is infected. Since the exposure to infectious droplet nuclei usually cannot be eliminated, various environmental control measures can be used in high-risk areas to reduce the concentration of droplet nuclei in the air. Such measures include maximizing natural ventilation and controlling the direction of airflow. Community authorities should advocate for building modern houses with big windows, advocate to community members to open windows all the time and refer TB presumptive client to health facility for early diagnosis and treatment.

3.6.3 Personal protective measures (respiratory protection)

This aims at protecting community members and family member collaboration with administrative and environmental control measures.

A weakened immune system enables latent TB to become active TB disease. The risk of acquiring TB can be reduced by staying healthy; eating balanced and adequate diet; avoiding smoking and illicit drugs or too much alcohol; and getting prompt treatment for any health problems.

CHWs including sputum fixers should be encouraged to observe TB infection control. Creating Community awareness on importance of adherence to TB treatment will prevent the community against drug Resistant TB. DR-TB care providers at community level should be sensitized on risk of transmission. Before culture conversion, DR-TB patient should be provided with basic personal protective equipment (surgical masks) for use in the home setting where there are vulnerable groups like children under five, elderly and chronic ill people and PLHIV.

Note: Administrative control measures are the most important among the three levels. Environmental control measures and personal protective measures (respiratory protection) will not work in the absence of solid administrative controls. Each level operates at a different point in the TB infection control process.

3.6.4 Specific ways for TB Infection control

The following are some specific ways to prevent TB from spreading:

- **Cough hygiene and ventilation:** This includes covering the mouth and nose when coughing or sneezing, raising awareness on how TB is transmitted and ensuring that houses, clinics, workplaces and other "congregate settings" are well ventilated. This is particularly important for rooms where people with infectious TB spend a lot of time. Natural ventilation, by opening doors and windows, and sunlight in living spaces are very helpful.
- **Early diagnosis and case finding:** Diagnosing and treating active TB early stops it from being passed on to others. "TB case finding" refers to identifying people with signs and symptoms of active TB and supporting them to be diagnosed and treated. When active TB is diagnosed in a person, contacts should also be screened for TB symptoms and signs
- **BCG (bacillus Calmette - Guérin) vaccine:** This was first used in 1921 and continues to be the only vaccine for TB. It is provided at birth and it is useful in severe forms of disease.
- **Prevention with medication:** People with latent TB who are at increased risk of developing active TB, such as people living with HIV and children younger than five years who are in contact with a TB patient, could be given a course of the anti-TB drug (s) to prevent the development of TB. This prevention treatment is often called TB preventive therapy (TPT).

3.6.5 Infection Control Measures in Special Settings

There are special settings in the community that are of high risk and call for special attention as far as TB infection, prevention and control is concerned. These include: -

- Congregate settings e.g., Prisons and elderly home.
- Informal settlements (slums)
- Refugee and internally displaced persons (IDP) camps
- Learning institutions (schools, colleges)
- Security forces training camps (military, police national youth service etc.)

TB spreads more readily in congregate setting due to longer duration of potential exposure, crowded environment, poor ventilation, and limited access to health care services.

In Prisons

All inmates on admission should be screened for TB. The prison and remand cell should follow and adhere to TB infection control guidelines. There is a need for active advocacy and sensitization of relevant ministry and departments for the implementation of TB infection control guidelines in the prisons.

Informal settlements (slums)

Adequate sensitization and advocacy on proper ventilation on the existing structures/ housing and practice of cough hygiene/manners should be instructed. Screening, contact tracing and lost to follow up tracking should be highly emphasized in such settings for avoiding more transmission.

Learning institutions and schools

TB infection control should be incorporated in the school health program. Learning institutions should adopt and own TB environmental measure to prevent transmission.

Public services transport

TB infection control should be implemented in public transport sectors such as buses, trains and air transport. There should be adequate ventilation by opening windows on both sides of the vehicles or applying mechanized ventilation. Coughing hygiene/manners should be advocated to all passengers. Advocacy and sensitization with different ministries and the community is required for this to succeed. Transportation of suspected DR-TB Patient's from one facility to another should be by well-ventilated means of transport with personal respiratory protective devices.

3.6.6 Infection control and legal implication

TB, DR-TB patient, Leprosy patient and the community should be adequately educated on the importance of adhering to DOTs. If for any reason a patient with TB/DR TB and Leprosy refuses to be treated or admitted to a special hospital, action shall be taken against him/her in accordance with the Public Health Act 2009.

3.7 Community Lead Monitoring (CLM application)

Community Led Monitoring (CLM) is a practice that combines systematic and routine data collection by communities with evidence-based advocacy to improve accountability, governance and quality of health services provided.

- CLM is managed, governed, and implemented by communities themselves.
- Community-based monitoring is done in settings or locations outside of formal health facilities.
- CLM trains, supports, equips and pays members affected directly by TB/Leprosy to themselves carry out routine, ongoing monitoring of the quality and accessibility of TB and Leprosy treatment and prevention services.
- CLM can supplement national TB data by collecting information on these challenges that would otherwise be excluded, producing shadow reports that hold governments accountable, and building evidence to inform civil society and community advocacy for improved care and services

3.7.1 One Impact, a CLM digital platform

In 2016 Stop TB Partnership (STP) developed OneImpact, a CLM digital platform, in partnership with affected TB communities and Dure Technologies. OneImpact is a TB community engagement platform designed to enhance community-led monitoring and to facilitate dialogue and collective action between affected TB communities, civil society, national TB programs and health, legal and social welfare systems for a people centered and rights-based and gender transformative approach to TB.

OneImpact[17] allows service users, community support groups, advocacy organizations, providers of TB services and policy makers to input, gather

[17] https://stoptbpartnershiponeimpact.org/ (Accessed August 19th 2021)

and use community-based information for more efficient local responses that respond directly to community needs and for longer term advocacy and program purposes; enhances the empowerment of people who have TB; by giving people, information about TB and available medical and peer support services, and the option to report challenges.

Enhances community engagement and support, by providing a platform for people to report challenges and connect with each other. Enhances responses; by generating real time data for advocacy, programs and services and prompting action and decision making. OneImpact consists of a library of Apps that can be downloaded and/or further adapted according to the specific needs of people affected by TB and community organizations supporting people with TB. The platform also offers developers tools to support the development/adaptations of apps to meet specific requirements.

One Impact has four applications;

- **Get Knowledgeable**: An App on all you need to know about TB
- **Get Access:** A TB service locator App that helps you access nearby TB health services and information about the services
- **Get Connected:** An App that connects you with other people with TB and TB support groups
- **Get Involved:** An App that allows you to report the challenges that are interfering with your ability to access TB services and complete TB treatment.

CHAPTER 4
COMMUNITY AND PATIENT ORGANIZATIONS

The patient organization aim to the increasing community participation in prevention and care of TB and Leprosy by promoting delivery of services at the community levels. The patient organization form umbrella organizations at national organization with the following objectives:

i. To coordinate community response towards prevention and care of TB and Leprosy
ii. To enhance networking, learning, dialogue and information sharing among members
iii. To establish and collaborate with CBOs and stakeholders working on TB and Leprosy
iv. To build capacity of collaborating CBOs and stakeholders working on TB and Leprosy
v. To oversee implementation, monitor and evaluate a progress of all collaborating CBOs and stakeholders in Tanzania
vi. To mobilize financial and material resources from local and international donors to support
vii. To manage grants and other resources provided to collaborating CBOs in Tanzania
viii. Advocate for provision of right-based, equitable and quality services to all TB and HIV patients
ix. To increase awareness, address reduction of stigma and create demand for TB and Leprosy service in the communities
x. To ensure gender mainstreaming in all collaborating CBOs
xi. To strengthen institutional capacity for sustainable organizational, technical, research and financial resources.
xii. Advocate for increased domestic health financing for TB and Leprosy in Tanzania
xiii. Promote innovations and patient's centred approach in implementation of TB and Leprosy services

4.1 Memberships

The patients' organizations, are memberships based and are governed by the constitutions which outlines the procedures of becoming a member.

Here are the categories of the memberships for a patient organization.

i. **Ordinary members**: former TB/leprosy patients organized through registered TB/leprosy clubs.

ii. **Volunteer members:** non-TB patients or non-leprosy patients who would like to participate in the organization.

iii. **Honorary members:** given to individuals because of the duties, privileges and recognition of duties and efforts they do to the communities they save.

4.2 Example of Patient Organizations

The Figure 5 is an example of the three patients' organizations that are present in Tanzania. Their brief description is here below:

MKUTA

- MKUTA is MWITIKIO WA KUDHIBITI KIFUA KIKUU NA UKIMWI TANZANIA MKUTA) a national TB patient organisation with a network of over 75 TB clubs (including Temeke) was officially registered in 2009.
- MKUTA missions is to build the capacity of Community Based Organizations in providing TB and HIV services and direct services delivery.
- MKUTA works with CBOs and stakeholders through a Memorandum of Understanding.
- MKUTA saves as an umbrella organization for all former TB patients' organizations in all the regions.

Mukikute

- Mapambano ya Kifua Kikuu na Ukimwi Temeke (Mukikute) is a non-governmental organisation (NGO) implementing community TB Care in Tanzania through empowering community affected with TB and HIV to take part in the response.
- The organisation was officially registered in 2007, as an organisation of former TB patients organizing for a stronger, rights-based community involvement to reduce the burden of Tuberculosis (TB) and Human Immunodeficiency Virus (HIV).
- Mukikute is the patient organization in Temeke region being formed by several TB clubs across the district.

Figure 5. Example of the patients' organizations in Tanzania.

CHAPTER 5
ROLES, RIGHTS AND RESPONSIBILITIES

5.1 Responsibilities and rights of TB and Leprosy Patient

5.1.1 Some of key responsibilities of the TB and Leprosy patient include:

- Take all medication doses under the supervision of treatment supporter
- Attend clinic visits as scheduled
- Provide quality sputum and other specimens when needed for monitoring
- Report all symptoms of possible medicine side effects
- Report any challenge associated with care
- Practice TB and Leprosy infection control measures as instructed/directed by HCWs and CHWs
- Share TB and Leprosy control information with relatives/family members
- Advice contacts/family members with TB and Leprosy symptoms to visit health facility for investigation
- Provide information that will facilitate contact investigation

5.1.2 Rights of TB and Leprosy Patients

TB and Leprosy patient has a right to select and change his/her treatment supporter any time.

- Right to life.
- Right to dignity and respect
- Right to access health care
- Right to equality and freedom from stigma and discrimination.
- Freedom of movement.
- Right to privacy and confidentiality.
- Right to informed consent.
- Right to education.
- Right to employment.
- Right to adequate food, housing, water and sanitation.
- Right to social security.
- Right to freedom of expression.

- Right to freedom of assembly and association.
- Right to participation.
- Right to justice and due process.
- Right to enjoy the benefits of scientific progress (right to science).
- Conjugal right

5.2 Roles of Treatment Supporter

Treatment supporter can be anyone (family member, spouse, relative, neighbors, health workers, or community health workers) as decided by the patient. Selection of treatment supporter can base on the criteria including interested in the well-being of the patient, willing and able to carry out the task, living close to the patient and being accepted by the patient.

A supporter will have to perform the following roles:

- Remind and encourage the patient to take their medicines everyday
- Supervise/observe the patient taking their medicines every day (HB-DOT)
- Mark number of daily dosages on the patient's identification card after the medicines are taken on daily basis
- Remind the patient on sputum collection for monitoring in case of bacteriologically confirmed cases
- Report to health care provider any problems including side effects observed/reported by the patient
- Accompany the patient to the health facility to obtain medicines
- Inform the health care workers in case of travel so that the patient can select another supporter
- Report to the health facility in case the patient refuses to take his/her medication for assistance.

5.3 Roles of Family members

Family member can be parents, spouse, brother, sister, aunt, uncle, and children etc. who lives in the same household with the patient.

- Support the patient emotionally, psychologically, nutritionally, financially and spiritually during the course of TB and Leprosy treatment.
- Comfort the patient and avoid stigmatization and discrimination.
- Accompanying the patients to health facility
- Encourage and motivate the patient to adhere on the medication

5.4 Roles of CHWs

- Carry out community-based TB and Leprosy activities accordingly to National Guidelines
- Empower community members on TB and Leprosy information through effective advocacy and social mobilization
- Identify people with presumptive TB and Leprosy, collect sputum samples and send them to health facility
- Provide feedback of presumptive case from health facility
- Ensure all TB cases are on treatment
- Supervise the patient and his/her treatment supporter during treatment
- Collect and provide data to health facilities and CSOs implementing TB and Leprosy

5.5 Roles of Community members

- Participate in identification of CHWs with accordance village/street meeting
- Support CHWs with needed resources to implement community TB and Leprosy activities through fund allocated at community level
- Determine appropriate and sustainable ways for motivating and supporting CHWs
- Engage in improving and sustaining community TB and Leprosy activities within their communities
- Work towards the elimination of stigma and discrimination at community level
- Collaborate with CHWs to identify vulnerable population including OVC/MVC, KP, PLHIV, GBV/VAC, PWD and assist them to access relevant services
- Use and take ownership of community TB and Leprosy services

5.6 Roles of Influential People

- Empower community members on TB and Leprosy information through effective advocacy and social mobilization
- Ensure linkage with community TB providers (TB survivor clubs, CHWs, etc.).
- Provide spiritual, emotional support and counselling to TB patients
- Sensitize communities about caring for patients at home

- Strive to reduce stigma and discrimination in communities and within families

5.7 Roles of Traditional birth attendants and Traditional healers

- Identify all presumptive TB cases and refer them to community health care worker or health facility for investigation
- Work closely with CHWs to seek and make use of updated TB and Leprosy guidelines
- Report to CHWs for lost to follow up patients
- Support and advocate for adherence to treatment

5.8 Roles of Community groups (TB survivors groups, IGA, Spiritual, PLHIV support groups)

- Provide community with basic information on TB and Leprosy
- Sensitize the community on elimination of TB/HIV and Leprosy related stigma and discrimination
- Serve as role models/share personal experience on dealing with TB and Leprosy disease and its prevention (testimony)
- Promote adherence to TB treatment and other services
- Link TB patients with IGA for poverty reduction in the community
- Link TB and Leprosy patient to spiritual and psychosocial support
- Facilitate positive behaviour change practices in the communities (Alcoholics, IDU, CSW, MSM)

5.9 Roles of Para-social, Para-legal workers

- Work in partnership with CHWs to provide support and care to TB and Leprosy
- Provide feedback to the CHWs on TB and Leprosy activities
- Educate and counsel community members on TB and Leprosy
- Facilitate legal proceedings to TB and Leprosy patients who refuse to take medication or refused to be admitted to health facilities in accordance with the Public Health Act 2009.

5.10 Roles of Drug Dispensers in ADDOs and Pharmacies

- Identify presumed TB/Leprosy clients and refer those in need for investigations

- Collect sputum sample and refer for investigation through CHW/X-TB/Volunteer.
- Educating presumptive TB cases on TB symptoms, importance of early diagnosis, and risks associated with not complying with the referral.
- Facilitate referrals of TB and Leprosy contacts.
- Refer to health facility clients on TB and Leprosy treatment who experience adverse effects.
- Keep records of all referrals made.
- Make follow up of referred presumptive TB clients:
- Provide health education on TB and Leprosy transmission and prevention.
- Link TB presumptive with CHWs.

5.11 Roles of Local government executive leaders

The government executive leaders could be ward executive officers, Village/Street Chairperson. Their roles include:

- Provide time for CHWs to talk about TB and Leprosy prevention, care and support during each community meetings
- Mobilization of resource for community TB and Leprosy activities
- Conduct dialogue meetings with CHWs so as to identify challenges and risk behaviour for key vulnerable groups
- Create demand for community TB and Leprosy care in their community
- Incorporate community TB and Leprosy care activities into local plans, budgets and supervise its implementation
- Facilitate multi sectorial collaborations for implementation of community TB and Leprosy care services

5.12 Roles of Health facilities for community TB and Leprosy care

5.12.1 TB diagnostic centers

- Receive TB presumptive samples from CHWs/Bodaboda, investigate them and initiate treatment accordingly and provide feedback.
- Educate CHWs on quality of samples, proper labelling of containers, proper filling of forms
- Receive sputum samples from peripheral and perform microscopy/ Gene Expert, record the results properly and provide feedback
- Ensure enough stock of laboratory reagents and supplies for microsco-

py, True Nat /GeneXpert for the facility
- Provide information for lost to follow up tracing
- Prepare the list of bacteriological confirmed and submit to CHW for CI
- Supervise community TB activities

5.12.2 TB clinics
- Record all TB/Leprosy presumptive clients from community to facility TB/leprosy presumptive registers
- Facilitate exemption for TB patients
- Record all confirmed TB cases in unit/DHIS2ETL register
- Educate TB disease for TB and Leprosy patients and their families/ treatment supporters
- Initiate and monitor treatment to all TB/Leprosy patients under DOT
- Link TB/Leprosy patients who are co-infected with other diseases such as HIV, diabetes, cancers, to relevant clinics
- Communicate with DTLC on diagnostic TB/Leprosy patients
- Initiate contact tracing
- Facilitate lost to follow up and TB/Leprosy contact tracing by provision of particulars to CHWs.
- Work closely, supervise and mentor/train CHWs to ensure quality implementation of TB and Leprosy activities.

5.12.3 Roles of sample transporters
The roles of sample transporters may include:
- To pick samples from community non-diagnostic centres and spork
- To register all samples in logbooks
- Transport sample to required diagnostic centres/hubs
- To pick result and send back to the community non-diagnostic centres and sporks

5.12.4 Other health facility departments
The other health facility department include: Wards, CTC, RCH, HTC, OPD facilities in charges. Their roles include:
- Conduct TB screening and PITC to clients in particular departments
- Record and refer all presumptive TB cases for TB diagnosis and treatment in case of positive TB

5.13 Roles of the CSOs

- Make TB and Leprosy as one of their priority agenda in communities
- Ensure TB control is effectively integrated into HIV community interventions
- Integrate TB/Leprosy, TB/HIV, DR TB activities into community-based framework/plans
- Plan and implement community-based TB and Leprosy activities according to the national guidelines
- Mobilize resources for community-based TB and Leprosy activities
- Share TB and Leprosy control information including data with DMO and other stakeholders
- Work closely with TB and Leprosy coordinators in respective areas of implementation
- Provide onsite mentorship and supervise CHWs
- Ensure effective linkages and referrals of presumptive TB and Leprosy patients
- Facilitate implementation of community TB and Leprosy interventions through strengthening linkage between the communities, Government and development partners

5.14 Roles of Development Partners

- Advocate for country adaptation of global policies and standards for TB and Leprosy control at community level
- Facilitate sharing of experiences from within and other countries
- Provide technical and financial support for community TB and Leprosy care in line with National priorities.

5.15 Roles of Administrative levels

5.15.1 CHMT

- Conduct needs assessment and plan for district community TB interventions to be integrated into healthcare delivery systems
- Ensure integration of community TB and Leprosy services in Comprehensive Council Health Plans (CCHP).
- Mobilization and allocation of resources for community TB and Leprosy care.
- Facilitate incentive of CHWs for community TB and Leprosy interventions

- Coordinate and supervise implementing partners for community TB and Leprosy
- Facilitate multi sectorial collaboration for implementation of community TB and Leprosy services
- Create community awareness and demand for community TB and Leprosy services
- Support and ensure community involvement and participation in community TB and Leprosy services
- Establish an effective networking, referral and feedback systems to ensure TB and Leprosy continuum of care
- Build capacity of providers and supervisors for quality community TB and Leprosy care
- Manage regular stocks of essential community TB and Leprosy care equipment, supplies and drugs
- Conduct quarterly stakeholder's meetings to review the quality of care provided
- Facilitate engagement of CSOs into community TB and Leprosy control in the district.
- Collect, analyse and utilise data for community TB and Leprosy care in a district and share reports to stakeholders.
- Supervise all community TB/Leprosy interventions in the council

5.15.2 RHMT

- Ensure Community TB and Leprosy Services are integrated in Regional Comprehensive Health Plans.
- Interpret policy guidelines for Community TB and Leprosy care
- Support, facilitate and coordinate implementation of Community TB and Leprosy care in the region
- Facilitate engagement of CSOs into community TB and Leprosy control in the region.
- Collect, analyse and utilise data for community TB and Leprosy care in the region and share reports to stakeholders.

5.15.3 NTLP

- Develop and update Community TB and Leprosy services policy, guideline, training manuals, IEC materials, SOPs and monitoring tools.
- Support to facilitate and coordinate implementation of Community TB and Leprosy care in the country.

- Facilitate engagement of CSOs into community TB and Leprosy control in the country.
- Facilitate integration of community TB and Leprosy control activities into other health/non-health programmes
- Collect, analyse and utilise data for community TB and Leprosy care in the country and share reports to stakeholders.
- Train and mentor of National trainers on community TB and Leprosy care
- Prepare, disseminate and receive feedback on new policy guidelines and standards for community TB and Leprosy care
- Evaluate performance and impact of Community TB and Leprosy care initiatives
- Conduct operational research on community TB and Leprosy care for service delivery improvement

5.15.4 NACP

- Facilitate integration of community TB and Leprosy control activities into other HIV programmes in the country.

CHAPTER 6
TB AND LEPROSY SERVICES DURING COVID-19 PANDEMIC

6.1 Introduction

The COVID-19 virus first appeared in Wuhan, China, at the end of 2019 but quickly spread to many parts of the world, and it was declared by WHO by the end of January 2020 to be a Pandemic. Much remains to be known about the COVID-19 virus. According to current evidence, the COVID-19 virus is primarily transmitted through respiratory droplets and contact routes. The virus can spread from an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe. The effect of the virus is more pronounced among people with underlying diseases and those with other respiratory disorders such as TB and other chronic lung diseases.

6.2 Active Case Finding

Screening TB patients for COVID-19 and COVID-19 patients for TB using the symptoms mentioned in Table 4, needs to be explored in settings where simultaneous exposure to both diseases is high. Community involvement in both diseases is very important, expand active case finding activities, and strengthen sample collection and transportation systems, and TB testing at the community and household levels.

Table 4. Similarities and differences of symptoms between TB and COVID-19

Symptoms	TB Symptoms	COVID 19 Symptoms
Specific Symptoms	Cough, Night sweat, fever, weight loss and coughing sputum mixed with blood	Fever, cough, fatigue, anosmia, shortness of breath and myalgia's.
Common Symptoms	fever, cough, fatigue, shortness of breath	fever, cough, fatigue, shortness of breath

Other signs and Symptoms	Fatigue, shortness of breath	Sore throat, nasal congestion, headache, diarrhea, nausea and vomiting. loss of smell (anosmia) or loss of taste, reduced alertness, reduced mobility, diarrhea, loss of appetite and delirium.

Innovations for TB Diagnosis to increase TB notification are needed and may include:

- Plan catch-up campaigns to recover the back-log of TB cases that were missed due to the COVID-19 pandemic. This could be a periodic, community-based campaigns to promote and increase TB/COVID -19 testing and patient support services by mobilizing community volunteers, civil society organizations and the public at large.
- Mobile TB services have an important role during the catch-up phase to accelerate TB testing and treatment and should be considered wherever the COVID-19 situation allows. Mobile vans fitted with digital portable or handheld x-ray machines, improved bacteriological diagnosis and early drug resistance detection using rapid molecular tests, and concomitant testing for HIV, diabetes, and COVID-19 offers great opportunity for community-based early diagnosis

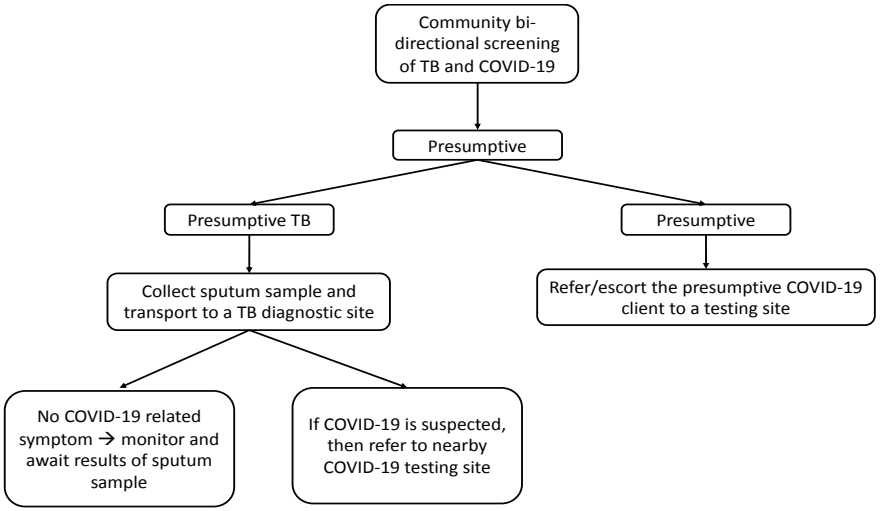

Figure 6. Flow diagram of community screening and linkage to TB/COVID-19 testing sites.

Result Feedback for TB and COVID-19

- For COVID-19 patients, if the facility performs rapid test, the result will be given to the patient directly.
- If samples are sent to Zonal laboratory, result will be sent back to RMO/DMO then to the Facility in-charge were sample were sent from then the patient will be informed.

Remember:

Signs and Symptoms of COVID-19 and TB are similar, so take the sample for COVID-19 and TB for confirmation.

6.3 Contact Investigation for TB

Contact (COVID-19) is a person or a group of people who were in contact with a confirmed COVID-19[18] Patient two days before the onset of signs and symptoms.

Contact (TB) is a person or a group of people who were in contact with a confirmed TB patient before and after the bacteriological confirmation.

[18]Confirmation of Covid -19 should come from the HF line list.

Investigation modalities

I. Preparation of tools

Table 5. Recording and reporting tools used for COVID-19 and TB

COVID-19	TB
• Rejesta ya watu waliokuwa karibu na mgonjwa • Contact listing form • Daily contact follow-up form • Contact reporting form • Contact field summary reporting form	• TB card number 01 • TB Screening Questionnaire (TSQ) • Community TB Register 13B

Resources mobilization and Logistics

- Geographical mapping
- Tentative budget

III. Preparation PPE and other protective gears

Bi-directional screening: check the national guidelines and refer in this section.

- Refer to the TB and COVID-19 practical guide
- Use TSQ

6.4 Treatment adherence and monitoring of TB and Leprosy patients

While experience on COVID-19 infection in TB patients remains limited, it is anticipated that people with both TB or leprosy and COVID-19 may have poorer treatment outcomes, especially if TB or leprosy treatment is interrupted following the implementation of the health safety and covid 19 control measures or any other unforeseen issues. Both diseases require early detection and treatment to improve patient outcomes and reduce transmission among contacts and communities.

6.4.1 Refilling program to be reschedule

The proposed refill of drugs for TB and Leprosy during COVID-19 is shown in Table 6.

Table 6. Proposed refill schedule during COVID-19 surge.

Disease	Treatment Phase	Routine Basis	During COVID-19 pandemic
TB/DR-TB	Intensive phase	One Week	Two weeks
	Continuation phase	Two weeks	One Month
Leprosy	Treatment	One Month	Two Months
		One Month	Two Months

6.4.2 Monitoring of treatment at the community

TB treatment is provided using a patient-centered treatment approach under direct observed therapy (DOT) either at the health facility or home preferably at the domicile of the patient. Both, a patient and his/her supporter should be educated on prevention measures for covid 19 when visiting each other and to the health facility for drug refill and clinical evaluation.

Recommendation for TB and Leprosy patient monitoring:

- The clinical evaluation schedule and follow-up of sputum investigation for TB patients at month 2 and 5 should follow and match with the timings of drug refills.
- Community health care workers are encouraged to limit household visits and wherever possible use their mobile phone to call or sending text messages more frequently when monitoring treatment of their respective patients or households they are supporting.[19]
- Strengthen lost to follow up tracing for TB and COVID-19. CHWs must educate all lost to follow up patients on the importance of adhering to treatment and corresponding disadvantages of missing treatment

6.4.3 TB and Leprosy commodities

Essential TB and Leprosy commodities should be readily available during the surge of the pandemic or other emerging situations. Suggested innovations:

- Use of volunteers and community health workers for home delivery of medicines.

[19] Sensitize patients to be registered in the TAMBUA TB bulky messaging system

- Allow flexibility to issue additional stock of medicines to ensure uninterrupted supply of drugs to people with TB and leprosy.

6.5 Infection Prevention Control

General Precaution Measures for COVID-19 Infection are shown in Figure 7.These measures have to be adhered to at all times as CHW interact with clients and among themselves.

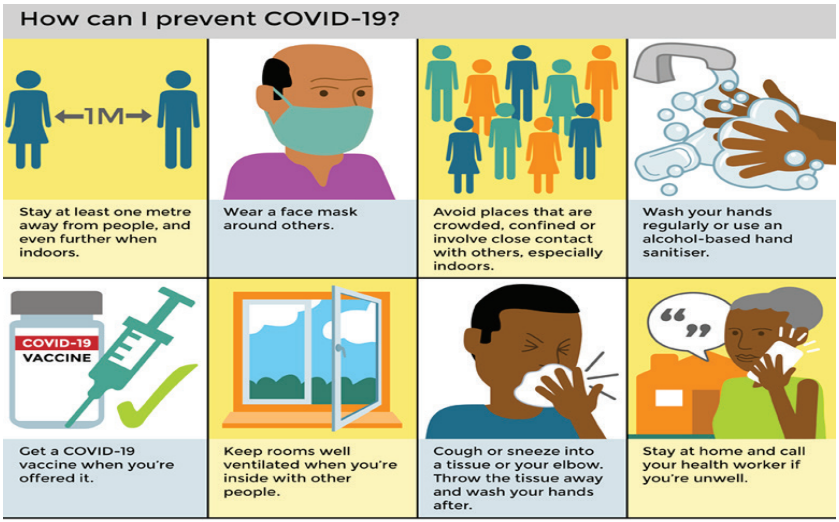

Figure 7. General preventive measures of COVID-19.

In addition, the following measure are useful:

- Avoid unnecessary journey especially to areas with high risks but if the journey is unavoidable follow precaution measures.
- Notify the presence of COVID-19 suspect to nearby health facility.
- Attend early to nearby health facility after seeing signs of the disease or call free No. 199 or dial *199# for father assistance.

Standard Precautions Recommended Measures For COVID-19 Presumptive

Standard Precautions recommended measures for suspects include the following

Figure 8. Precautionary measures recommended for COVID-19 presumptive

6.6 Vaccination Programs for COVID-19

6.6.1 Ministry of Health Guide on Vaccination

Tanzania developed a National Guideline for COVID-19 vaccination in 2021 as part of the strategy to control the epidemic and ensure the wellbeing of the community. The aim of the government is to protect all its people against COVID-19 by providing all the available effective and scientifically preventive measures against COVID-19, including provision of Quality, safe and efficacious vaccines.

The government is aiming at vaccinating at least 60% of its population targeting front-line health care workers, people older than 50 and those with underlying medical conditions including Tuberculosis patients who are more likely to suffer a severe form of COVID-19 and are associated with increased morbidity and mortality. Every person has a role to reach this

target including the CHWs. Based on their roles, CHWs need to understand the advantages of being vaccinated against COVID-19 and follow all the COVID-19 infection prevention protocols when attending TB patients, TB Contacts and the community.

COVID-19 vaccines are available in all government and private health care facilities and are being provided free of charge.

6.6.2 Implementation Phase of vaccination program in Tanzania

What are COVID – 19 vaccines?

COVID-19 vaccines are biological products that have been developed to provide acquired immunity against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease 2019 (COVID-19).

Types of COVID-19 Vaccines

While there are several COVID-19 vaccines under development and use, the country will only use COVID-19 vaccines that have been approved and registered by Tanzania Medicines and Medical Devices Authority (TMDA) as highlighted in the table below.

Table 7. Type of CVOVID-19 vaccines, route of administration and number of doses

	Inactivated	Protein Subunit	Adenovirus	mRNA
Vacinne	Sinopharm Sinovac	Novavax	Janssen AstraZeneca Sputnik V	Pfizer-BioNTech Moderna
Route of Administration	Intramuscular (Deltoid muscle; upper left arm	Intramuscular (Deltoid muscle; upper left arm	Intramuscular (Deltoid muscle; upper left arm	Intramuscular (Deltoid muscle; upper left arm
Number of Doses	Sinopharm 2 doses, 21 to 28 days apart Sinovac: 2 doses, 28 days apart	Novavax 2 doses, 21 days apart	Janssen 1 dose AstraZeneca 2 doses, 28 days apart Sputnik V: 2 doses, 21 days apart	Prizer-BioNTech 2 doses, 21 days apart Moderna: 2 doses, 28 days apart)

Benefits of getting vaccinated

The COVID-19 vaccines produce protection against the disease, as a result of developing an immune response to the SARS-Cov-2 virus. This immunity helps to fight the virus if exposed to.

- COVID-19 vaccination provides strong protection against serious illness, hospitalization and death
- Getting vaccinated against COVID-19, can reduce the risk of getting infected and spreading the virus that causes COVID-19 to others.

Even after receiving COVID-19 protection, people are should adhere to all the COVID-19 infection prevention control protocols.

6.6.3 CHWs roles in the COVID-19 vaccination program

Table 8. The proposed roles of CHW in COVID-19 vaccination programs

SN	Planning and Coordination	Identification of target populations	Vaccine acceptance and uptake	Vaccination rollout tracking and follow-up
1	Participate in planning vaccination activities at their work place	Conduct a community census and draw a map of the work area including target groups withing the community to be vaccinated	Follow up on rumors that are being circulated or heard in a community at risk of an outbreak or an outbreak and provide clarification or submission to the relevant authorities	Participate in national campaigns and Village rallies and hold rallies
2	Provide community health education to raise public awareness about epidemics or various health emergencies, to take precautions and identify safe preventive measures	Carrying out surveillance of suspects or people close to the patient or victim of a serious illness as per the guidelines.	Work towards building trust, removing myth and/or encouragement to facilitate effective community entry and acceptance among target communities (i.e. demand generation).	Mobilize target populations and accompany them to immunization sites.

3	Provide information, health education and counselling to TB patients, contacts of TB patients, individuals, households, social groups and the community at large using communication techniques and bring about positive behavioral changes in the community.	Link people willing to be vaccinated to the health facility for vaccination	Mobilize community influencers such as religious and local leaders, traditional healers, teachers, youth groups, women and men's groups, and community-based organizations, in reaching out to the public, to create an enabling environment for COVID-19 vaccination acceptance and uptake	During vaccine outreach, identify locations that are likely to reach target populations.
4	Contribute their knowledge and experience on vaccine rollout activities in the community through CHWs representation in regional and subregional (CBHS Coordinator)	Register households and individuals mobilized on the Covid-19 vaccine to ensure accurate forecasting of vaccines needed	Engage communities in continuous dialogue to promote COVID-19 vaccination, build community trust and provide information about public health and social measures such as the use of masks, sanitizers, hand washing, and physical distancing	Help with vaccination status verification and scheduling.
5	Work with CSOs and Implementing partners to monitor and evaluate community-level health activities in their workplaces			Trace lost to follow-up (those that have not completed the required doses) and facilitate the return to complete vaccine

6	Avoid spreading misleading information that could lead to panic among community members			Refer all clients for Covid-19 vaccination to health services or other social services

Facts to be considered for the ICE materials

- refer to the accelerated plan of COVID-19 vaccinations to align the messaging with treatment and other vaccinations programs
- When to vaccinates: before, during and after treatment of TB and Leprosy
- Myths about vaccines should be included – briefly

6.7 Awareness and Social Mobilization

Health Education – Potential Intervention.

Empower community members of TB, Leprosy and COVID19 information through social mobilization.

Awareness materials for TB, Leprosy and COVID19

Aim is to increase uptake of COVID-19 vaccination, case identification and stigma reduction, through the following intervention:

- Conduct door to door visits including high risk groups [20]
- Participate in community gatherings and specific events at village and ward levels
- Distribution of IEC materials to community members
- Provide testimonies sharing experiences on TB, leprosy and COVID19 disease and vaccination
- .Conduct health talks at health facilities and community level
- Using existing groups in communities such as cultural troops, choirs, drama groups to convey messages on TB, Leprosy and COVID-19

Social mobilization

a. Identify and engage leaders and influential people to promote key TB, Leprosy and COVID-19 messages

[20]schools, learning institutions, orphanage centers, prisons, mining sites, mining communities, markets, sports sites, transport facilities, bus stands, refugee camps, army barracks, night clubs, celebrity communities and sites; and any other relevant gatherings

b. Reach vulnerable/key population groups and communities in need of TB, Leprosy and COVID-19 services
c. Facilitate /conduct community or club discussions and dialogues to raise awareness, obtain freed back from relevant communities, Collaborate with the stakeholders/CSO on feedback etc.
d. Collaborate, participate and mobilize communities towards uptake of TB, Leprosy and COVID-19 services (prevention and care).
e. Participate with government and partners in media engagement in services of TB, Leprosy and COVID-19.
f. Empower current and former TB, Leprosy and COVID-19 patients to deliver positive messages to the public about prevention, diagnosis, treatment and impact mitigation
g. Promote community based ACF targeting high risk groups

CHAPTER 7
MONITORING AND EVALUATION OF COMMUNITY TB AND LEPROSY

Monitoring and Evaluation (M&E) are processes involved in examining various program components to track and assess program progress and value. The purpose of M&E is to track implementation and outputs systematically and measure the effectiveness of programmes. It helps determine exactly when a programme is on track and when changes may be needed. M&E form a base for modification of interventions and assessing the quality of activities being conducted. It is essential in helping managers, planners, implementers, policy makers and donors acquire the information and understanding the need to make informed decisions about programme operations. It helps to identify the most valuable and efficient use of resources. M&E provides necessary data to guide strategic planning design implement programmes and projects allocate and re-allocate resources in better ways.

7.1 Monitoring & Evaluation processes

7.1.1 Data collection

Data collection is the process of gathering and measuring information on targeted variables in an established systematic fashion, which then enables one to answer relevant questions and evaluate outcomes. Data collection on community TB and Leprosy activities is done by CHWs under supervision of DTLC, TB/HIV Officer and Health facility in-charge using standardized community TB data collection tools developed by the MoH.
These standardised TB data collection tools[21] include:

- Fomu ya uchunguzi wa awali wa TB na Ukoma katika Jamii (T B / LEP12)
- Rejesta ya wanaohisiwa kuwa na TB na ukoma katika jamii (TB/LEP 13A)
- Rejesta ya ufuatiliaji wa wagonjwa wa TB na ukoma waliokatiza/hawakuanza matibabu (TB/LEP 13B)
- Fomu ya taarifa ya mwezi ya huduma za TB na ukoma ya watoa huduma ngazi ya jamii (TB/LEP 14)
- Fomu ya rufaa kwenda kliniki ya kifua kikuu na ukoma (TB/LEP 15)

[21] NTLP Manual, 2020

- Dodoso la uibuaji wa changamoto za jinsia na haki za binadamu zinazohusiana na huduma za kifua kikuu na ukoma
- Logbook ya kusafirisha sampuli za kifua kikuu (TB)
- Fomu ya orodha ya wasafirishaji wa sampuli za kifua kikuu (TB)
- Logbook ya ukusanyaji na usafirishaji wa sampuli za kifua kikuu (TB)
- Logbook ya kituo ya usimamizi wa usafirishaji wa sampuli za kifua kikuu (TB)

7.1.2 Data reporting

At monthly/quarterly basis, CHWs shall tally data from the registers and enter this information into the standard Fomu ya taarifa ya mwezi ya huduma za TB na ukoma ya watoa huduma ngazi ya jamii (TB/LEP 14)

7.1.2.1 TB/LEP 14 Form

This form should be filled by a TB survivor group leader or CHW leader. It is used to provide a summary report based on indicators during the reporting month and should be submitted to health facilities in-charge in which the group or CHW is affiliated. The reports will be verified at HFs through comparison, between TB unit register, community presumptive TB registers, Community Presumptive Leprosy Form and lost to follow up registers. After verification, the HF shall compile the reports (using the same form) for the catchment area and submit to the district level. The DTLC will use the same form to compiled community TB, TB/HIV and DR-TB report for the district. The information will auto be generated by the system to fill (TB 07) "Quarterly case notification report for TB and TB/HIV".

7.1.2.2 Community TB and Leprosy services reporting mechanism

The report should follow the following channel:

- The reports from the communities shall be sent to the health facility of the catchment area by the 7th day of the following month.
- The reports from HFs shall be sent to the DTLC by the 14th day of the following month.
- The DTLC/TBHIV Officer will collect and compile the reports from all HFs, aggregate them and send the district report to regional and national levels and share with stakeholders. The DTLC should verify the reports from facilities by correlating the data in the unit registers.

Implementers at all levels should retain copies of their reports for purpose of future utilization and planning. Information feedback shall be as follows: -

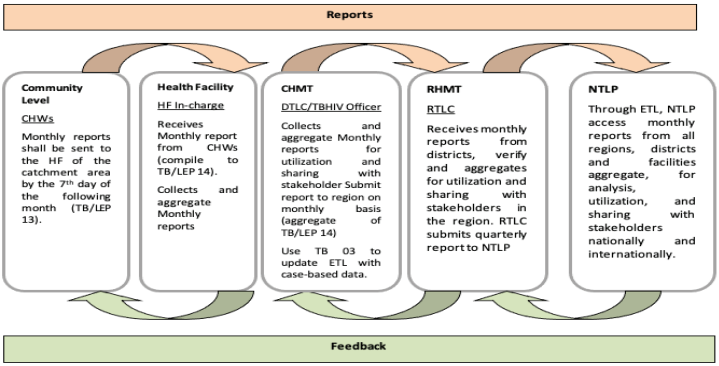

Figure 9. Information flow framework between community and health system[22]

7.1.3 Data analysis, interpretation and use

The community data generated at different levels should be analyzed and used to make an informed decision and strategic planning of TB and Leprosy services in respective levels. Data summary reports and feedback shall be shared with all levels including the implementing stakeholders:

- CHWs shall share these reports with
  - Health facility in charge in their catchment areas
  - Village government
  - Other group members
- Health facility in charge shall share these reports with
  - CSOs in their catchment area
  - TB survivors' groups, Prevention of Disabilities (POD) committee or any other CHWs
  - Village authority
  - Other key stakeholders in the catchment area
- DMO shall share these reports with
  - All health facilities in their District
  - Local Government Authority
  - Other key stakeholders in the district

[22]Community TB Care Handbook for CHWs (NTLP, 2013)

- RMO shall share their reports with
  - All Districts within their Region
  - Other key stakeholders in the region
- NTLP Programme Manager shall share reports with
  - Regional Medical Officers
  - Other Ministries
  - Implementing and development Partners
  - Other key National and International stakeholders.

MoH encourages documentation and publication of M&E data, best practices, and lessons learnt. Any publications or presentations based on community TB and Leprosy data must be submitted to NTLP at all levels for clearance before submission. This includes abstracts for national and international conferences.

7.1.4 Data Storage

All community TB and Leprosy data collected is confidential, and shall be treated with the same level of protection as all other medical records. Every effort shall be made to ensure that records cannot be accessed by persons other than those who are authorized to do so. Data shall be stored in a highly secured manner for example in a lockable file cabinet, on a password-protected, secure computer, mobile phones or in other secure locations.

7.2 Supportive Supervision and mentorship

The MoH supportive supervision guidelines describe supportive supervision as a "process which promotes quality outcomes by strengthening communication, identifying and solving problems, facilitating teamwork, providing leadership support to empower health care providers to monitor and improve their own performance".

Mentorship is described as a process conducted by a person (the mentor(s)) or team to another person or groups (the mentee(s)) in order to help that other person or group to perform their work more effectively.
The purpose of supervision and mentorship in community TB and leprosy services

The purpose of supervision at community level is to:

- Provide leadership and guidance to community TB and leprosy care providers through mentorship
- Monitor implementation of planned activities against defined programme goals and targets
- Monitor that all necessary tasks are properly performed.
- Ensure that training and resources including finance and supplies are properly used and are available to community TB and leprosy care providers to carry out their duties
- Ensure accountability and responsibility
- Ensure adherence to the set standards of community TB and leprosy care and control.
- Identify/address barriers to service delivery to improve community TB and Leprosy services on a daily basis.

Levels	Description
Supervision of the region by national level	The national level should supervise community TB and Leprosy activities in the regions at least once per year. Regions with specific challenges should be visited more frequently. The supervision should be jointly done with implementing partners of the respective region.
Supervision of the district by the regional level	The regional level should supervise community TB and Leprosy activities in the districts at least twice per year. Districts with specific challenges should be visited more frequently. The supervision should be jointly done with implementing partners of the respective districts. The district team should accompany the regional team to health facilities
Supervision of health facilities by district level	The district level should supervise community TB and Leprosy activities in each diagnostic centre at least once per month and each DOT centre once per quarter. Health facilities with specific challenges should be visited more frequently. The supervision should be jointly done with implementing partners of the respective district.
Supervision of community healthcare providers by health facilities:	The HF should supervise community TB and Leprosy activities in the community at least once per quarter. CHWs/community groups with specific challenges should be visited more frequently. The supervision may be supported by the implementing partners of the respective community.

Community Based TB and Leprosy Supervision tools

The community TB and Leprosy supervision checklist will be used by na-

tional, regional, district and health facility teams to supervise community-based TB and Leprosy services *(see Annex 9)*

7.3 Indicators for community-based TB and Leprosy control performance

In order to measure performance of community TB and Leprosy control interventions, the following indicators have been selected to monitor and evaluate the program (see Table 9 and Table 10).

Table 9. Community and facility level TB and Leprosy activities Indicators

Main Community Intervention	Indicator	Source tool
To provide education and screening of TB in the community	Number of campaigns conducted	Monthly narrative report
	Total Number of people who were screened for TB	TB/Lep 14
	Number of people who were presumed with TB from the community	TB/Lep 14
	Number of Presumed TB people who were referred for investigations	TB/Lep 14
	Number of Presumed TB people who were diagnosed with TB	TB/Lep 14
	Number of TB index cases whom contacts have been investigated for TB	TB/Lep 14

To provide education and Screening of Leprosy in the community	Number of campaigns conducted	Monthly narrative report
	Number of Leprosy index cases whom contacts have been investigated for TB	TB/Lep 14
	Number of Leprosy patients missed appointments and lost to follow up traced back to treatment	TB/Lep 14
	Number of people who were screened for Leprosy	TB/Lep 14
	Number of people who were presumed with Leprosy from the community	TB/Lep 14
	Number of Presumed Leprosy people who were diagnosed with Leprosy	TB/Lep 14
To provide transportation for TB sample referrals	Number of sample results received after being transported to diagnostic facility	Community Transportation log book
To provide support for TB patients during treatment	Number of TB patients missed appointments and lost to follow up traced back to treatment	TB/Lep 14
To provide support for Leprosy patients during treatment	Number of Leprosy patients missed appointments and lost to follow up traced back to treatment	TB/Lep 14

To involve informal health service, providers in TB screening: (ADDO, Traditional Healers, Drug users peer)	Number of presumptive TB people from other health providers in the community ADDO Traditional healers Peers-IVD	TB/Lep 14
To implement and monitor CRG	Number of challenges reported which received feedback	TB /Lep 14
	Number of TB clients who report stigma in HF that inhibited them from seeking and accessing TB/ Leprosy services disaggregated by gender (female, male)	TB /Lep 14
	Number of TB patients/clients who have stopped taking TB treatment because of either of too severe drug side effects/couldn't access information/couldn't access services/Did not receive enough counselling/lack of nutritional support	TB /Lep 14

Table 10. District, Region and National level TB and Leprosy Community activities Indicators

Main Community Intervention	Indicator	Definition: Numerator	Denominator	Period	Source tool
To provide education and screening of TB in the community	Number of campaigns conducted	Number		Quarterly	Narrative report
	Proportion of TB index patients whose contacts have been investigated for TB	Number of TB index patients whose household contacts were investigated for TB	All TB patients registered in that period	Quarterly	TB 03
	Proportion of TB Notification as a contribution of community referral	All forms TB Notification by community referrals	All form TB Notification	Quarterly	TB 03

To provide education and Screening of Leprosy in the community	Number of campaigns conducted	Number		Quarterly	Narrative report
	Number of people who were screened for Leprosy	Number		Quarterly	TB/Lep 14
	Proportion of people who were presumed with Leprosy from the community	Total Number of people who were presumed with Leprosy from the community	Total number of people who were screened for Leprosy	Quarterly	TB/Lep 14
	Proportion of Presumed Leprosy people who were diagnosed with Leprosy	Total number of people who were diagnosed with Leprosy	Total number of people who were presumed to have leprosy	Quarterly	TB/Lep 14
	Proportion of Leprosy index patients whose contacts have been investigated for Leprosy	Number of Leprosy index patients whose household contacts were investigated for Leprosy	All Leprosy patients registered in that period	Quarterly	TB/Lep 14
To provide transportation for TB sample referrals	Proportion of sample results received after being transported to diagnostic facility	Total number of samples which were transported by CHW and whose results were received back	Total number of samples transported by community health care worker	Quarterly	TB/Lep14

To provide support for TB patients during treatment	Proportion of TB patients receiving Home DOT	Total number of patients receiving Home DOT	Total number of patients receiving DOT	Quarterly	TB 03
	lost to follow up rate	Total number of TB patient who were lost to follow (based on case definition) X100	Total number of TB notified patients	Quarterly	TB 03
To involve informal health service providers in TB screening: (ADDO, Traditional Healers, Drug users peer)	Proportion of presumptive TB people from other health providers in the community: ADDO Traditional healers Peers-IVD	Total number of presumptive TB people from providers in the community: ADDO Traditional healers Peers-IVD	Total number of presumptive TB from community	Quarterly	TB/Lep14
To implement CRG (including CLM)	Proportion of challenges whose feedback were sent to community	Total number of challenges reported which received feedback/response	Total number of challenges reported	Periodically (survey)	TB/Lep 14
	Proportion of TB clients who report stigma that inhibited them from seeking and accessing TB services disaggregated by gender (female, male)	Total number of TB clients who report stigma that inhibited them from seeking and accessing TB services disaggregated by gender (female, male)	Total number of TB notified patients	Periodically (survey)	TB/Lep14

	Number of TB patients/clients who have stopped taking TB treatment because of either of too severe drug side effects /couldn't access information /couldn't access services /Did not receive enough counselling/lack of nutritional support	Number of patients/clients who have stopped taking TB treatment because of either of too severe drug side effects/couldn't access information/couldn't access services/did not receive enough counselling/lack of nutritional support	Total number of TB notified patients	Periodically (survey)	TB/Lep14

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ANNEXES

1.1 Annex 1: Community TB activities which can be integrated into RCH programmes

TB prevention in RCH settings	
1. TB awareness-raising, infection control (including cough hygiene), stigma reduction, IEC and BCC	• Train CHWs/CHVs, community midwives, NGO/CSO staff, mother-to-mother peer supporters and community leaders on the importance of TB screening and early treatment for pregnant women. • Target households to increase awareness, especially those with a person who has pulmonary TB.
2. Provide IEC materials and job aids on TB prevention for use by CHWs, CHVs and midwives	• Develop and provide culturally appropriate materials for use at household and community levels and in RCH clinics. • NGOs/CBOs should take a lead on developing materials, supported by larger NGOs/CSOs and the NTLP. All materials should be tested or pilot tested with the target audience to ensure they are easy to understand and are culturally acceptable.
3. Engage in specific BCC campaigns and stigma reduction aimed at informing women and families and dispelling myths about TB and HIV	• Train grassroots NGOs/CSOs, and mother-to-mother peer supporters to take a lead on BCC and stigma reduction at local level in local languages. • Hold events such as street theatre in public settings where women and families gather, e.g. markets, places of worship, antenatal clinics, and mother and child support groups.
4. Improve vaccination coverage, including BCG for infants.	• Engage grassroots NGOs/CSOs and mother-to-mother peer supporters to work with CHWs and RCH community outreach and vaccination campaigns, and ensure that all children needing vaccination are identified and able to access it. • Use regular community health outreach visits and child health days to reach the largest numbers.

TB case detection, referral and surveillance in RCH settings	
1. Screen, identify and refer mothers, their partners and child contacts with presumptive TB to the health facility for TB and HIV diagnosis and management	
2. Provide education on the importance of TB testing and linking to HIV testing and counselling for all mothers and family members who may benefit from it	• Train CHWs and CHVs, NGOs/CSOs and mother-to-mother peer supporters to inform and support households and family groups (including male family members) and antenatal support groups on TB screening and HIV testing and counselling.
3. TB contact tracing, sputum collection, sputum transport	• Train CHWs, CHVs and community midwives on screening methods, TB contact tracing and sputum collection, safe storage and transport. • Ensure that under-fives and new-borns, who are vulnerable to TB, are identified during contact tracing as well as adults and older children. • Ensure that sputum collection and transport follow national policy and protocols; this will also depend on the availability of laboratory facilities.

4. Referrals to link health facilities for women and children with presumptive TB	• Ensure that systems are in place for referring patients from the point of contact in the community through to the health facility and re-referring them back to the community for ongoing adherence and other forms of support. • Ensure close linkages between community and health facilities, with agreed referral forms and recording systems. • Provide transport support (such as bus fares or lifts) where needed. • Provide accompaniment by peer supporters to assist mothers and young children in completing referral journeys and accessing TB care
TB treatment adherence support in RCH settings	
1. Home-based TB DOT and adherence counselling	• NGOs/CSOs and NTLP can work together to ensure that CHWs and CVs have the skills needed for these tasks. • In addition to DOT adherence support, include stigma reduction, home-based care and tracing of patients who are lost to follow-up; checking TB, HIV and antenatal appointment cards; and referring mothers on TB treatment for follow-up sputum smears.
Social and livelihood support in RCH settings	
1. Link pregnant women and mothers to local support mechanisms	• Ensure access, when needed, to cash transfers, insurance, nutrition, voluntary savings and loan schemes and income generation projects.
2. Involve others in the home to create a suitable home environment for TB and other treatment	• Ensure that psychological and physical support is available in the home and in peer support centres for mothers and children. • CHWs can link clients with local NGOs/CSOs for these activities.

TB Advocacy in RCH settings	
1. Advocacy on supplies of TB and HIV drugs and laboratory tests	• Monitor availability of essential supplies, drugs and tests, and advocate for consistent, good-quality supplies, equipment and human resources to be available at local facilities. • Advocacy can address medicine shortages and quality problems and local availability of equipment and tests, e.g. laboratory microscope, tests for TB and HIV screening (including for new-borns and infants). • In cases of emergency, local NGOs/CSOs and community health providers can advocate with national or international providers to provide supplies as a short-term solution, where resources are available. **Note**: CHWs, NGOs/CSOs and NTLP at all levels should work together to create effective coordination between RCH, TB and HIV services.
2. Advocacy on access to services	• Bringing services closer to where people live is a priority for ensuring early access to diagnosis and treatment, particularly for pregnant women and mothers with young children who find it difficult to travel. Advocacy may be needed to ensure that TB and HIV treatment and diagnostic services are available at a local health centre. • Local NGOs/CSOs, CHWs and Village/Ward/Facility health committees can act as advocates on behalf of mothers and children to ensure RCH, TB and HIV services.
3. Advocacy for policy changes	• Policy changes may be needed at community level and all levels of the NTLP, RCH services, laboratory and pharmacy services. For example, changing policy to allow CHWs to collect and transport sputum or permitting trained midwives to initiate treatment for pulmonary TB. Task shifting to allow CHWs to do more at the household level should be encouraged. • NGOs/CSOs should work together within the NCB and with the NTLP to address needs and provide guidance for the country.

4. Advocacy for research	• Research is an important part of TB activities, especially in community settings where it is not yet clear what approaches are the best for community-based TB activities. Operational research is a useful approach, allowing different types of evidence to be gathered and involving communities and NGOs/CSOs in asking and answering the research questions. • NGOs/CSOs, researchers and the NTLP should work in partnership to gather evidence of what works, for adoption by the NTLP and other departments.
TB stigma reduction in RCH settings	
1. Raise community awareness on stigma experienced by pregnant women, mothers and young children with TB.	• Address key issues of stigmatization affecting pregnant women and mothers, specifically blame, rejection by partner, marriage breakdown and loss of financial support. • Use public settings such as markets or community centres for stigma reduction events, such as street theatre, public testimonials, group discussions and participatory activities.
2. Sensitize, train and mentor community leaders and MNCH and CHWs on stigma reduction	• Train NGO/CSO staff, TB/HIV patients, community leaders, mother-to-mother peer supporters and women's groups, on stigma reduction for mothers and young children with TB.
3. Support CHWs to include stigma reduction during contact tracing	• Work with NTLP staff and CHW supervisors to train and support CHWs on stigma reduction among families of mothers and children with TB.

1.2 Annex 2: Community TB activities which can be integrated into HIV programmes

TB prevention in HIV care	
1. TB awareness-raising in HIV care settings	• Educate people on TB when they attend HIV care services, for example at community centres during outreach, mobile and stand-alone voluntary counselling and testing sites and sexually transmitted infection clinics. • Educate providers and people attending clinics on cough hygiene. • Promote the TB Patients' Charter and International Standards for TB Care as part of HIV prevention work. • Educate community HIV care and support providers on TB prevention and the importance of IPT. • Provide integrated training to CHWs and CVs on TB/HIV stigma and TB/HIV literacy.
2. Community TB/HIV awareness-raising and stigma reduction	• Use radio and TV, printed brochures and posters to provide IEC on TB/HIV, using peer educators and people recovering from TB, supported by NGO/CSO communications and programme teams. • Emphasize prevention through cough hygiene, and promote ventilation and exposure to sunlight as additional measures to reduce risk. • Emphasize that TB can be cured with effective TB treatment and that it is a different disease from HIV infection, which can be controlled with ART.
TB detection in HIV care	
1. TB screening	• Develop standardized tools and simple TB screening protocols based on international guidance to help identify people at highest risk. • Train CHWs, staff and volunteers at HIV voluntary counselling and testing sites, community centres and households to use the screening tools and refer people with TB symptoms for diagnosis.

2. Sputum collection and transport	• Utilize standardized tools and simple TB screening protocols for sputum collection in households, community centres and health posts. • Train CHWs, HIV outreach workers and carers to collect, store, label and transport sputum specimens to laboratories for examination.
TB contact tracing	• Train CHWs and CVs on contact tracing in households and other community settings. • Prioritize contacts of sputum positive patients, as they are most at risk, but also respect confidentiality to prevent the risk of stigma.
Referral between community HIV and TB services	
1. Link patients with clinics for TB diagnosis and care (clinical examination and treatment).	• Ensure that TB patients can connect with TB services. They may need active support and accompaniment to access services, including transport. • Develop referral linkages between TB services and community HIV services such as voluntary counselling and testing sites and community HIV centres, including back-referral to CHWs and peer supporters for ongoing support and follow-up.
2. Ensure that patients are able to get transport to TB services	• Engage peer supporters to provide support and accompaniment where needed. • Mobilize resources to pay fares or hire vehicle transport for those in need to travel from community HIV centres, voluntary counselling and testing or ART sites to TB centres.

3. Train providers on facilitating community referrals.	• Work with CHW supervisors, TB and HIV clinic staff and peer supporters to develop and use a two-way referral system, with referral and back-referral forms and recording systems that are linked with national reporting mechanisms. • Train peer supporters and other CVs on tracing TB and HIV clients who fail to keep appointments.
TB treatment adherence support in HIV settings	
1. Provide adherence counselling and support for TB treatment and IPT.	• Train ART adherence counsellors, CHWs, peer support groups, peer educators, carers and family members on TB treatment and IPT. • Send SMS text reminders and appointment reminders, and trace patients who miss appointments. Monitor progress and side-effects, re-referring clients when needed. • Address stigma reduction as an important factor affecting TB and HIV treatment adherence.
2. Home-based TB and HIV care and support including stigma reduction in family and community	• Engage family members, peer supporters, CSOs and CHWs to provide integrated TB and HIV treatment adherence support, including preventive treatment with isoniazid and cotrimoxazole and support for dealing with the effects of stigmatization. • Also consider providing TB and HIV adherence support at community centres or HIV drop-in centres as an alternative for those who do not want to disclose their status. • Reinforce messaging on the importance of treatment adherence during pre-ART counselling and after initiation in community outreach and in IEC materials.

Social and livelihood support for people affected by TB/HIV	
1. Nutrition support and supplementation	• Ensure that patients receiving treatment have access to adequate, balanced nutrition to support them in recovering from TB and opportunistic infections due to HIV infection, especially during the early stages of TB or HIV treatment. Note that this is a specific medical need apart from any longer-term food access issues
2. Income generation and vocational training	• If the organization is implementing income generation and vocational training etc. specifically include people with, affected by or at risk of HIV infection and TB.
TB advocacy in HIV settings	
1. Monitor availability of TB supplies, equipment and services and advocate for better access	• Engage CHWs, patient groups, community leaders, TB advocates and champions in monitoring activities. • Where available, use electronic messaging or cell phone reporting systems to communicate shortages to national level for rapid action and advocacy
2. Monitor policy barriers on access to TB and HIV services, especially for the most vulnerable groups.	• Train NGO leaders, TB and HIV advocates and champions on how to advocate, and measure its success using or adapting available tools. • Ensure advocacy at local and national levels, using mechanisms for partnership and collaboration, e.g. national networks such as the NCB for TB.
TB stigma reduction in HIV settings	
1. Raise public awareness on TB and HIV stigmatization.	• Train patient and peer support groups, TB champions and advocates in stigma reduction activities. • Use community theatre, public testimonials and disclosure by people living with TB and HIV, public community sensitization events in markets, sports events, places of entertainment.

2. Training and capacity-building	• Provide TB and HIV stigma reduction training for community leaders, CHW supervisors, peer support groups, teachers, religious leaders, health workers, NGO staff and people in authority, such as police. • Support disclosure and acceptance of people living with TB and HIV infection and taking treatment in affected communities and in workplaces, e.g. health facilities, schools.
3. Take action against discrimination.	• Support legal action for loss of work or property related to having TB or HIV infection, for example in law courts, employment tribunals, parliament or local councils. • Engage in public campaigns against specific forms of discrimination. • Train NGO/CSO leaders and coordinating bodies, networks of affected people and communities on how to act against discrimination and provide legal support to people affected by TB and HIV infection.

1.3 Annex 3: Community TB activities which can be integrated into PHC programmes

TB prevention in PHC settings	
1. Awareness-raising, infection control, stigma reduction, IEC, BCC, training of providers	• Conduct surveys related to TB. • Develop and distribute IEC materials on TB. • Train on counselling and effective communication with people who may have TB. • Develop TB radio messages and jingles. • Include TB in PHC for both children and adults. • Engage in family and community dialogue on TB during home visits. • Promote BCG vaccination.

TB detection in PHC settings	
1. Screening, contact tracing, sputum collection and transport, training providers	• TB screening of children under five during child health days and nutritional surveys, school health programmes and de-worming campaigns; • TB screening during outreach visits; • Training school health clinic staff on sputum collection and safe storage; and • Training providers at school and in the community on how to assess TB signs and symptoms and how to refer children for TB diagnosis and treatment.
Referral to TB services from PHC settings	
1. Linking people at risk of TB with clinics, including transport support and facilitation	• Link people who might have TB to a referral or infectious disease hospital. • Provide transport support to help patients complete referral journeys. • Support transport of sputum specimens to the nearest health facility.
TB treatment and adherence support in PHC settings	
1. Home-based DOT, counselling, adherence, home visits, pill counting, stigma reduction, training providers, home-based care and support	• Conduct home visits to support adherence (at least weekly). • Provide training on counselling and effective communication skills (family and community dialogue). • Monitor treatment adherence and adverse drug effects. • Re-refer patients who have difficulties due to side-effects of anti-TB drugs or poor adherence.
TB surveillance in PHC settings	
1. Record data at community level; maintain summary records and registers on referrals and transfers at health facility.	• Engage community members to form a community monitoring body. • Train CHWs to maintain record sheets and registers. • Train school clinics to keep registers.
2. Report on the contribution of communities to TB services	• Develop a mechanism for reporting to the NTP at district and national level.

Social security, food and nutrition security, livelihoods in PHC settings	
1. Provide social safety nets to support people affected by TB, especially during the recovery phase of treatment.	• Consider food and nutrition supplementation and conditional and/or non-conditional cash transfers. • Develop community insurance schemes, and train providers to support people's access to inclusive markets, voluntary savings and loans and income-generating activities. • Link organizations with limited capacity with other organizations offering social, nutrition and livelihood support.
TB advocacy in PHC settings	
1. Monitor the availability of supplies, equipment and services at health facilities, and report any gaps and weaknesses.	• Engage community and faith-based leaders to add their voices to improve TB services. • Train health providers on stigma and barriers to community use of services.
Social mobilization and TB stigma reduction in PHC settings	
1. Use community theatre/drama groups, patient/peer support groups, community champions, testimonials, sensitizing/ training facility and CHWs and leaders	• Design and conduct community "docudramas" on TB. • Identify and engage TB champions. • Host public testimonials by people who have been cured of TB. • Support peer-to-peer groups (e.g. school hygiene groups, women's or men's groups). • Train social mobilizers on TB.

1.4 Annex 4: Community TB activities which can be integrated into Agricultural programmes

TB prevention in agriculture programmes	
1. Engage farmers' groups members to promote TB prevention.	• Train members in TB awareness-raising among rural households (men, women and young people), including how to prevent/reduce the risk of TB and other diseases.
2. Improve community information on TB prevention through community sensitization and awareness-raising	• Use IEC materials, TB campaigns, school competitions, debates. • Increase capacity of community leaders through training on TB prevention. • Train lead farmers to be TB champions in rural communities. • Educate people on healthy living to reduce vulnerability to TB. • Link ultra-poor households with livelihood support schemes.
TB detection and referral in agriculture programmes	
1. Train group members to recognize TB symptoms and encourage community members with symptoms to be tested.	• Discuss TB signs and symptoms. • Establish an easy-to-use, reliable system for referral to CHWs or a clinic. Note: Issues of confidentiality and trust are particularly important in small communities and groups.
Social and livelihood support for people affected by TB in agricultural settings	
2. Integrate TB into training on life skills and confidence-building within agricultural learning	• Train ultra-poor caregiver and producer groups in TB screening, nutrition, production and use of nutritious foods and income generation to support affected families. • Develop/establish savings groups to support ultra-poor households and caregivers. • Establish livelihood support and cash transfer mechanisms for affected households. • Train selected community members on TB adherence support.

1.5 Annex 5: Community TB activities which can be integrated into Livelihood programmes

TB prevention in livelihoods development settings	
1. Use livelihoods development programme supervision mechanisms to raise awareness on: TB basics, including transmission and prevention, signs and symptoms, stigma reduction, importance of nutrition for protection from disease, personal hygiene and living conditions	
2. Include education on aspects of TB during visits to families by programme officers, who generally use a checklist to monitor livelihoods and life skill development; education on TB can be included in this checklist.	
3. Integrate marginalized ultra-poor groups into the wider local community	• Use an existing village committee or work with village leaders to set one up, to provide support to the target group and raise awareness about TB among the whole community. • Hold regular (monthly) village meetings called by the village committee to inform people about TB and other social issues; use media such as video shows to make a greater impact on the community. • The local manager of the livelihoods development programme can lead the task of forming the committee and facilitating the monthly meetings. • Organize and build the capacity of the committees so that they continue to address TB and other issues after the livelihoods development programme withdraws.

4. Address health in livelihoods programmes: Recruit and train CVs on prevention, detection and treatment of TB along with other health services	• Invite the health volunteers to village committee meetings to raise awareness on TB. • Health volunteers can organize community health forums to discuss TB along with other health issues.
TB detection in livelihoods development settings	
1. Train the programme officer on TB signs and symptoms so that she or he can identify people with TB symptoms during home or group visits	• The programme officer refers the person to a sputum collection point, or: • If a health volunteer is trained in sputum collection, the programme officer can ensure that she or he visits people with TB symptoms at home to collect sputum and send it to the laboratory for testing.
2. Link health volunteers in the livelihood programme to the local TB diagnostic facility.	
3. If there are no health volunteers, link the programme officer with the local TB programme (NTP) team to make sure that any presumptive cases of TB are tested and diagnosed.	
4. Mobilize village development committees to support sputum transport from remote areas (livelihood programme staff can facilitate the process).	
TB referrals in livelihoods development settings	
1. Livelihoods programme staff and programme health volunteers support referrals by identifying the nearest clinics, accompanying the patient and providing support for transport.	
2. Village development committees can also support referrals in the same ways.	

Treatment adherence support in livelihoods development settings	
1. Health volunteers associated with the livelihood programme can encourage patients to take their medicines regularly through DOT.	
2. If there are no health volunteers, the programme officer can support DOT during home visits, including counselling on treatment adherence and completion and the importance of adherence support by caregivers in the household.	
Social and livelihood support for people with TB	
1. Provide extra support to TB patients in livelihoods programmes, including:	• special stipends for income support during the TB treatment period, • special nutrition support to support recovery from TB and • Mobilizing additional care from village committees, e.g. child care support.
TB advocacy in livelihoods development settings	
1. Use livelihoods programme staff and events to educate people on TB and reduce social stigma around TB.	Use social communication strategies such as community theatre/drama at local level.
2. Provide feedback from the field to meetings within or outside the organization, aimed at strengthening the TB programmes. For example, highlight issues such as supplies, quality of services, realities about transport and the challenges related to the referral services, as relevant	
3. Contribute to policy dialogue with local and national government, on the basis of the programme's field observations.	

1.6 Annex 6: Community TB activities which can be integrated into education programmes

TB prevention in educational settings	
1. Early childhood development: "the earliest is the best":	• Engage school managers, teachers, young children and the national education service. • Implement TB activities in nurseries, early childhood development and pre-school centres. • Teach young children about hygiene and sanitation, such as cough hygiene, body and hand washing, drinking clean water and being in fresh air and sunshine. • Provide TB life skills education through play-based activities such as dramatic play, art, social games, songs and telling stories. • Develop a simple TB curriculum if not already available, and train preschool teachers to implement it
2. Primary school	• Engage teachers, children and academic authorities. • Implement TB activities in primary schools, villages and other places where children of this age group gather. • Continue training on TB life skills with more detailed focus on identifying signs of TB and what one should do if signs persist. Include basic information about HIV and other infections and drug abuse: - Include TB in the basic science curriculum. - Train children using the child-to-child approach so that they can train each other on TB awareness and prevention. - Train teachers on the child-to-child approach, BCC and active methods in order to facilitate implementation of TB activities. - Include TB in school activities, e.g. competitions, social games, trips of discovery. - Emphasize TB messages with materials such as booklets, flyers, T-shirts, pens and posters to help children and adults remember key information.

3. Secondary school	• Focus in more depth on scientific explanations of TB and its links with HIV infection, building on the TB learning in primary school. • Include information on prevention of HIV, sexually transmitted infections, drug abuse and tobacco use. • Engage teachers, adolescents and young people in implementing TB screening activities in junior schools and high schools.
4. Non-formal education	• Engage community facilitators, NTP and NGO staff and supervisors to work on community TB education. • Train adult men and women on TB prevention through behaviour change, including cough/ sneezing hygiene and safe disposal of sputum. • Include TB in literacy activities, focusing on how to prevent TB.
Detection	
Train teachers in TB screening of their pupils and fellow teachers	
Include TB prevention in adult literacy curricula.	
. Train literacy group members to screen fellow students for TB based on their growing knowledge and awareness.	
Referral	
Teachers and adult literacy class facilitators should refer those with TB signs and symptoms to CHWs or directly to health facilities, depending on their age.	

Treatment adherence support	
1. Teachers can support children taking TB medication to ensure adherence.	
2. Use parent–teacher association meetings as a forum for discussing adherence and improving TB treatment literacy.	
Advocacy	
1. Engage parent–teacher associations to increase awareness of TB and advocate for TB messages to be included in school curricula by school boards and government education departments.	
Stigma	
1. Increase knowledge and discussion about TB at all levels of schooling. Increased awareness and understanding are powerful ways to reduce stigma	
2. Engage in specific anti-stigmatization activities using approaches such as the Understanding and challenging TB stigma toolkit (see resources list below).	

3. Educate teachers and parents to recognize the signs and to act if children are being stigmatized when they or members of their family are known or thought to have TB or HIV infection.	

1.7 Annex 7: Community TB activities which can be integrated into WASH programmes

Prevention	
1. Public awareness meetings and door-to-door hygiene and sanitation promotion	• Include TB messages as part of the overall promotion.
2. Develop IEC and BCC materials to link TB prevention with improved hygiene	• Promote ventilation, good cough hygiene and hand-washing with soap. • Use health surveillance assistants, CHWs and CVs to communicate messages.
Train health extension workers, CVs (WASH committees) and sanitation entrepreneurs (providing hardware, soap etc.) on TB basics, counselling and the linkages between TB, HIV infection and WASH.	
Teach the basics of TB and HIV infection to school sanitation clubs.	
Promote good hygiene practices in families and communities.	
TB detection	
1. Screen family members with TB symptoms during door-to-door/ household visits to promote sanitation and hygiene.	

2. Use the volunteer water and sanitation committees to identify and follow up cases within their membership and in the wider community, especially groups associated with WASH programmes.	
3. Deliver messages on TB and conduct screening for referrals during campaigns (for example, vaccination, water chlorination) or when dealing with emergency outbreaks such as cholera. This could be community wide or target certain groups e.g. schoolchildren.	
4. Invest in capacity and build skills for observation of symptoms and knowledge of health status of community members.	
Referral for TB services	
1. Use volunteer committees to refer people who may have TB to CHWs for screening and onward referral to health facilities for diagnosis and treatment.	
2. Establish partnerships/alliances, especially with clinics and laboratories, for follow-up, with diagnosis and treatment for those referred by CVs and workers.	
TB treatment adherence support	
1. Work to improve the sanitation facilities at TB treatment centres to encourage patients to attend (patients can sometimes discontinue treatment due to poor hygiene facilities at clinics).	

2. Support community WASH volunteers to provide home-based DOT support to community members or ensure DOT support by others.	
TB advocacy	
1. Community groups should advocate for the provision of adequate WASH services and infrastructure in health facilities	
2. Promote improved coughing and sneezing behaviour in the community.	

8.1 Annex 8: Community TB, TB/HIV and DR – TB Monitoring and Evaluation Tools

8.1.1 Community TB & Leprosy Screening Form

Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto
Mpango wa Taifa wa Kudhibiti Kifua Kikuu na Ukoma

TB/LEP 12

Fomu ya Uchunguzi wa awali wa TB na Ukoma katika Jamii

Jina la Mtoa huduma za afya ngazi ya jamii..... Jina la Kikundi/Asasi ..... Mwezi wa Kutolea Taarifa (mwezi/mwaka) ...../20.....

Jina la Kitongoji /Mtaa.....Kata..... Halmashauri.....

1	2	3	4	5	6	7	8	9			10							11				12	13	14	15
Na	**Tarehe**	**Jina la mteja (Majina matatu)**	**Jinsi (me/ke)**	**Umri (miaka)**	**Namba ya simu ya mteja na mtu wa karibu**	**Mahali Mteja Anapoishi (Kitongoji/Mtaa)**	**Uchunguzi wa TB au ukoma** *(Andika TB kama ni uchunguzi wa TB. Andika UK kama ni uchunguzi wa*	**Mahali mteja alipofanyiwa uchunguzi**			**Matokeo ya mahojiano kuhusu TB**							**Matokeo ya mahojiano kuhusu ukoma**				**Aina ya Rufaa:** **1. Sampuli** **2. Mteja** *(weka namba 1 au 2)*	**Jina la kituo cha kutolea huduma za afya rufaa ilikoenda**	**Amepima VVU (weka N kama jibu ni ndiyo, H kama jibu ni hapana)**	**Maoni/Maelezo ya Ziada**
								Familia yenye mgonjwa wa TB au ukoma *(Andika namba ya wilaya ya*	**Familia isiyo na mgonjwa wa TB au ukoma weka (-)**	**Mkusanyiko wa watu/sehemu nyingine** *(Weka namba kutoka*	***Dalili alizonazo (weka (√) panapohusika**							****Dalili alizonazo (weka (√) panapohusika**							
											KH	D	H	KJ	KJ	****Dalili za TB nje ya mapafu**	Hana dalili	B	NV	G	UV	Hana dalili				
1																									
2																									
3																									
4																									
5																									
6																									
7																									
8																									
9																									
10																									

* KH= **Kikohozi**. D= Makohozi yaliyochanganyika na **Damu**, H= **Homa**, KU= **Kupungua uzito**, KJ = Kutokwa **jasho jingi** kuliko kawaida hasa nyakati za usiku
****Dalili** za TB nje ya mapafu ni kama vile: kupumua kwa shida, maumivu ya kifua, uvimbe nk
***B= Baka au Mabaka yasiyo na hisia, NV= Ngozi kuota vinundu au kukakamaa, G= Ganzi mikononi/miguuni, UV= Kupata ulemavu au vidonda sugu

Kielelezo A:	
1. Duka la dawa	7. Shule/Vyuo
2. Mganga wa jadi	8. Sokoni
3.Machimbo/ migodi	9. Kambi za Wavuvi
4.Mikutano ya hadhara	10. Maskani
5. Magereza	11. Kwingineko (Taja)
6. Nyumba za Ibada	

8.1.3 Community TB Referral form

TB/LEP 15

WIZARA YA AFYA, MAENDELEO YA JAMII, JINSIA, WAZEE NA WATOTO
Mpango wa Taifa wa Kudhibiti Kifua Kikuu na Ukoma
(Huduma za Kifua Kikuu na Ukoma Ngazi ya Jamii)

FOMU YA RUFAA KWENDA KLINIKI YA KIFUA KIKUU NA UKOMA

1. Sehemu hii ijazwe na mtoa huduma za kifua kikuu na ukoma katika jamii

Jina la mteja aliyefanyiwa uchunguzi wa awali wa TB au ukoma (Majina matatu) …….. Umri (Miaka) …… Jinsi: Me Ke	Kitongoji/Mtaa …… Kata …… Halmashauri …….. Mkoa ……
Tarehe ya rufaa (Siku,Mwezi, Mwaka) ……/……/……	Namba ya simu ya mteja ……..
Sababu za rufaa Dalili za TB (Weka (√) panapohusika) [ ] Kikohozi zaidi ya wiki mbili [ ] Homa za mara kwa mara hasa nyakati za jioni [ ] Kupungua uzito [ ] Kutokwa na jasho jingi hasa nyakati za usiku [ ] Kukohoa makohozi yenye mchanganyiko na damu [ ] Dalili nyingine (taja) ..... Dalili za Ukoma: (Weka (√) panapohusika) [ ] Baka au Mabaka yasiyo na hisia [ ] Ngozi kuota vinundu au kukakamaa [ ] Ganzi mikononi/miguuni [ ] Kupata ulemavu au vidonda sugu	Taja changamoto ulizozipitia katika upatikanaji wa huduma za TB [ ] au ukoma [ ] Orodhesha mojamoja …… …… …… …… …… Zingatia: Uchunguzi na matibabu ya TB na ukoma hutolewa bila malipo. Kwa WAVIU ni kikohozi cha muda wowote.
Rufaa kutoka Jina la Kikundi …… Jina la mtoa rufaa (CHW) …… Namba ya simu ya CHW …….. Taasisi/ Shirika linalowezesha ……	Rufaa kwenda Huduma za kitabibu: Jina la Kituo: .....

2. Sehemu hii ijazwe na mtoa huduma wa kituo cha tiba kinachopokea mgonjwa.

Huduma iliyotolewa: (weka alama ya (√) panapohusika) [ ] Upimaji wa makohozi [ ] Upimaji wa VVU [ ] Uchunguzi wa Kitabibu (X-ray, Score Chart n.k) [ ] Uchunguzi wa ukoma [ ] Msaada wa suluhisho za changamoto alizopitia mteja katika huduma za TB na Ukoma. Taja hatua zilizochukuliwa …… …… …… ……	Matokeo ya huduma: (weka alama ya (√) panapohusika) [ ] TB, DR TB au ukoma haujagundulika [ ] TB kwenye makohozi [ ] TB sehemu nyingine [ ] DR TB-Kifua kikuu sugu [ ] Sampuli haina ubora [ ] Amegundulika na ukoma
Tarehe ya kupokelewa mgonjwa (Siku,Mwezi,Mwaka) ……/……/……	

ZINGATIA: Fomu hii itunzwe kliniki ya kifua kikuu na ukoma kwenye faili

8.11.3 Rejista wa wanaoisiwa kuwa na TB katika jamii

Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto
Mpango wa Taifa wa Kudhibiti Kifua Kikuu na Ukoma

TB/LEP 13 A

REJESTA YA WANAOHISIWA KUWA NA TB NA UKOMA KATIKA JAMII

Jina la Kituo .... Halmashauri................................ Mkoa................................

1	2	3	4	5	6	7	8	9	10	11	12	13								14	15	16	17	18
Na	Tarehe	Jina la Mteja (majina matatu)	Jinsi (Me/Ke)	Umri (Miaka)	Namba ya simu ya mteja na mtu wa karibu	Mahali Mteja Anapoishi (Kitongoji/Kijiji/Mtaa)	Uchunguzi wa TB au ukoma (Andika TB kama ni uchunguzi wa TB. Andika UK kama ni uchunguzi wa ukoma, Andika UV19 kama ni uchunguzi wa UVIKO 19))	Mahali mteja alipofanyiwa uchunguzi (Andika namba kutoka Kielelezo A)	Aina ya Rufaa: 1. Sampuli 2. Mteja 3. Chanjo UV19 (weka namba 1, 2 au 3)	Jina la kituo cha huduma za afya rufaa ilikoenda	Aina ya Kipimo GeneXpert, Hadubin, Trunati, X-ray, Score Chart, Nyinginezo	Matokeo ya rufaa (weka √ panapohusika)								Amepima VVU (weka N kama jibu ni ndiyo, H kama ni hapana)	Ameanza tiba ya TB/ DR TB au ukoma (weka √ kama ameanza na namba ya TB/DR-TB au ukoma kwa chini)	Matokeo ya matibabu kulingana na rejesta ya kituo cha tiba (TB03// DR TB au LEP03 Register)	Jina la Mtoa rufaa ngazi ya jamii	Maoni/ Maelezo mengine (Jina la Asasi na maelezo mengine)
												TB, DR TB au ukoma haujagundulika	TB kwenye makohozi	TB sehemu nyingine	DR-TB Kifua kikuu sugu	Sampuli haina ubora	Amegundulika na ukoma	Amepata chanjo ya UV19						
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
10																								

Kielelezo A:
1. Duka la dawa
2. Mganga wa jadi
3. Machimbo/ migodi
4. Mikutano ya hadhara
5. Magereza
6. Nyumba za Ibada
7. Shule/Vyuo
8. Sokoni
9. Kambi za Wavuvi
10. Maskani
11. Kwingineko (Taja)

8.11.4Rejista ya wagonjwa wa TB/ DR TB waliokatisha/ wasioanza matibabu

Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto
Mpango wa Taifa wa Kudhibiti Kifua Kikuu na Ukoma

TB/LEP 13 B

REJESTA YA UFUATILIAJI WA WAGONJWA WA TB NA UKOMA WALIOKATIZA/ HAWAKUANZA MATIBABU

Jina la Kituo..... Halmashauri ..... Mkoa.....

1	2	3	4	5	6	7		8			9			10	11	12	13
Na.	**Tarehe ya ufuatiliaji**	**Jina la mgonjwa (majina matatu),** *chini andika namba ya TB/DR-TB au ukoma yeweliyoya mgonjwa kama ameanza matibabu*	**Jinsi (Me/Ke)**	**Umri (Miaka)**	**Aina ya Mgonjwa wa TB au ukoma** *(Andika TB au UK)*	**Mgonjwa wa TB au ukoma anayefuatiliwa** *(Weka alama ya (√) panapohusika)*		**Mahali mgonjwa anapoishi**			**Matokeo ya ufuatiliaji** *(Weka alama ya (√) panapohusika)*			**Amerudi kwenye matibabu** (ndio au hapana)	**Sababu ya kutoanza matibabu** (Toa sababu)	**Jina la Mtoa huduma za afya ngazi ya jamii**	**Maoni/ Maelezo mengine** (Jina la Asasi na maelezo mengine)
						Hajaanza Matibabu ya TB au ukoma	Amesanza matibabu ya TB au ukoma	Mtaa/Kijiji	Jina la Mwenyekiti wa Mtaa/Kitongoji/Kijiji/Mtu maarufu	Namba yasimu ya mteja na mtu wa karibu	Amepatikana	Hajapatikana	Amefariki				
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	

8.11.5 Fomu ya Orodha ya Wasafirishaji wa Sampuli za Kifua Kikuu (TB)

Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto

Mpango wa Taifa wa Kudhibiti Kifua Kikuu na Ukoma

FOMU YA ORODHA YA WASAFIRISHAJI WA SAMPULI ZA KIFUA KIKUU (TB)

(Fomu itumike ngazi ya Kituo, Halmashauri na Mkoa)

HALMASHAURI ____ MKOA ______________________________________

Taarifa za msafirishaji wa sampuli

Na.	Jina la kituo cha upimaji	Jina la msafirishaji	Namba ya simu (*unaweza jaza zaidi ya namba moja*)	Namba ya usajili wa chombo cha usafiri	Kijiji/Mtaa	Kata	Jina la Mwenyekiti wa Kijiji/Mtaa	Namba ya simu ya Mwenyekiti wa Kijiji/Mtaa	Maelezo ya ziada

8.11.6 Rejesta ya Kusafirisha Sampuli

Cover Page

Mpango wa Taifa wa Kudhibiti Kifua Kikuu na Ukoma

FOMU YA ORODHA YA WASAFIRISHAJI WA SAMPULI ZA KIFUA KIKUU (TB)

(Fomu itumike ngazi ya Kituo, Halmashauri na Mkoa)

HALMASHAURI _____ MKOA _____

Inner Cover Page

Taarifa za msafirishaji wa sampuli									
Na.	Jina la kituo cha upimaji	Jina la msafirishaji	Namba ya simu (*unaweza jaza zaidi ya namba moja*)	Namba ya usajili wa chombo cha usafiri	Kijiji/Mtaa	Kata	Jina la Mwenyekiti wa Kijiji/Mtaa	Namba ya simu ya Mwenyekiti wa Kijiji/Mtaa	Maelezo ya ziada

Sample Transport Log

Usafirishaji wa sampuli na uchukuaji wa majibu katika vituo vya huduma za afya										
Na.	Tarehe	Aina	Jina la kituo kinachotoa	Idadi iliyotolewa	Sahihi ya mtoa huduma aliyetoa	Jina la kituo kinachopokea	Idadi iliyopokelewa	Sahihi ya mtoa huduma aliyepokea	Sahihi ya msafirishaji	Maoni/Maelezo
		Sampuli								
		Majibu								
		Sampuli								
		Majibu								
		Sampuli								
		Majibu								
		Sampuli								
		Majibu								
		Sampuli								
		Majibu								
		Sampuli								
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		Sampuli								
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		Sampuli								
		Majibu								
		Sampuli								
		Majibu								
		Sampuli								
		Majibu								
		Sampuli								
		Majibu								

8.11.7 Dodoso La Uibuaji Wa Changamoto Za Jinsia Na Haki Za Binadamu Zinazohusiana Na Huduma Za Kifua Kikuu Na Ukoma

Jamhuri ya Muungano wa Tanzania

Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto

Mpango wa Taifa wa Kudhibiti Kifua Kikuu na Ukoma

DODOSO LA UIBUAJI WA CHANGAMOTO ZA JINSIA NA HAKI ZA BINADAMU ZINAZOHUSIANA NA HUDUMA ZA KIFUA KIKUU NA UKOMA

1. Je, katika jamii yako mnayo mila au desturi yoyote inayokuzuia kupokea huduma za kifua kikuu/ukoma? Ndio Hapana
2. Dodosa kama mhisiwa/mgonjwa amepata changamoto katika huduma za kifua kikuu/ukoma kati ya hizi zifutazo:

A. Katika familia

i. Kupigwa na mwanafamilia
ii. Kufichiwa kadi ya matibabu
iii. Kuzuiwa na mwanafamilia kwenda kupata huduma za kifua kikuu
iv. Kunyimwa fursa ya kupata elimu kuhusu kifua kikuu na ukoma
v. Kutukanwa na mwanafamilia
vi. Kunyanyapaliwa
vii. Kuachika
viii. Kutengwa na wanafamilia
ix. Kunyimwa nauli ya kwenda kupata huduma
x. Kunyimwa unyumba

B. Katika kituo cha kutolea huduma za afya

i. Kutukanwa/Kufokewa
ii. Kunyimwa taarifa juu ya ugonjwa na matibabu
iii. Kutelekezwa au kucheleweshwa kupata huduma
iv Kudharauliwa
v. Kunyimwa dawa

C. Katika jamii

vi. Kunyanyapaliwa/kutengwa
vii. Kutukanwa
viii. Kufukuzwa kazi
ix. Kunyimwa kupata huduma za msingi za kijamii m.f kukatazwa kwenda kuchota maji, kutoshirikishwa au kufukuzwa kwenye vikundi vya kijamii

D. Changamoto nyinginezo taja

……
……
……
……

Changamoto zilizoainishwa katika kipengele A – D zijazwe katika fomu ya rufaa namba TB/LEP 15.

TB/LEP 15

WIZARA YA AFYA, MAENDELEO YA JAMII, JINSIA, WAZEE NA WATOTO

Mpango wa Taifa wa Kudhibiti Kifua Kikuu na Ukoma
(Huduma za Kifua Kikuu na Ukoma Ngazi ya Jamii)

FOMU YA RUFAA KWENDA KLINIKI YA KIFUA KIKUU NA UKOMA

1. Sehemu hii ijazwe na mtoa huduma za kifua kikuu na ukoma katika jamii

Jina la mteja aliyefanyiwa uchunguzi wa awali wa TB au ukoma (*Majina matatu*) **……..** **Umri (*Miaka*) ……. Jinsi: Me ☐ Ke ☐**	**Kitongoji/Mtaa ……** **Kata ……** **Halmashauri ……..** **Mkoa ……..**
Tarehe ya rufaa (*Siku,Mwezi, Mwaka*) ……../……../……	**Namba ya simu ya mteja** ……
Sababu za rufaa **Dalili za TB (*Weka (√) panapohusika)*** [ ] Kikohozi zaidi ya wiki mbili [ ] Homa za mara kwa mara hasa nyakati za jioni [ ] Kupungua uzito [ ] Kutokwa na jasho jingi hasa nyakati za usiku [ ] Kukohoa makohozi yenye mchanganyiko na damu [ ] Dalili nyingine (taja) …… **Dalili za Ukoma: *(Weka (√) panapohusika)*** [ ] Baka au Mabaka yasiyo na hisia [ ] Ngozi kuota vinundu au kukakamaa [ ] Ganzi mikononi/miguuni [ ] Kupata ulemavu au vidonda sugu **Kupata chanjo ya UVIKO 19**	**Taja changamoto ulizozipitia katika upatikanaji wa huduma za TB [ ] au ukoma [ ]** *Orodhesha mojamoja* …… …… …… …… …… **Zingatia**: Uchunguzi na matibabu ya TB na ukoma hutolewa bila malipo. Kwa WAVIU ni kikohozi cha muda wowote.
Rufaa kutoka **Jina la Kikundi ……** **Jina la mtoa rufaa (CHW) ……** **Namba ya simu ya CHW ……..** **Taasisi/ Shirika linalowezesha ……**	**Rufaa kwenda** **Huduma za kitabibu:** Jina la Kituo: ……

8.11.8 Rejesta ya Ukusanyaji na Usafirishaji wa Sampuli za Kifua Kikuu (TB)

Cover Page

Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto

Mpango wa Taifa wa Kudhibiti Kifua Kikuu na Ukoma

REJESTA YA UKUSANYAJI NA USAFIRISHAJI WA SAMPULI ZA KIFUA KIKUU (TB)

JINA LA KITUO _____

HALMASHAURI _____ MKOA _____

Inner Page

Usafirishaji wa sampuli a huduma za afya										
Na.	Tarehe	Jina la mteja	Jinsia	Umri	Sampuli inapotoka (*mfano: OPD, IPD, jamii nk*)	Idadi ya sampuli zilizosafirishwa	Jina la mtoa huduma aliyetoa	Jina la msafirishaji	Majibu ya matokeo ya upimaji wa sampuli	Maoni/Maelezo

8.11.9 Monthly/Quarterly community summary report form

Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto

Mpango wa Taifa wa kudhibiti Kifua kikuu na Ukoma

TB/LEP 14

FOMU YA TAARIFA YA MWEZI YA HUDUMA ZA TB/DR-TB NA UKOMA YA WATOA HUDUMA NGAZI YA JAMII

Jina la mtoa huduma ngazi ya jamii (CHW) _____ Jina la kituo cha huduma za afya anachotolea taarifa:_____

Jina la Kikundi _____

Jina la Kijiji_____Kata_____Halmashauri_____ Mkoa_____

Mwezi wa kutolea taarifa _____mwaka 20_____

Tarehe ya uwasilishwaji wa ripoti: ___/___/20_____

TB/DR-TB_____ Ukoma ____

Uchunguzi wa kifua kikuu na ukoma katika jamii

1	2		3		4		5		6					7		8		9	
	Idadi ya watu waliochunguzwa TB au ukoma (Rejea TB/LEP 12)		Idadi ya wahisiwa wa TB au ukoma (Rejea TB/LEP 12)		Idadi ya wahisiwa waliopewa rufaa ya upimaji wa TB au ukoma (Sampuli+Mtejai) Rejea TB/LEP 12		Idadi ya wahisiwa au sampuli waliopimwa/zilizopimwa a TB au ukoma (Rejea TB/LEP 13A)		Idadi ya waganjwa waliopimwa TB (Rejea TB/LEP 13A)					Idadi ya waganjwa waliopimwa ukoma (Rejea TB/LEP 13A)		Idadi ya waganjwa wa TB au ukoma walioanza matibabu		Idadi ya waganjwa wanaojua hali yao ya maambukizi ya VVU	
									GeneXpert	Trunati	Hadubini	Maamuzi ya Kitabibu		Hadubini	Maamuzi ya Kitabibu				
												X-ray	Score chart						
Umri (miaka)	KE	ME	KE	ME	KE	ME	KE	ME								KE	ME	KE	ME
0-14																			
15 na zaidi																			
JUMLA																			

Uchunguzi kwa wanaoishi na mgonjwa wa TB au ukoma

1	2		3		4		5		6		7		8		9		10	
	Idadi ya waganjwa TB /DR-TB au ukoma (Rejea regista ya TB 03/DR-TB/LEP 03)		Idadi ya watu wanaoishi na mgonjwa mwenye TB/DR-TB au ukoma waliofanyiwa uchunguzi		Idadi ya watu wanaoishi na mgonjwa mwenye TB/DR-TB au ukoma waliofanyiwa uchunguzi		Idadi ya watu waliochunguzwa na kuhisiwa kuwa wana TB au ukoma		Idadi ya watu waliohisiwa kuwa na TB au ukoma waliopewa rufaa		Idadi ya watu waliofanyiwa kipimo cha TB au ukoma kati ya wale waliopewa rufaa		Idadi ya waganjwa waliogundulika kutoka familia zenye waganjwa TB/DR-TB au ukoma wakati wa ufuatiliaji		Idadi ya waganjwa waliogundulika wa TB/DR-TB au ukoma na wanaoishi na mgonjwa wa TB au ukoma		Idadi ya watoto chini ya miaka mitano waliosichishwa dawa Kinga - TPT	
Umri (miaka)	KE	ME	KE	ME	KE	ME	KE	ME	KE	ME	KE	ME	KE	ME	KE	ME	KE	ME
0-5																		
5-14																		
15 na zaidi																		
JUMLA																		

Uchunguzi wa kifua kikuu na ukoma katika maeneo maalum

Eneo	Idadi ya watu waliochunguzwa TB au ukoma		Idadi ya wahisiwa wa kifua kikuu au ukoma		Idadi ya wahisiwa waliopewa rufaa ya upimaji wa TB (Sampuli + Mtejai) au ukoma		Idadi ya sampuli au wateja waliopimwa TB au ukoma		Idadi ya waganjwa waliogundulika kuwa na TB au ukoma		Idadi ya waganjwa wa TB au ukoma walioanza matibabu		Idadi ya waganjwa wanaojua hali yao ya maambukizi ya VVU	
	KE	ME	KE	ME	KE	ME	KE	ME	KE	ME	KE	ME	KE	ME
1. Duka la dawa														
2. Mganga wa jadi														
3.Machimbo/ migodi														
4.Mikutano ya hadhara														
5. Magereza														
6. Nyumba za Ibada														
7. Shule/Vyuo														
8. Sokoni														
9. Kambi za Wavuvi														
10. Maskani														
11. Kwingineko (Taja)														

Waliokatizaa/ hawakuanza matibabu ya TB au ukoma (TB/LEP 13B)

	Idadi ya waganjwa waliochelewakuanza matibabu matibabu waliofuatiliwa		Matokeo ya ufuatiliaji (Angalia Kielelezo A)	
Umri (miaka)	KE	ME	KE	ME
0 - 14			A=	A=
			H=	H=
			K=	K=
15 na zaidi			A=	A=
			H=	H=
			K=	K=
JUMLA			A=	A=
			H=	H=
			K=	K=

Waliokuwa na changamoto za huduma ya kifua kikuu na ukoma

	Idadi ya watu waliopata changamoto (Kifua Kikuu)		Idadi ya watu waliopata changamoto (Ukoma)	
Aina ya Changamoto	ME	KE	KE	ME
Katika familia				
Katika kitua cha kutolea huduma za afya				
Katika jamii				
Changamoto nyingineza				
Jumla				

Kielelezo A	
A	Amesanzakarudi kwenye
H	Hajapatikana
K	Amekufa

Jina la Mtoa taarifa.....

Sahihi.....

Namba ya simu.....

Jina la Mratibu aliyehakiki taarifa.....

Sahihi.....

Namba ya simu.....

219

9.1 Annex 9: Community TB, TB/HIV and DR TB) supervision tool

Wizara ya Afya

Mpango wa Taifa wa Kudhibiti Kifua kikuu na Ukoma
Fomu ya usimamizi elekezi wa huduma za kifua kikuu, kifua kikuu na UKIMWI na kifua kikuu sugu ngazi ya jamii

Jina la Mgonjwa: _____ Jinsi ya Mgonjwa _____
Umri_____
Namba ya matibabu ya mgonjwa wa kifua kikuu _____
Kituo cha Tiba: _____
Hali ya ndoa: _____
Jina la msimamizi wa matibabu: _____
Tarehe ya usimamizi shirikishi: ……../……../……..

Maelekezo:
Tafadhali jaza fomu hii kwa kumuhoji mgonjwa, familia na msimamizi wa matibabu nyumbani kwa mgonjwa.

- Tumia dodoso hili kila unapotembelea familia ya mgonjwa wakati wa usimamizi shirikishi.
- Elezea umuhimu wa dodoso kwa familia na mgonjwa na mhakikishie kuwa habari zote anazozitoa zitakuwa za usiri mkubwa sana
- Elezea kuwa mahojiano yatachukua si zaidi ya dakika thelethini.
- Omba ridhaa ya familia na mgonjwa kuendelea na mahojiano.
- Baada ya kumaliza kujaza dodoso, jadiana matokeo ya usimamizi shirikishi na mkubwa wako wa kazi.

Mambo yanayohusu mgonjwa			
	Majibu tarajiwa	**Ndiyo/ Hapana/ Sijui**	**Hatua ya kuchukuliwa**
1. Muulize mgonjwa kama anaona dalili za kiafya zisizo za kawaida tangu aanze matibabu			Kama sivyo muhakikishie mgonjwa usalama wa dawa.
Usiulize zaidi. Angalia kwenye sanduku kama mgonjwa anataja dalili za ugonjwa unaohusika	Ukurutu, kuwashwa kwa mwili.		
	Kichefuchefu/kutapika		
	Maumivu ya tumbo		
	Maumivu ya viuongo		
	Kupoteza hamu ya kula		
	Kuona hafifu		
	Kuwa na ganzi mikononi /miguuni		
2. Kuna mwanafamilia mwingine anayekohoa? Dodosa kwa muda gani?			Kama ni kikohozi cha zaidi ya wiki 2, mshauri aende kituo cha tiba kwa uchunguzi.
3. Dodosa mgonjwa kujua kama anatumia njia salama ya kukohoa?			Kama sivyo, onyesha njia salama ya kukohoa.
Kama ndio, anatumia njia gani?	Anafunika mdomo kwa kitambaa, kiganja, kiwiko, masiki n.k		

Mambo yanayohusu mgonjwa			
	Majibu tarajiwa	**Ndiyo/ Hapana/ Sijui**	**Hatua ya kuchukuliwa**
4. Dodosa mgonjwa kama anajua njia salama za kutupa (dispose) makohozi? Mf. kukohoa kwenye kopo?			Kama hajui, mueleze njia salama.
5. Dodosa mgonjwa kama anajua jinsi ya kuwakinga wanafamilia wasiambukizwe ugonjwa?	Kujumuika na wanafamilia eneo lenye mzunguko mzuri wa hewa (nje) Kuepuka msongamano		Kama hajui, muelezee njia sahihi za kuwakinga wanafamilia.
6. Dodosa mgonjwa kama amepimwa VVU?			Kama hajapimwa, mpe refaa kwenda kwenye ushauri nasaha. Kama amepimwa zaidi ya miezi 6 iliyopita na hana maabukizi, mshauri akapimwe tena.
7. Dodosa mgonjwa kuhusu uhusiano kati ya familia na yeye hasa suala la unyanyapaa			Eleza:
8. Dodosa mgonjwa kuhusu maoni ya msimamizi wake wa matibabu			Eleza:
9. Uliza kama mgonjwa ana swali lolote			Jibu kulingana na swali.

Mambo yanayohusu mgonjwa			
	Majibu tarajiwa	**Ndiyo/ Hapana/ Sijui**	**Hatua ya kuchukuliwa**
10. Je, mgonjwa ameieleza familia ugonjwa alionao?			Kama hapana, jadiliana nae umuhimu wa kueleza na madhara ya kutoeleza familia.

Mambo yanayohusu FAMILIA ya mgonjwa			
	Majibu tarajiwa	**Ndiyo/ Hapana/Sijui**	**Hatua ya kuchukuliwa**
11. Dodosa, wanafamilia wangapi wanaishi nyumba moja na mgonjwa?	Watoto wangapi wenye umri chini ya miaka 5? ___		
	Wazee (>miaka 60) _____		
	WAVIU_____		
12. Dodosa muda muafaka wa mgonjwa kumeza dawa?			Kama hamezi muda muafaka, toa maelezo na elimu
13. Kama mgojwa alishawafahamisha familia ugonjwa alio nao: Dodosa wanafamilia kuhusu ufahamu wa ugonjwa anaoumwa ndugu yao? (jina la ugonjwa, jinsi unavyoenea, matumizi ya dawa, muda wa matibabu, jinsi ya kujikinga, chakula, usafi, maisha kwa ujumla).			Elimisha familia kulingana na majibu yao.

Mambo yanayohusu FAMILIA ya mgonjwa			
	Majibu tarajiwa	**Ndiyo/ Hapana/Sijui**	**Hatua ya kuchukuliwa**
14. Dodosa kama kuna mwanafamilia mwingine mwenye dalili za kifua kikuu? Dodosa kwa muda gani?			Kama kuna mwenye dalili mshauri aende kituo cha tiba kwa uchunguzi.
15. Wanafamilia wangapi wamechunguzwa kifua kikuu?			Taja idadi dhidi ya jumla ya wanafamilia.
16. Dodosa familia kuhusu ufahamu wa jinsi ya kuwakinga wanafamilia wasiambukizwe ugonjwa?	Kama ndio, dodosa njia (Anafunika mdomo kwa kitambaa, kiganja, kiwiko, masiki. Kujumuika na mgonjwa eneo lenye mzunguko mzuri wa hewa (nje)		Kama sivyo, Toa elimu.
17. Dodosa kama familia inajua njia salama za kutupa (dispose) makohozi? Mf. kukohoa kwenye kopo?			Kama hawajui, waeleze njia salama.
18. Chunguza uhusiano kati ya familia na mgonjwa hasa suala la unyanyapaa			Kama mgojwa ananyanyapaliwa to elimu
19. Uliza kama wanafamilia wana swali lolote			Jibu kulingana na swali.

Mambo yanayohusu msimamizi wa matibabu			
	Majibu tarajiwa	**Ndiyo/ Hapana/ Sijui**	**Hatua ya kuchukuliwa**
20. Mgonjwa anameza dawa inavyotakiwa?	Kama ndio dodosa umezaji, utunzaji wa dawa n.k		Kama hapana, toa maelezo:
21. Dodosa yafuatayo kuhusu uelewa na utendaji wa msimamizi wa matibabu	Aina ya matibabu ya mgonjwa na dozi yake		Kama kuna mapungufu, elimisha
	Madhara yanayoweza kuambatana na dawa		
	Jinsi ya kugundua madhara ya dawa na hatua za kuchukua		
	Ujazaji wa kadi ya matibabu		
	Utunzanji wa dawa		
	Uchunguzi wa kifua kikuu kwa wanafamilia ndani ya wiki mbili baada ya kugundulika mgonjwa.		
	Upimaji wa makohozi kwa wakati		
22. Uliza kama msimamizi wa matibabu ana swali au maoni			Jibu kulingana na swali.

Mambo yanayohusu Mtoa huduma za kifua kikuu ngazi ya jamii/ mwanakikundi katika jamii.			
	Majibu tarajiwa	**Ndiyo/ Hapana/ Sijui**	**Hatua ya kuchukuliwa**
Taarifa za vikundi			
23. Idadi ya wana kikundi. wangapi wako hai?			
24. Idadi ya vikundi vya kijamii vinavyojihusisha na udhibiti wa kifua kikuu			

Mambo yanayohusu Mtoa huduma za kifua kikuu ngazi ya jamii/ mwanakikundi katika jamii.			
	Majibu tarajiwa	**Ndiyo/ Hapana/ Sijui**	**Hatua ya kuchukuliwa**
Uelewa wa vikundi/ mhudumu wa afya jamii			
25. Pima uelewa wa wanakikundi kwa kuwauliza maswali juu ya TB, TB/HIV na DR TB ikiwa ni pamoja uzuiaji wa maambukizi ya kifua kikuu katika jamii.			
Usimamizi shirikishi			
26. Toa na kujadili mrejesho wa usimamizi shirikishi uliopita			
27. Uwepo /upatikanaji wa vitendea kazi(orodhesha)			
28. Majukumu yaliyotekelezwa katika kipindi cha robo mwaka uliopita			
29. Uwezeshaji uliotolewa kwa kikundi/ mhudumu (vifaa, mafunzo, pesa, kutia moyo n.k)			

Mambo yanayohusu Mtoa huduma za kifua kikuu ngazi ya jamii/ mwanakikundi katika jamii.			
	Majibu tarajiwa	**Ndiyo/ Hapana/ Sijui**	**Hatua ya kuchukuliwa**
30. Dodosa yafuatayo kuhusu uelewa na utendaji wa msimamizi wa matibabu	Aina ya matibabu ya mgonjwa na dozi yake		Kama kuna mapungufu, elimisha
	Madhara yanayoweza kuambatana na dawa		
	Jinsi ya kugundua madhara ya dawa na hatua za kuchukua		
	Ujazaji wa kadi ya matibabu		
	Utunzanji wa dawa		
	Uchunguzi wa kifua kikuu kwa wanafamilia ndani ya wiki mbili baada ya kugundulika mgonjwa.		
	Upimaji wa makohozi kwa wakati		

Mambo yanayohusu Mtoa huduma za kifua kikuu ngazi ya jamii/ mwanakikundi katika jamii.			
	Majibu tarajiwa	**Ndiyo/ Hapana/ Sijui**	**Hatua ya kuchukuliwa**
31. Idadi ya watu waliohisiwa kuwa na TB kupitia jamii husika			Jadili changamoto za utunzaji wa kumbukumbu na maazimio/ mkakati wa kukabiliana na changamoto.
(a) Idadi ya wagonjwa waliogundulika kuwa na TB			
(b) Idadi ya wagonjwa waliopo kwenye matibabu			
32. Idadi ya waliofuatiliwa na kurudishwa/ kuanzishiwa matiababu			
33. Angalia utunzaji wa kumbukumbu zote na ukamilifu wake			
34. Jadili changamoto katika utendaji wa kazi			
35. Uliza kama msimamizi wa matibabu ana swali au maoni			Jibu kulingana na swali.
TOA MREJESHO NA SHUKRANI KWA WAHUSIKA KWA USHIRIKIANO (KILA UMALIZAPO KUNDI)			

TAARIFA YA USIMAMIZI SHIRIKISHI WA HUDUMA ZA KIFUA KIKUU NGAZI YA JAMII

Toa taarifa ya usimamizi shirikishi wa huduma za kifua kikuu , kifua kikuu na UKIMWI na kifua kikuu sugu katika kituo cha huduma na wadau wanaohusika kwa kufuata vipengele vifuatavyo:

Matokeo ya usimamizi shirikishi (mazuri, mapungufu, changamoto) _____

_____

_____

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Hatua zilizochukuliwa: _____

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_____

Maoni: _____

_____

_____

_____

_____

_____

Jina la msimamizi shirikishi_____Cheo_____

Sahihi _____Tarehe_____/_____/_____