THE UNITED REPUBLIC OF TANZANIA


Ministry of Heath

# OPERATIONAL FRAMEWORK & BUDGET SUMMARY FOR TUBERCULOSIS AND LEPROSY PROGRAMME (2023/2024-2025/2026)

December, 2023

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## LIST OF ABBREVIATIONS

| | |
|---|---|
| ACF | Active Case Finding |
| ACSM | Advocacy, Communication and Social Mobilization |
| ADR | Adverse Drug Reactions |
| ADDO | Accredited Drug Dispensing Outlets |
| aDSM | Active TB drug-safety monitoring and management |
| AFB | Acid Fast Bacilli |
| AIDS | Acquired Immuno-Deficiency Syndrome |
| APHFTA | Association of the Private Health Facilities in Tanzania |
| CBR | Community Based Rehabilitation |
| CCHP | Comprehensive Council Health Plan |
| CDC | Centre for Diseases Prevention and Control |
| CHMT | Council Health Management Team |
| CNR | Case Notification Rate |
| COE | Centre of Excellence |
| CRG | Community Right and Gender |
| CTRL | Central Tuberculosis Reference Laboratory |
| DMO | District Medical Officer |
| DOT | Directly Observed Treatment |
| DOTS | Directly Observed Treatment, Short course |
| DPharm | District Pharmacist |
| DR-TB | Drug Resistant TB |
| DST | Drug Susceptibility Testing |
| DTLC | District Tuberculosis and Leprosy Co-ordinator |
| ELR | Electronic Leprosy Register |
| EQA | External Quality Assurance of AFB microscopy, culture |
| ETL | Electronic TB and Leprosy Register |
| ETR | Electronic TB Register |
| FBO | Faith Based Organization |
| FLD | First Line Drugs |
| GFATM | Global Fund Against AIDS, Tuberculosis and Malaria |
| GLC | Green Light Committee |
| GLRA | German Leprosy and Tuberculosis Relief Association |
| GPSA | Government Procurement Services Agency |
| HIV | Human Immunodeficiency Virus |
| HCW | Health Care Worker |
| ICT | Information, Communication Technology |
| IEC | Information Education and Communication |
| IPT | Isoniazid Preventive Therapy |
| KCMC | Kilimanjaro Christian Medical Centre |
| KIDH ` | Kibong'oto Infectious Disease Hospital |
| KNCV | Royal Netherlands Tuberculosis Association |
| KVPs | Key and Vulnerable Population |
| LEA | Legal Environment Assessment |
| LED | Light Emitting Diode |
| LF LAM | Lateral Flow urine Lipoarabinomanna Assay |
| LGAs | Local Government Authorities |
| LPA | Line Probe Assay |
| LTBI | Latent TB Infection |

| | |
|---|---|
| MAM | Moderate Acute Malnutrition |
| MAT | Medically Assisted Treatment |
| MDR | Multi- Drug Resistance |
| MKUTA | EX- TB patients umbrella organisation |
| MSD | Medical Stores Department |
| NGO | Non-Governmental Organisation |
| NOSP | National Operational Strategic Plan |
| NTLP | National Tuberculosis and Leprosy Programme |
| OHSC | Occupational Health and Safety Compliance |
| POD | Prevention of Disability |
| PO-RALG | President's Office, Regional Administration and Local Government |
| PSU | Pharmaceutical Supplies Unit |
| PT | Proficiency Testing |
| PV | Pharmacovigilance |
| PWID | People Who Inject Drugs |
| QI | Quality \|Improvement |
| QIT | Quality  Improvement Team |
| RHMT | Regional Health Management Team |
| RMNCAH | Reproductive Maternal Newborn Child Adolescent Health |
| RLT | Regional Laboratory Technologist |
| RMO | Regional Medical Officer |
| RR | Rifampicin Resistance |
| RPharm | Regional Pharmacist |
| RTLC | Regional Tuberculosis and Leprosy Coordinator |
| SADC | Southern Africa Development Cooperation |
| SAM | Severe Acute Malnutrition |
| SDR | Single Dose Rifampicin |
| SBCC | Social and Behaviour Change Communication |
| SOP | Standard Operating Procedure |
| TB | Tuberculosis |
| TB – DNA | TB Diagnpstic Network |
| TBS | Tanzania Bureau of Standards |
| TTCN | Tanzania TB Comunity Network |
| TDR | Tropical Disease Research |
| TIM | TB in mining |
| TMDA | Tanzania Medicines and Medical devices Authority |
| TPT | TB Preventive Therapy |
| TSQ | TB Disease Questionnaire |
| TWG | Technical Working Group |
| TLCU | Tuberculosis and Leprosy Central Unit |
| WHO | World Health Organization |
| WTBD | World TB Day |

## BACKGROUND

Tanzania envisions to end TB and eliminate Leprosy by 2030. In 2021, 132,000 people fell ill with TB representing an incidence rate of 208 TB cases per 100,000 population. The incident rate has been reduced by 32% and deaths by 55% compared to 2015 baseline. The Global TB report further shows 80% of the TB burden is among HIV-negative individuals. It also shows a slight rise in TB incidence during and after the covid 19 period. Tanzania is on track to reach the 2025 End TB milestone of reducing TB incidence rate by 50% and number of deaths by 75%. However, the country is still missing about 46,000 people with TB and even though a low burden RR/MDR-TB country, the proportion of TB cases with laboratory confirmed RR/MDR-TB decreased from 2.1% in 2018 to 0.8% in 2022.The major five risk factors attributed to TB disease in the country are undernutrition, HIV, alcohol disorders, smoking and diabetes. While there are no statistics of the TB burden in some of the risk factors, analysis of the 2022 WHO global TB report indicated that 36% (8,649/24,000) of the incident HIV positive TB cases were missed in 2022.

Leprosy remains a neglected disease, yet causing more physical deformities than other infectious diseases. Even though Tanzania attained global target for leprosy elimination, the country is still among those notifying more than 1,000 cases per year. In 2022, Leprosy prevalence rate was 0.3/10,000 population down from 0.4/10,000 in 2015. At the national level, the Leprosy prevalence rate has remained below 1 case per 10, 000 population since 2006. In 2021, 14 districts councils (12 of the mainland and 2 districts from Zanzibar) reported higher rates above the national prevalence of 1 case per 10,000 population.

To respond to the diseases burden, The National Tuberculosis and Leprosy Program (NTLP) is implementing the sixth National TB and Leprosy Strategic plan of which implementation's began during the unprecedented times of the COVID19 pandemic. Like in other parts of the world the Program witnessed disruptions of TB and leprosy care which was reflected by the decreasing of the pace of increased TB notifications to 2.3% in 2021 as compared to 8.3% in 2019.Mitigation plan was put in place for the TB program performance recovery.

The midterm review was conducted to assess the progress of implementation towards the set goals. A good performance of the NSP VI was established in coverage of the impactful interventions for TB case finding while quality of services for both diseases and Leprosy detection were noted to lag behind. It was noted that only 49.6% of TB notifications were New and relapse pulmonary clinically diagnosed cases. Epidemiolocal analysis established up to 40% TB notifications were from community TB activities contribution of which more than 70% were clinically diagnosed cases. The Analysis suggested low quality of TB screening and sensitivity of the TB diagnostic algorithm being used to be among the reason for the finding. More still, the low number of bacteriologically confirmed TB cases detected was reported to be due to the limited access to molecular diagnostics and to interruption in GeneXpert cartridge supply, sub-optimal sputum referral system and low knowledge on TB diagnosis among HCWs. Only 43.8% of notified new TB cases were tested for rifampicin resistance in 2022. TB treatment success rate in adult with drug susceptible TB improved from 90% in 2019 to 96% in 2022.

High level commitment to Community Right and Gender (CRG) in TB was noted with recommendations to scale up and widening the scope of the Community TB care and CRG interventions with emphasis on building Health care workers (HCWs) and Community Health workers (CHWs) knowledge and skills. Further engagement of other providers was noted to perform not very well apart from efforts in engagement of providers such as Accredited Drug

Dispensers Outlets (ADDO,) Traditional healers (TH,) and private health facilities. The MTR report also highlighted efforts for collaboratives interventions in the management of TB Co morbidities, noting significant achievement of the TBHIV collaborative activities and initial efforts for TB Diabetic collaborative services.

## INTRODUCTION

The NTLP is now in its mid-way of implementation of the sixth TB and Leprosy Strategic Plan NSP (2020-2025). In 2022 the first ever comprehensive country model leprosy review was conducted and after a stakeholder meeting, a Leprosy zero roadmap for 2022-2030 and action plan for 2022-2025 were developed. In 2023 a midterm review of the NSP VI was conducted to inform the remaining period of implementation. In addition, the first two years of the NSP VI have witnessed significant lessons learnt due to ongoing national and global health and social economic changes and emerging challenges. In line with all of these there has been rapid release of guidance and plans especially on the use of new technologies and innovations in the quest to re -imagining TB care especially after the lessons learnt during the COVID19 pandemic.

The NSP VI midterm review recommended addressing identified gaps while sustaining the gains through focus on a more systematic approaches in implementation of case finding interventions, improve the quality of TB screening, strengthen the technical and managerial capacity of NTLP structures at all levels, stabilize commodity supply chain, introduce, and scale up the use of new medicines and new diagnostic tools, revisit the DR-TB treatment model and efforts to close the 35% funding gap through strengthening engagement of other providers, CSOs and Multisectoral accountability.

Therefore, the NSP sixth Addendum and thus this Operational plan have taken onboard the recommendations of the review to align with the Global Plan to end TB 2023-2030 and other updated Strategies such as the 2023-2028 Global Fund Strategy, USAID'S global TB strategy 2023–2030 and the revised WHO TB consolidated guidelines to ensure implementation of people centered, gender responsive and human rights-based interventions. In the remaining period of implementing this strategic plan, the Ministry has planned to implement the Zero leprosy plan and roadmap.

The Operational Plan will span in the remaining period of the sixth NSP and accommodate a further one year to align with the period of Health Strategic Plan V (2021-2026) and the Global Fund cycle 7 implementation period.

### *1.1 Process of preparing operation plan*

The National TB and Leprosy Operational Framework, was developed in a participatory manner, as a follow up of the National Strategic Plan core document development. This was achieved through consultative workshops and meetings. Interventions and activities in this OP were developed concurrently with the NSP, and the Global Fund 2020-2022 cycle application processes. Another phase was for the stakeholders to contribute towards the strategic (CORE) plan, hence contributing, endorsing or reviewing the strategies which also influenced the operational plan. A final workshop was "operational plan workshop" which had detailing the priority activities. The draft was sent out for inputs by the Stakeholders. A small team sat down to reflect on the inputs and incorporate them into the final draft. During this workshop, the team defined expected results in each strategic intervention.

Following a midterm review and epidemiological review as part of MTR, an addendum to the NSP sixth was developed with one revised Objective and new strategic intervention. This Operational plan was developed by the writing team formed by a consultant, NTLP and PO RALG officials with inputs gathered from stakeholders including the representatives from CSOs during the two workshops conducted in Mwanza ;27th February – 10th March 2023 and 27th March to 1st April 2023in Arusha Tanzania.

### *1.2 Purpose of operation and work plan*

While the purpose of the strategic plan was to identify the appropriate program strategic interventions and targets for the next five years the operational plan's focus is to describe and implement the interventions using the right approaches and available resources for the next three years. The operational plan therefore details what needs to be done. The plan sets the initial ground for costing the interventions and subsequently developing the budget for the 'whole plan'.It also prepares way for more details 'Work Plan' which is more realistic for costing.The Work plan details each activity into multi- year targets, time frame and responsibility with means of verifying what has been done.

### *1.3 Priority areas for the future and challenges*

The NTLP, Ministry of Health, and partners will need to build on their strengths in order to implement activities in the plan while taking corrective actions on areas for growth. There are potential opportunities that the program needs to take advantage of while guarding against the threats or major challenges. The (Strengths, Weaknesses, Opportunities and Threats (SWOT)) analysis conducted during 'the performance review workshop' process pointed out what actions were proposed. The results of the analysis appear in the core plan.

## SECTION I: TB CARE AND PREVENTION.

**OBJECTIVE 1:** To increase TB treatment coverage from 53% in 2018 to 90% in 2025 by innovatively addressing barriers to access, utilization and the needs of the key and vulnerable populations for TB care and prevention services.

### *1.1 Intervention 1: Quality Improvement for TB case detection.*

Scale-up health facility-based active case finding using Quality Improvement model for TB case detection.

**Narrative description.**

The lessons learned during the implementation of quality Improvement (QI) strategy for TB case detection has informed areas for improvement. The Program aims not only to sustain QI TB efforts but also scaling up countrywide to up to 50% of available health facilities national wide to maximize impact. Building on the lessons and experience gathered, the Programme will review the QI toolkit to incorporate new lessons and in particular, strengthening linkages between units at health facilities and TB diagnosis.

In the next three years, efforts to find and treat missing people with TB using a combination of innovative strategies will continue. These efforts will involve scaling up to all newly constructed health facilities of intensified facility-based case finding activities using the QI TB model. The targeted coverage for this intervention is expected to accomplish the screening of a total of 4.3 million patients in HFs to increase the probability of reaching the missing cases.In addition this intervention will also ensure availability of first line ant TB drugs for adults and children

In line with the Midterm review findings, this intervention will be sustained through assurance of quality delivery and scale up to other facilities specifically high-volume primary care level facilities including newly constructed ones. The review highlighted the need to focus on the facility case finding as it provides more opportunity to yield more people with TB. Further to contribute to the achieving Universal Health Coverage, (UHC) the intervention will ensure 100 % of the health centers and half of all dispensaries are covered during this period .100% of hospitals which are the referral points for all will also be covered. The intervention will be complemented by the CRG interventions which will build capacity of providers in providing gender responsive and human right based QI TB services. The use of new recommended tools for screening and diagnostic will be introduced such as use of Chest Xray as a screening tool with CAD4TB or without.

**Expected results.**

i. Reach epidemic pick by contributing to notification of 101,703 cases by 2023.
ii. 100% Public Hospitals and Health centers, 50% public dispensaries/private health facilities implementing QI-TB model by 2025/26

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 1.1 Scale-up health facility-based active case finding using Quality Improvement model for TB case detection | 1.1.1 Review QI toolkit to include the screening cascade and updating roles of focal persons and health facility WIT-TB<br>1.1.2 Scale up Active case finding (ACF) and QI model from 2,800 to 3500 health facilities (including private and newly constructed public facilities | i. Reach epidemic pick by contributing to notification of 101,703 cases by 2023 |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 1.1.3 Sensitize Managers and facility teams on ACF using QI toolkit in newly constructed hospitals and health centers<br>1.1.4 Conduct ACF QI mentorship by National and District Councils mentors in 26 regions<br>1.1.5 Conduct ACF QI quarterly review and exchange meetings at HFs through facility QIT and HF sections in 5 high volume sites in 184 councils<br>1.1.6 Procure and distribute first line TB drugs<br>1.1.7 Capacitate HF QI teams to analyze and use TB data. | ii. 100% Public Hospitals and Health centers / 50% public dispensaries/ private health facilities implementing QI-TB model |

***1.2 Intervention 2: Community Based TB Care.***

Engage formal CHWs and community actors to deliver community-based TB(CBTB) care including active case finding and contact investigation.

**Narrative description.**

Community contribution has been recorded to be gradually increasing from 10% in 2015 to 26% in 2019. Significant improvement has been seen specifically in the regions under the support. Other regions remain consistently low and thus, in line with the Ministry's community health policy guideline, community active case finding and contact investigation activities will be streamlined across all regions. Emphasis will be on reaching hard to reach areas through innovative integrated people centered case finding activities such as mobile clinics using mobile clinics through vans and boats.

The existing community guidelines will be updated to incorporate the linkage, coordination of TB services.Following Stigma index survey, stakeholders including CHWs and EX-TB patients will be oriented and engaged to address social determinates which hinder utilization and access of TB services. Furthermore, various approaches for advocacy and communication including digital methods will be used.

This intervention will link health facilities with community interventions using updated guidelines.In line with midterm review findings, community activities have yielded more TB patients with a significant of more clinically diagnosed (67 %). Contribution have reached at 40% Focus on quality of execution of these activities will be emphasized in the remaining period of the NSP VI

**Expected results.**

i. Community contribution to TB case notification increased from 26% (2019) to 30% by 2025.
ii. ≥ 90 % of household contacts of bacteriologically confirmed TB cases are screened for TB.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 1.2 Engage formal CHWs and community TB actors to deliver community-based TB (CBTB) care including active case finding and contact investigation | 1.2.1 Print and distribute community-Based TB. DR TB, TB/HIV guide, orientation package, CHV handbook,<br>1.2.2 Support CHWs and Ex-TB Volunteers to implement community-based TB interventions and outreach services (including incentive & enablers)<br>1.2.3 Support Motorcycle riders (BODABODA) for TB to transport sputum specimen from lower HFs to GeneXpert sites and bring back feedback results in all councils<br>1.2.4 Conduct yearly TB screening among traditional healers and their clients in all councils<br>1.2.5 Conduct semi-annual joint national and sub-national coordinative supportive supervision and mentorship to ensure quality implementation of Community TB care in all regions<br>1.2.6 Scale-up of TAMBUA TB mHealth self-screened approach all regions. | Community contribution to TB case notification increased from 26% (2019) to 30% by 2025<br><br>≥ 90% of household contacts of bacteriologically confirmed TB cases are screened for TB by 2025 |

**1.3 Intervention 3: TB services in prisons**.
Strengthen TB services in prisons and other congregate settings including boarding schools.

**Narrative description.**
When implementing the last NSP, the country conducted improved TB case finding activities in prisons and congregate settings. A total of 71 high volume prisons were reached and equipped with skills to actively implement case finding activities for people who are remanded and inmates. The model involves sensitization of prison authorities on TB services in prisons, appointment of a TB focal person in all prisons and routine screening of admitted and in-coming prisoners. TB in prisons services is regularly monitored by the district authorities through the CHMTs, DTLC and TB/HIV Officers. In this strategic plan, other prisons and congregate settings including boarding schools will be reached. The intervention will also focus on ensuring quality TB screening in these settings through monitoring and supervision.
Expected results.

i. 100% of prisons implementing improved TB services (active TB screening).
ii. All councils are routinely implementing TB health education in boarding schools.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 1.3 Strengthen TB services in prisons and other congregate settings including boarding schools | 1.3.1 Conduct systematic TB screening and management among remands and inmates in all councils<br>1.3.2 Minor repairs of health facilities in prisons in selected regions and districts<br>1.3.3 Monitor TB services in prisons in all regions<br>1.3.4 Develop, pretest, print job Aids for schools<br>1.3.5 Support coordination to prison department to monitor and supervise TB services in the prison countrywide.<br>1.3.6 Support coordinative meetings between MoH and Prison department | 100% of prisons implementing improved TB services (active TB screening) in prisons setting<br><br>184 councils have active TB health education in schools. |

***1.4 Intervention 4: TB services among elderly.***

Improve access to TB services among elderly people.

**Narrative description.**

The prevalence survey and routine data surveillance show a significantly higher prevalence among people of over 60 years of age. A comparison of age specific notification rates strongly suggests that adults (over 45 years of age) are under-diagnosed. Activities in this intervention will strengthen case detection, notification, treating of early at health facilities and community settings. In the next NSP, there will be an emphasis in identifying and screen elderly at OPD and in-patients. Community TB care services, will expand to reach households with elderly, formal elderly homes and conduct frequent screening for TB.

Factors which associated with low notification of elderly will be assessed. Elderly people will be a priority group during contact investigation. The community will be educated to give access to health care to the elderly people. This will be achieved through development and distribution of IEC materials and airing of TV and radio messages.

**Expected results.**

i. Increase TB case notification rate of the elderly by 30% from 2019.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 1.4 Improve access to TB services among Elderly people | 1.4.1 Conduct screening of TB in elderly homes<br>1.4.2 Develop and distribute IEC materials, TV and Radio messages to address TB in the elderly<br>1.4.3 Map elderly homes to facilitate TB screening and follow up | Increased TB case detection of the elderly by 30% from 2019. |

***1.5 Intervention 5: TB services among other vulnerable groups.***
Reach people with a high risk of TB including key and vulnerable populations

**Narrative description.**
Reaching people with a high risk of TB (infection or disease) including key and vulnerable populations and those living in poor and rural settings, hard to reach areas (miners, PWUIDs, fisherfolks, slums) is a priority in this SP.

The NTLP has conducted community-led demand creation and systematic screening activities for Key and Vulnerable Populations such as fishermen, schools, traditional healers slum sites. The program has also strengthened partnerships with traditional and religious leaders to address socio-cultural and religious drivers of TB related stigma and discrimination against the key and vulnerable populations e.g. health-seeking behavior for TB services among KVPs groups. However, there is still low accessibility to TB services at health facilities.Furthermore, people who use drugs (PWUD) and People injecting Drugs are at increased risk of tuberculosis, compared to the rest of the population who are not using drugs; this risk is higher with HIV infection.

The sixth NSP will scale up the integrated TB services in the Methadone Assisted Clinics in country, in line with the Ministry's scale-up plans of these clinics in other regions. Guided by a 3 years Community, Rights and Gender Operational Plan, the scope of these intervention will include outreach services using mobile clinics vans, communication and advocacy activities in targeted locations. Consultative meetings will be conducted with all concerned authorities to ensure quality care, which is right based and gender-responsive.

**Expected results.**
i. 30% of KVPs reached by 2025
ii. TB and TB/HIV services provided in all MAT clinics in the country.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 1.5 Reach people with a high risk of TB (infection or disease) including key and vulnerable populations and those living in poor and rural settings, hard to reach areas (PWIDs, fisherfolks, slums | 1.5.1 Conduct TB outreach services to reach people with high-risk TB<br>1.5.2 Conduct consultative meeting with Medically Assisted Treatment (MAT) on TB services to KVPs<br>1.5.3 Conduct mentorship and supportive supervisions to monitor TB services in the Methadone clinics | 30% or 600,000 of KVPs reached by 2025<br><br>TB and TB/HIV services provided in all MAT clinics in the country. |

### *1.6 Intervention 6.1: TB in mining*

Increase access to TB services in artisanal mining sites:

**Narrative description**

Mining occupants are now captured in the electronic TB register (DHIS2ETL) accounting for 1.5% of the total notifications. Thus this strategic intervention will use continue to focus on means to reach this population such as the use of mobile TB clinic van to conduct outreach services.The outreach campaigns will also be used as a means of gathering more information about the population.

There will also be preventive measures targeting artisan mineworkers including dust control measures and the scale up of use of innovative digital adherence technology (DAT) which was implemented under DOT 99 treatment adherence and monitoring project in Geita region.

Scale up OHSC including capacity building to HCWs and CSOs in mining areas on TB and other occupational lung diseases management:

TB in the mining SADC regional grant has established a center of excellence for occupational lung diseases and TB at Kibon'goto. The center has demonstrated best practices in offering TB and lung diseases to mining population in Mererani mining area and surrounding community. From Nov 2017 to May 2020 in 2019 a total of 4977 clients were attended at the center, of these 597(14.3%) were diagnosed with TB where by 95% were initiated treatment.

In this regard, the program intends to scale up these services to other mining areas with large concentration of artisan mineworkers especially in the lake zone. Furthermore, local CSOs will be capacitated on management of occupational lung diseases including TB.

Sustain coordination mechanism of multisectoral approaches to address issues of TB in mining sector.

Coordination teams for overseeing implementation of TB control services in mining sector at regional and national levels with members from health, mineral, labour, local government and CBOs will be strengthened. Teams will be meeting on quarterly basis to monitor progress of implementation of TB services in the mining sector. Reports of these meetings will be shared at all levels. TB patients' right to work, safety, compensation, health examination, treatment and services contracts should be well stipulated and adhered to by employers. Workers unions as custodian of mineworkers will have a role to oversee that these rights are observed. In order to sustain TB control interventions in the mining sector and surrounding communities, the MOHSW will partner with Mining companies and development partners including Global Fund, CDC/PEPFAR and WHO to raise funds for supporting implementation of TB control services in mines.

Scale up and strengthen cross border TB initiatives (CBI):

The cross-border TB initiatives are currently implemented in Tanzania and Rwanda (Rusumo area) and Tanzania and Kenya (Tarakea). The initiatives have showed some promising results on TB case detection and supporting treatment adherence among TB patients in the borders. This NSP intends to scale up this innovative intervention into 8 more borders across the country through strategic guidance of MOH and PORALG.

**Expected results**

i. 50% of artisan mineworkers screened for TB by 2025.
ii. 100% of mineworkers receiving TB and OHSC services.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 1.6 Increase access to TB services in artisanal mining sites | 1.6.1 Sensitize LGAs and implementing partners to scale up innovative interventions in hard-to-reach KVPs<br>1.6.2 Conduct sensitization meeting with mining owners, managers, unions, NGOs, CBOs and stakeholders<br>1.6.3 Conduct TB systematic screening to mineworkers and surrounding communities.<br>1.6.4 Conduct TB and TB/HIV outreach services using mobile van in mining areas.<br>1.6.5 Sustain and Support establishment of additional occupational health service centers for mining key population<br>1.6.6 Review and update dust control kit for mineworkers.<br>1.6.7 Conduct training on TB and occupational lung diseases to HCWs from both public and private health facilities.<br>1.6.8 Train community-based organizations (CSOs) in mining areas on TB and TB/HIV and occupational lung diseases services<br>1.6.9 Conduct consultative meetings with regional authorities to integrate TB services into existing cross border health committees.<br>1.6.10 Conduct situational analysis to explore readiness of the border areas for TB services<br>1.6.11 Conduct orientation to MO i/c, Clinicians, DOT providers from health facilities on cross border TB initiatives<br>1.6.12 Build capacity of the local CSOs to implement TB CBI<br>1.6.13 Conduct quarterly coordination meetings for Technical Working Group for TB in the mining.<br>1.6.14 Support TWG members to disseminate TIMS best practices in national and international forums.<br>1.6.15 Conduct TB screening in cross - border communities | 50% of the 6 million artisan mineworkers screened for TB by 2025<br><br>100% of borders health facilities implementing CBI |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 1.6.16 Support TB awareness campaigns and community mobilization to enhance health seeking behavior among border communities<br>1.6.17 Facilitate use of digital mobile technology to monitor TB treatment adherence and referral system in border areas.<br>1.6.18 Facilitate quarterly inter- facilities cross border coordination meetings.<br>1.6.19 Support cross borders quarterly coordination meetings. | |

### *1.7 Intervention 7: Programmatic Implementation of TB contact Investigation*

Strengthen Programmatic implementation of TBCI

**Narrative description**

TBCI is among the components of the first pillar of end TB strategy. The Contact tracing of House hold and close contacts is the strongly recommended population for systematic screening by the WHO. It is an effective way of reaching people with TB which is also emphasized among the Global Plan to end TB priority actions and also priority in the USAID first Objective of the TB strategy (2023-2030). TBCI increases the opportunity for early TB case detection and initiation of treatment both for TB disease and TB infection. The goal of TBCI is to stop Mycobacterium tuberculosis transmission in the community through improved case detection reduced diagnostic delays and initiation of early treatment. Thus, improving the process of TBCI will benefit the Program to accelerate the achievement of set global and national TB goals.

The focus will be to strengthen the intervention so that it can be implemented in a more structured way. A situational analysis will be done to establish gaps and thus identify needs which will be used to establish a TBCI framework/Roadmap. A guide and other tools will be developed and Indicators established so that the intervention can be monitored and supervised. To align with the current needs, innovations and technologies will be applied to maximize the impact of the interventions such as use of new tools for screening, tailored screening algorithms for specific KVPs groups, digitized tracking means to improve sample transportation and explore the impact of geospatial mapping of the index and contact persons.

**Expected results**

i. TBCI coverage increased by 100% (from 45% baseline)

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 1.7 Strengthen Programmatic implementation of TBCI | 1.7.1 Conduct a workshop to review the developed guide and the SOPs<br>1.7.2 Review, print and disseminate guide, tools and SOPs for TBCI scale up in collaboration with TB stakeholders. | TBCI coverage increased by ≥ 90% |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 1.7.3 Develop TBCI training materials<br>1.7.4 Train TOT and mentors on TBCI: RTLCs, DTLCs and D/R Community coordinators on TBCI<br>1.7.5 Train Health providers on TBCI: DOT providers and Community providers<br>1.7.6 Conduct TBCI mentorship<br>1.7.7 Conduct operational research (one per year) on improvement of TBCI<br>1.7.8 Procure Motorcycles for hard-to-reach facilities /villages – two districts, two facilities for every region<br>1.7.9 Conduct Quarterly TBCI Technical meetings-virtual | |

### *1.8 Intervention 8: Quality of TB care and prevention*

Ensure quality of TB care and prevention cascade

**Narrative description**

This intervention will focus on means to ensure quality of TB screening interventions is restored and maintained as recommended in the recent and previous reviews.

For the past seven years the Program has focused on improvement of coverage TB case detection. Epidemiological analysis and Mid tern results findings suggest a need of now to focus on quality of the TB screening; A national level data analysis of 71 726 adult TB cases were notified and started on treatment in 2021. Among them, 28 328 (39.5%) were bacteriologically confirmed: 17 377 (61.3%) had a positive Xpert and 10 949 (38.7%) had a positive smear microscopy. A total of 43 398 (60.5%) TB cases were clinically diagnosed and among them 15 058 (34.7%) had a negative Xpert and 9 444 (21.8%) had a negative smear microscopy while the remaining 18 896 (43.5%) had no evidence of a negative bacteriological test (Table 2). A higher proportion of EPTB was observed among those clinically diagnosed, while no difference was found according to HIV-status. These results at national level pointed out that about 60% of the patients initiated on TB treatment while no bacteriological evidence and that among them, 56.5% initiated treatment while they had evidence of a negative bacteriological test (Xpert negative or smear microscopy negative). Further, the thematic areas assessment identified gaps in skills of the providers and focal people and hence focus on capacity build have been emphasized.

TB is a condition that is particularly sensitive to the quality of health systems as a person with TB must navigates along and complex process of care seeking, diagnosis, linkages to care, treatment initiation, notification to NTLP and follow up. The intervention will provide avenue to unpack the epidemiological review findings then apply quality improvement process to identify quality gaps along the TB continuum of care. While appreciating that the TB screening processes and activities cuts across other interventions and objectives, that this intervention will leverage efforts with other linked interventions.

The core package of interventions which is a means to assure core interventions across the regions and districts will be disseminated and its adaptation monitored. At the final year of implementation of this plan, the NTLP Manual will be updated to include the newly adopted and adapted strategies, technologies and products.

**Expected results**

1. Proportion of Bacteriological confirmed notified TB patients increased

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 1.8 Ensure quality of TB care and prevention services | 1.8.1 Conduct stakeholders' workshop to synthesize epi review and other report<br>1.8.2 Develop a mentorship package for the identified quality improving areas<br>1.8.3 Train mentors on developed QI mentorship package<br>1.8.4 Conduct mentorship to ensure quality of TB screening<br>1.8.5 Adaptation of the Core package of interventions: Dissemination and monitoring (coordinative meeting budget; virtual meeting to coordinators)<br>1.8.6 Review training packages: QI, Community, TBCI Ped DTLC course (Management and Technical; TA)<br>1.8.7 Conduct virtual orientation of WHO guidelines<br>1.8.8 Attend WHO /UNION courses – coordinators<br>1.8.9 Develop E learning TB and leprosy modules and incorporate to the MoH e learning platforms – CPD/CME<br>1.8.10 Review the NTLP Manual | Proportion of Bacteriological confirmed notified TB patients increased |

## SECTION II: TB DIAGNOSTIC SERVICES.

**OBJECTIVE 2:** To expand access to quality TB diagnostic services, including the adoption of new diagnostic technologies.

### *2.1 Intervention 2.1: Access to TB diagnostic services.*

Enhance universal access to TB diagnostic services.

### *2.1.1 Narrative description.*

This intervention focuses on increasing universal accessibility and availability of TB laboratory diagnostic network services in the country aimed at increasing TB case notification rate (CNR). Activities under this intervention are designed to strengthen integrated sample referral system and maintenance of TB laboratory services. The programme will update existing guidelines and SOPs, develop TB laboratory strategic plan (which provides guidance on entire operations of TB Diagnostic Network in the country) and build capacity of human resource through training and mentorship in the TB laboratories. Furthermore, the programme will procure equipment and commodities for TB laboratories and effect equipment maintenance and service contracts in order to reduce equipment downtime.

The case finding initiatives depends on functionality of the sample transportation system, taking into account that coverage of TB diagnostic facilities is only at 19%. The Program have different modalities of the sample transportation such as a contact with the Post office, integrated sample system which is supported mostly by the TBHIV partners and transportation by the community actors. In efficiencies in these systems has been identified and linked with poor outcome of case finding activities. This intervention has been placed strategically to respond to the gaps of the implementation of these systems. The intervention will explore means of monitoring the integrated sample transportation by introducing a TB module to eRS and indicators at all levels. There will be a stakeholder's meetings in order to learn, address bottle necks and monitor progress.

**Expected results**.

i. All TB treatment centers provide, TB diagnostic services on site or by specimen referral among TB treatment centers
ii. 70% of TB cases diagnosed new and relapse tested using WRD at the time of diagnosis

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 2.1 Enhance universal access to TB diagnostic services | 2.1.1 Conduct periodic Assessment on TB diagnosis Network (TB DNA)<br>2.1.2 Develop and disseminate national TB Laboratory Strategic Plan<br>2.1.3 Review, update and distribute TB testing algorithm, SOPs and Job aides<br>2.1.4 Provide bi-annual technical assistance to zonal TB laboratories<br>2.1.5 Conduct bi-annual TB laboratory services supportive supervisions and mentorship.<br>2.1.6 Perform periodic preventive maintenance, repair, and calibration for all TB laboratory equipment | All TB treatment centers provide, TB diagnostic services on site or by specimen referral among TB treatment centers<br><br>70% of TB cases diagnosed new and relapse tested using WRD at the time of diagnosis |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 2.1.7 Sensitize regional HCWs on the availability and use of TB diagnostic tests<br>2.1.8 Support transportation of TB specimens through integrated specimen referral mechanism<br>2.1.9 Procure and distribute TB laboratory equipment, commodities and supplies<br>2.1.10 Conduct quarterly stakeholders (GPSA, TRA, TMDA, eLMS, PO-RALG, TBS and MSD) virtual meetings for TB commodities and supply chain management.<br>2.1.11 Conduct refresher training in TB diagnostics to AFB Smear Microscopy and GeneXpert users<br>2.1.12 Adopt of TB Urine LAM and TB-LAMP. Train TB coordinators, Clinicians, DOT nurses and Lab. Techs on LF- LAM<br>2.1.13 Install and train end users to the procured machines<br>2.1.14 Train HCWs on use of Stool technique for Childhood TB diagnosis using GeneXpert<br>2.1.15 Conduct quarterly TB laboratory TWG meetings | |

***2.2 Intervention 2: Quality of TB Laboratory services.***
Strengthen quality assurance (QA) across TB diagnostic network.

**Narrative description**.
As of 2019, EQA program coverage was 85% for microscopy and 44.3% for GeneXpert. For the last five years, the EQA performance for sputum microscopy in terms of percentage of true positive among all positives has been above 97. The available EQA results for Genexpert from 2016 60 2018 show most (over 88%) of the responded sites scored within the acceptable percentage (80 – 100%) for Profiency testing.

CTRL is successfully implementing a Quality Management system and has been accredited under ISO 15189 since 2018 and still maintains accreditation with an extension of scope to cover seven tests by the end of 2022. It also provides technical assistance to the TB laboratory at lower levels which has resulted in accreditation of 30 TB laboratories for GeneXpert or AFB Smear Microscopy. To strengthen the QMS trainings will be conducted and SOPs developed.

This intervention aims to build capacity to the TB Laboratories in implementation of Quality Management system (QMS) and quality assurance to ensure delivery of accurate and reliable

laboratory test results, laboratory accreditation, and EQA performance. These processes provide objective evidence of complying with required standards for patient's care.

Capacity building of all providers and coordinators along the cascade of TB diagnostic network, will be conducted through training, supportive supervision and mentorship. The programme will increase engagement of R/DLTs to support coordination of TB diagnostic network including sample transportation at their respective levels.

**Expected results.**

i. 50% of GeneXpert sites with ISO accredited

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 2.2 Strengthen quality assurance (QA) across TB diagnostic network | 2.2.1 Provide Proficiency testing (PT) to zonal TB Laboratories for GeneXpert, LPA, Culture and Microscopy (Enroll Molecular sites to EQA Scheme)<br>2.2.2 Develop and disseminate National TB External Quality Assurance Guidelines (Conduct workshop to develop SOPs and Manuals)<br>2.2.3 Capacitate reference and zonal TB laboratories to prepare and coordinate EQA programme<br>2.2.4 Conduct quarterly EQA data review workshop (Conduct biannual meetings to review EQA performance)<br>2.2.5 Conduct quarterly QMS mentorship to TB regions and districts to facilitate accreditation of GeneXpert and microscopy (Conduct supportive supervisions and mentorship)<br>2.2.6 Retain accreditation status (GeneXpert, smear microscopy) and extend accreditation scope (LPA, culture, DST) for reference and zonal TB laboratories<br>2.2.7 Conduct annual management review meetings involving CTRL and zonal TB laboratories as per ISO 15189 requirements<br>2.2.8 Develop and disseminate National TB Laboratory Safety Manual<br>2.2.9 Conduct assessment on the current Blinded rechecking (LQAS) | 50% of GeneXpert sites with ISO accredited |

### *2.3 Intervention 3: TB medicine Drug Sensitivity Testing.*

Expand the coverage and utilization of phenotypic and genotypic DST.

**Narrative description**.

In 2019, CTRL was the only laboratory performing phenotypic DST. Genotypic DST for second line drugs was carried out at CTRL and two zonal laboratories. To expand coverage of DST utilization, this intervention focuses on increasing access to DST as per testing algorithm using conventional and molecular techniques in the country. Priority will be given to adoption of new technologies in diagnosis of TB and Leprosy, mapping and strengthening of TB data flow and patients results, building capacity for the TB laboratories staff and ensuring even distribution and access of TB Diagnostic molecular technologies. The national programme also aims at continuing to build capacity of TB laboratories staff in all zones and referral centers to ensure access of TB DST in the country.

**Expected results.**

i. 100% of all bacteriological confirmed TB patients has DST result for at least rifampicin
ii. 90% of laboratories with GeneXpert machines integrated to DHI2–ETL or GxAlert systems

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 2.3 Expand the coverage and utilization of phenotypic and genotypic DST | 2.3.1 Procure and install two sets of LPA machines to 2 zonal laboratories<br>2.3.2 Procure at least two GeneXpert machines to each council.<br>2.3.3 Map and re-distribute molecular diagnostic technologies appropriately<br>2.3.4 Train National and Zonal Laboratory staff on DST for new second line TB drugs | 100% of all bacteriological confirmed TB patients has DST result for at least rifampicin.<br>90% of laboratories with GeneXpert machines integrated to DHI2–ETL or GxAlert systems |

### *2.4 Intervention 4: Expansion of use of radiology services in TB care and prevention*

Expand the coverage and access to X-ray services, including digital X-ray in hard-to-reach areas and among the KVPs

**Narrative description.**

The chest x-ray is useful for diagnosing TB disease because TB disease in the lungs,is the most common form of TB disease. For adults without HIV infection, the chest x-ray will usually appear abnormal when a patient has TB disease in the lungs. It may show infiltrates or cavities.CXR is also useful for screening people living with HIV for TB. It is currently recommended by WHO for use in parallel with W4SS for ruling out TB disease before initiating TPT.

Through this intervention the program will adapt the use of CXR as a screening tool, continue to provide supervision on use of CXR as diagnostic tool and optimize the use of AI for reading i.e CAD4TB.

As the radiology service is not offered for free for children above five years and adults, the Program will explore different mechanisms to ensure access of this service to those in need.

**Expected results.**

i. 30% of KVPs are reached by 2025

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 2.4 Expand the coverage and access to X-ray services, including digital X-ray in hard-to-reach areas and among the KVPs | 2.4.1 Procure and distribute digital X-ray machines<br>2.4.2 Train users on Digital X-ray screening using the artificial intelligence<br>2.4.3 Support cost for Chest X-Ray screening and diagnosis for TB<br>2.4.4 Procure mobile digital X-ray for hard-to-reach areas. | 30% of KVPs are reached |

***2.5 Intervention 5: Laboratory Information System in molecular test facilities***
Strengthen Laboratory information system within TB diagnostic network

**Narrative description.**
The Program uses both paper and electronic systems for laboratory data collection. There are three electronic systems TB-LIS, DHIS2-eTL2 & GxAlert/ASPECT. The TB-LIS is only used at CTRL to feed all Specimens' information received for Culture and DST (LPA & Phenotypic DST), it captures all specimens associated information including pre-treatment results and it provides Culture results and DST results in the well-organized printing form that can be send back to peripheral facilities. This intervention has an aim of expanding the use of TB-LIS to zonal laboratories

**Expected results.**
ii. All zonal TB Lab with functional TB LIS

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 2.5 Strengthen Laboratory information system within TB diagnostic network | 2.5.1 Establish LIS to all molecular test facilities<br>2.5.2 Connect, maintain and update GeneXpert machines to electronic information systems for example GX-alert and DHIS2-ETL.<br>2.5.3 Training HCW on the use of LIS to monitor TB data<br>2.5.4 Develop sample referral tracking system<br>2.5.5 Train HCWs on the use of electronic referral system (eRS).<br>2.5.6 Training on biosafety and biosecurity to all personnel working with SRS (HCW and couriers) | All zonal TB Lab with functional TB LIS |

## SECTION III: CHILDHOOD TB.

**OBJECTIVE 3:** To maintain the proportion of children notified cases at 15%, increasing the ratio of TB incident cases for ages 0-4:5-14 to 1.5 by 2025

### *3.1 Intervention 1: Burden of TB disease among children and adolescents.*

Establish burden of TB disease among children and adolescents in different regions and districts.

**Narrative description.**

There has been significant efforts to notify children among TB cases. The proportion of children among TB cases notified reached 16% in 2019 which is high than expected in countries with high TB burden. However, the in-depth analysis of programme data show a low ratio (1.3) of age group 0-4 to 5-14. Understanding the magnitude of the TB disease in children and adolescents is critical for planning, implementation and measuring progress. The use of routine data triangulated with the assessment data will be critical to measure the disease burden, required actions and resources. Moreover, sub-national information is critical to outline priorities and effectively use the scarce resources available.

Expected results.

i. Subnational TB notification rate of children and adolescents identified.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 3.1 Establish burden of TB disease among children and adolescents in different regions and districts. | 3.1.1 Conduct subnational epidemiological assessment to understand the burden of TB in children and adolescent<br>3.1.2 Conduct clinical audits on TB deaths reported among children and adolescents<br>3.1.3 Map and identify geographical and hotspot locations with reported high number of children and adolescents with Tuberculosis | Subnational TB notification rate of children and adolescent established |

### *3.2 Intervention 2: Identification and linkage of all children and adolescents to comprehensive TB services.*

Meaningful engagement of all care providers in the health facilities and communities in identification and linkage of all children and adolescents to comprehensive TB services.

**Narrative description.**

Efforts to increase TB case detection for children and adolescents will go beyond health facilities. The program will ensure that community supportive systems and structures are sensitized and participate in TB prevention, care and support for children and adolescents. The program will ensure communities are sensitized for promoting utilization of available diagnostic and treatment services. Contact investigation will be strengthened, community screening and early referral will be implemented in a cost-efficient manner. The program will support regular outreach services for childhood TB. Case finding models in pediatric such as CAP TB will be scaled up for maximized Program performance. Cap TB was implemented in

22 sites in two regions of Tabora and Singida, it involves paediatric TB screening in all entry points (RCH, OPD and IPD), advance sample collection though NGA, sample transportation from collection to testing facilities and supporting contact tracing. The main CAP activities are complemented by capacity building sessions through on site and classroom-based trainings as well as mentorship.

**Expected results.**

i. 100% of children (< 5 years) who are household contacts of TB cases are screened for TB.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 3.1 Establish burden of TB disease among children and adolescents in different regions and districts. | 3.1.1 Conduct subnational epidemiological assessment to understand the burden of TB in children and adolescent<br>3.1.2 Conduct clinical audits on TB deaths reported among children and adolescents<br>3.1.3 Map and identify geographical and hotspot locations with reported high number of children and adolescents with Tuberculosis | Subnational TB notification rate of children and adolescent established |

***3.3 Intervention 3: Building Capacity of HCWs.***

Build capacity of healthcare workers to diagnose and manage childhood tuberculosis.

**Narrative description.**

Tanzania is among the founding members of the sub- Saharan Africa regional child and adolescent TB center of excellence platform. The first centre of excellence was established at Mwananyamala Hospital in i2012. Since then a number of centres of excellence have been established throughout the country. Experience gained from pediatric TB centers of excellence will be scaled across the country. Health facilities will be equipped with diagnostic tools including NGT for collection of gastric aspirates and GeneXpert to improve diagnosis. In addition, training in use of sputum induction, gastric aspiration, and interpretation of pediatric chest X-rays will be conducted.

Revised Job aids, children & adolescent TB guidelines and training materials will be distributed to all health facilities including TB/HIV care facilities implementing children and adolescent TB services.

Adolescent (10-19 years) data will be incorporated to routine data and reported in order to address their specific needs and monitor progress and outcome of TB control.
Furthermore, children and adolescent TB coordination mechanism will be strengthened to provide strategic guidance and leadership to accelerate children and adolescent TB services in the country..

**Expected results.**

i. 70% of children and adolescents are bacteriologically confirmed.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 3.3 Build capacity of healthcare workers to diagnose and manage childhood tuberculosis | 3.3.1 Train HCWs on TB diagnostic: sputum induction and gastric aspiration for children.<br>3.3.2 Review pediatric TB guideline to incorporate new and revised WHO guides including adolescent clinical and psychosocial needs.<br>3.3.3 Orient HCWs on the revised Pediatric guideline<br>3.3.4 Support Pediatricians to conduct mentorship.<br>3.3.5 Conduct quarterly pediatric TWG meetings (use of virtual platforms)<br>3.3.6 Train HCWs on new shorter paediatrics friendly TPT regimens | 70% of children and adolescents are bacteriologically confirmed |

***3.4 Intervention 4: Integration of TB services with other child and adolescent health services.***

Integrate TB services with other child and adolescent health services in facilities and communities.

**Narrative description.**

The d- IMCI is a comprehensive intervention that has a potential to improve quality care as it addresses a sick child holistically. Building on the lessons in five pilot regions where Pediatric TB has been incorporated in d-IMCI, the program will scale up this activity to more regions with focus on regions will low childhood notifications.

Furthermore, the program will provide training to the health care workers (HCWs) by using d-IMCI in collaboration with RCH program in order to capacitate the HCWs at every entry point to have not only a high suspicious index but also skills to diagnose and manage TB in children.

**Expected results.**

i. 10% of the notified pediatric TB cases are referred from RMNCAH.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 3.4 Integrate TB services to all other child and adolescent health services in the facilities and communities. | 3.4.1 Conduct bi - annual technical working group meetings to spearhead implementation of children and adolescent TB, TB/HIV, RMNCAH services and document best practices.<br>3.4.2 Train HCWs on TB d-IMCI to service providers from public and private health facilities in 5 selected regions.<br>3.4.3 Conduct d-IMCI post training follow.<br>3.4.4 Deploy experts to conduct bi-annual pediatric TB mentorships/coaching to low performing high volume sites, including follow-up. | 10% of the notified pediatric TB cases are referred from RMNCAH. |

## SECTION IV: PROGRAMMATIC MANAGEMENT OF DRUG RESISTANT TB (PMDT).

**OBJECTIVE 4:**
To increase RR/MDR-TB cases detected and enrolled for treatment from 54% to 90% of the estimated cases among notified cases by 2025.

***4.1 Intervention 1: MDR-TB case finding and management.***
Strengthen MDR-TB case finding and management.

**Narrative description.**
In the year 2019, only 54% of estimated RR/MDR TB cases were detected implying that there are still missed cases inspite of increased case detection for the past five years.Early detection and treatment initiation for RR/MDR-TB patients is essential and so is contact investigation for all confirmed cases.

Contacts of all confirmed RR/MDR TB cases will be routinely traced and screened for DR-TB by TB coordinators/DOT providers. The programme will track all confirmed DR TB cases and ensure they are linked to treatment. Thus, scaling up of new molecular diagnostic technologies is importat in order to facilitate efficient detection of DR-TB.

The use of recently (2019) WHO recommended all oral shorter and longer individualized regimens will be the focus of patient care. The all oral shorter regimen has been introduced under operational research where it will generate information for decision making on efficacy and feasibility of using all oral shorter regimen for eligible RR/MDR TB patients in the future.

Use of all oral longer regimen has been introduced in the country since November 2019 to mitigate severe adverse events caused by injectables.The programme will continue to conduct targeted supportive supervision and enhanced zonal cohort reviews to regions providing MDR TB care.

Second line TB medicines will be procured through GDF mechanisms to ensure availability and timely distribution to facilities providing MDR -TB care. Likewise, programme will support supplies and IPC gears procurement; including N95 respirators for healthcare workers and surgical masks for MDR-TB patients, nutrition, transport stipend and cover costs for baseline and follow up investigations which are not available to facilities treating MDR TB patients.

**Expected results.**
i. 100% of contacts of RR/MDR TB patients are screened for TB.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 4.1 Strengthen MDR-TB case management | 4.1.1 Review MDR-TB guideline and develop audio visual training materials for HCWs including pediatric formulation materials<br>4.1.2 Train HCWs on Programmatic management of Drug Resistance TB (PMDT)<br>4.1.3 Support TB coordinators and DOT providers to conduct contact investigation for all confirmed RR/ MDR- TB cases | 100% of contacts of RR/MDR-TB patients screened for TB |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 4.1.4 Conduct targeted Supportive supervisions and mentorship on DR-TB management<br>4.1.5 Procure Anti-tuberculosis second-line medicines<br>4.1.6 Procure supplies and Personal Protection Equipment such as respirators and masks<br>4.1.7 Support of baseline and follow up investigations for patients on treatment across country<br>4.1.8 Conduct quarterly cohort review in zones<br>4.1.9 Introduce and scale up use of BPaL/ BPaLM in the country<br>4.1.10 Conduct mortality audits to all DR-TB patients dying during treatment | |

***4.2 Intervention 2: Decentralizing MDR-TB Care***

Scale up and strengthening of MDRTB decentralized sites.

**Narrative description.**

In efforts to strengthen decentralized sites the Programme proposed establishment of zonal, regional and district MDR TB centres in the decentralization framework.

The zonal/regional/district MDR TB centres will admit patients who meet admission criteria, provide laboratory infrastructure for MDR-TB diagnosis (culture/DST,LPA), treatment monitoring (TB culture) and treatment toxicity monitoring (tests for renal, liver, thyroid, ECG and other tests).

Currently 10 centres have received support for MDR TB ward/laboratory refurbishment/ construction, out of these four are zonal centres at different stages of development (Mwanza, Dar es salaam, Dodoma, and Kilimanjaro) i.e. they are not yet fully functional.

The programme will support these sites to become fully functional and establish additional two new zonal MDR TB centres in Mbeya and Mtwara.

Kibong'oto Hospital will continue to assume the role of Centre of excellence for the MDR-TB services in the country. The hospital will receive support for the TA and other capacity building activities to reinforce programmatic management of drug resistant TB in the country. Five ambulances will be procured to facilitate referral and movement of potentially infectious patients from diagnostic/lower level treatment facilities to zonal MDR TB facilities and center of excellence.

**Expected results.**

i. < 10% of the RR/MDR-TB initiated treatment are lost to follow up.
ii. 100% of existing district hospitals initiating MDR- TB services.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 4.2 Scale up and Strengthening of MDR-TB Decentralized sites | 4.2.1 Support referral and transportation of MDR-TB patients with special needs to and from the zonal treatment centers<br>4.2.2 Support Case management teams to undertake mentorship to newly established MDR -TB treatment centers<br>4.2.3 Scale up ECHO to all MDR-TB decentralized sites<br>4.2.4 Establish permanent DR-TB treatment initiation facilities including formulation of Concilium at each treatment initiation site | < 10% of the RR/MDR-TB initiated treatment is lost to follow up |

***4.3 Intervention 3: PMDT services support***

Strengthen system to support PMDT services.

**Narrative description.**

Use of new MDR-TB treatment regimens requires close follow up, timely identification and management of adverse events for patients on treatment. For smooth implementation of these new regimens' capacity building of health care workers on PMDT and aDSM is of paramount. The use of digital/electronic technologies (m-Health, telemedicine, ECHO, e-learning, digital adherence technologies) will be emphasized during implementation of most of activities in this intervention. In addition, the education materials including revised guidelines will be digitized (audio visual clips) and the programme will utilize its e-learning platform as a quick guide for the existing and newly employed coordinators and HCWs.

in Tanzania, about 45% of TB patients face catastrophic costs during TB treatment. The proportion is even higher (80%) for RR/MDR TB patients. Therefore, socio economical support (nutrition, transport stipend and follow up/baseline test costs) will be provided to RR/MDR-TB patients.

Expected results.

i. All regions reporting ADR.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 4.3 Strengthen system to support PMDT services | 4.3.1 Review, update, and print aDSM and PV training package and tools incorporating new DR-TB medicines and regimen (including ADR reporting)<br>4.3.2 Train Regional aDSM Focal person on aDSM for new MDR-TB medicines and Pharmacovigilance including ADR reporting | 100% of regions reporting ADR |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 4.3.3 Support regional aDSM Mentorship and supportive supervision<br>4.3.4 Conduct PMDT bi-annual TWG meeting<br>4.3.5 Provide nutrition and transport stipend for all RR/MDR-TB Patients on treatment<br>4.3.6 Support annual external PMDT review (WHO/GLC mission)<br>4.3.7 Procure ancillary medicines for managing adverse events | |

## SECTION V: CO-MORBIDITIES AND COLLABORATIVE TB-HIV ACTIVITIES.

**OBJECTIVE 5:** To Strengthen management of co-morbidities including collaborative TB/HIV activities, and Prevention of TB for persons at high risks.

***5.1 Intervention 1: Collaborative TB/HIV service.***
Strengthen collaboratives TB/HIV services.

**Narrative description.**
The TB/HIV Committees at all levels will be strengthened and supported to conduct quarterly meetings to discuss implementation progress, harmonization of activities with partners, avoidance of activities duplication and increase accountability.

RHMT and CHMTs will be oriented on the updated national TB/HIV policy guidelines to understand their roles and responsibilities. Health facilities quarterly exchange meetings will be supported to exchange information on integration of services at the point of care including referrals.

**Expected results**.
1 100% of TB cases have DST result for at least rifampicin

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 5.1 Strengthen collaboratives TB/HIV services | 5.1.1 Conduct annual TB/HIV stakeholder's coordination meeting<br>5.1.2 Support all regions to conduct annual TB/HIV regional coordination committee meetings<br>5.1.3 Print and distribute collaborative TB/HIV guidelines<br>5.1.4 Conduct training on revised collaborative TB/HIV policy guidelines<br>5.1.5 Train TB clinicians and DOT nurses on HIV management in order to expand under one roof services<br>5.1.6 Develop diagnostic guideline and SOPs for the use of LAM for Advanced HIV clients and CRP TB screening.<br>5.1.7 Conduct mentorship to HCWs on the use of LAM for Advanced HIV clients and CRP for TB screening tools<br>5.1.8 Procure C-reactive protein (CRP) and TB-LAM for eligible PLHIV<br>5.1.9 Conduct Operation research for the use of CRP as the screening tool for TB for ART naïve PLHIV<br>5.1.10 Conduct TOT training on the use of advanced radiological services.<br>5.1.11 Support TOT to conduct quarterly mentorship on the use of advanced radiological services | 100% of TB patients have known HIV status |

### *5.2 Intervention 2: TB/DM Co morbidities.*

Scale up other collaborative TB /DM activities.

**Narrative description.**

For the past three years the program has introduced collaborative TB/DM interventions in the country. This strategic intervention aims at reducing the burden of TB and DM among people with co- morbidities. The NTLP in collaboration with stakeholders developed national guidelines for collaborative TB/DM care and control services and also trained over 300 HCWs from both public and private health facilities on these services. Furthermore, the ETL is now capturing TB patients with DM condition. In this NOSP the program will expand and strengthen the TB/DM services to all regions. A research study to ascertain the magnitude of TB and DM co-morbidties among both patient groups will also be carried out.

**Expected results.**

i. 100% of hospitals implementing TB/DM services.
ii. Burden of TB among DM patients and vice versa established.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 5.2 Scale up collaborative TB /DM activities | 5.2.1 Conduct workshop to develop orientation package on collaborative TB /DM<br>5.2.2 Conduct orientation to RHMT and CHMTs on collaborative TB/DM services.<br>5.2.3 Conduct TOT training on collaborative TB/DM services.<br>5.2.4 Orient in-charges at diabetic clinic, DOT clinic, OPD and in patients' sections, matrons in health facilities from selected districts and regions on TB diabetes collaborative activities<br>5.2.5 Facilitate referral and linkages between and DM clinics.<br>5.2.6 Support mentors to conduct mentorship to health facilities implementing TB and DM collaborative TB/DM services in all regions | 100% of hospitals implementing TB/DM services |

### *5.3 Intervention 3: TB infection Management*

Strengthen prevention of LTBI among at risk groups.

**Narrative description.**

A significant number of people who have latent TB infection (LTBI) remain a source of active TB. Thus, systematic testing and treatment of LTBI in at-risk populations is critical to eliminating TB disease by 2050. Efforts to screen high-risk groups for TB, such as miners and prisoners, will continue, this will include exploring the feasibility of using more sensitive screening laboratory tests. Other priority activities include introducing innovative digital ways of monitoring TPT, and improving adherence.

**Expected results**.

i. 90% of eligible at-risk groups started on TPT.
ii. 90% of eligible at-risk groups completed TPT.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 5.3 Strengthen prevention of LTBI among at risk groups | 5.3.1 Conduct systematic review to collect evidence on effectiveness and feasibility of existing TPT medicines<br>5.3.2 Adapt and Develop new Latent TB Infection policy guidelines<br>5.3.3 Conduct training to TOT on LTB/TPT new guidelines<br>5.3.4 Orient Regional and CHMTS teams on new LTBI/TPT guide lines | 90% of eligible at-risk groups started on TPT<br><br>90% of eligible at-risk groups completed TPT |

***5.4 Intervention 4: Tobacco smoking cessation.***
Implement Tobacco Smoking cessation in TB programming.

**Narrative description.**
Globally the prevalence of TB among smokers is almost three times higher compared to non- smokers. Active smoking increases the severity of TB presentation and also chances of TB relapse.

The association between tobacco smoking and TB in Tanzania has not been studied, however the Tanzania adult Global tobacco survey showed that overall 6.8% (2.0 million adults) currently use tobacco, only 36.5% of the smokers who visited health care providers in the last 12 months were advised to quit smoking (2018 TANZANIA GLOBAL ADULT TOBACCO SURVEY).

Furthermore, WHO has released guidelines to assist TB patients to quit smoking that this plan will adapt and implement.

Expected results.
i. A guide for TB patients to quit smoking in place.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 5.4. TB and Tobacco Smoking cessation | 5.4.1. Adapt the WHO guide for TB patients to quit smoking<br>5.4.2. Develop training package for HCWs to assist TB patients to quit smoking.<br>5.4.3. Develop IEC materials for TB – Smoking cessation<br>5.4.4. Print and distribute IEC materials for TB smoking cessation to health facilities<br>5.4.5. Conduct operational study on TB and smoking. (Baseline – end line) | A guide for TB patients to quit smoking in place |

***5.5 Intervention 5: Nutrition care for TB patients.***
Offer nutrition care and counselling for TB patients.

**N**

**arrative description.**
Undernutrition increases the risk of TB. It is estimated that undernutrition causes about one quarter of all new TB cases globally. TB causes weight loss, micro and macro nutritional deficiencies. Improving food security would greatly contribute towards TB prevention and offering nutrition support will prevent malnutrion among TB patients.

**Expected results.**
i. Job aids, EIC/SBCC materials on TB and nutrition Developed and disseminated.
ii. TB patients with malnutrition identified and managed.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 5.5 Nutrition care and counselling for TB patients | 5.5.1 Develop and disseminate tool kits/ Job aids, IEC and SBCC materials on Nutrition and TB<br>5.5.2 Conduct training to HCW on Nutrition care and counselling for TB patient at health facility<br>5.5.3 Conduct nutritional monitoring to TB patients (including elderly and other KVPs) in all health facilities at TB clinics | Job aids, EIC/SBCC materials on TB and nutrition Developed and disseminated<br><br>TB patients with malnutrition identified and managed |

***5.6 Intervention 5.6: Post TB associated disability and Lung disease***
Adopt comprehensive PTLD care in the NTLP guidelines.

**Narrative description.**
Studies have shown that about 45% of post TB patients have disabling post TB Lung Diseases/ conditions (PTLD) such as persistent cough, wheeze, and dyspnea. The unpublished TB Sequel study report has shown up to 73% of TB patients had various degrees of lung impairment of which 26% had severe lung impairment by spirometry measurements

This intervention has been introduced to map the PTLD and build capacity of the program and health care workers on PTLD management. The program will collaborate with professionals in this subject matter to develop a guide and training materials.

**Expected results.**
i. guideline and SOPs for PTLD developed by 2024

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 5.6 Adopt comprehensive PTLD care in the NTLP guidelines. | 5.6.1 Develop technical report on how best to implement PTLD in the health facilities<br>5.6.2 Conduct a PTLD stakeholder meeting to consolidate baseline research findings | Guideline and SOPs for PTLD developed by 2024 |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 5.6.3 Development of guideline and SOPs for operational manual, Algorithms PTLD.<br>5.6.4 Capacity building to HCWs & CHWs on monitoring of the PTLD.<br>5.6.5 Conduct SS/OJT/Mentorship to HF and Community (Spirometer, | |

## SECTION VI: MULTISECTORIAL COLLABORATION AND ACTIONS

**OBJECTIVE 6:**
To Enhance Multi-Sectoral Collaboration and Action for increased, coordinated and accelerated response towards ending TB by 2025.

The Multisectoral Accountability Framework for Tuberculosis response (MAF-TB) aims to support effective accountability of government and all stakeholders in order to accelerate progress to end the tuberculosis epidemic and to be aligned fully with the National Development Vision, End TB Strategy and the 2030 Agenda for Sustainable Development. Under this objective, the Program has planned to facilitate, coordinate and accelerate multi sectoral responses including advocating for TB resources by instigating and sustaining collaborations and actions from various Ministries, Departments, Agencies, the private sector and communities through their organizations (CSOs/NGOs).The envisioned multi-sectoral response, intends to bring together existing social protection mechanisms to support individuals and households affected by TB.

### *6.1 Intervention 1: National TB Multisectoral Committee*
Establish the National TB Multisectoral Committee

**Narrative description.**
The intervention aims at creating a Multi sector Steering Committee which will be formed by the Prime Minister's Office in collaboration with MOH and other ministries. The committee will provide oversight, coordination and periodic high-level review of the National Tuberculosis response. The Committee will be key decision markers in their respective accountable duties relate to the TB control. They will provide guidance on development and implementation of relevant TB legislation and policies. The process of forming the committee began with consultative meetings with the prime minister's office which led to successfully official launch of the MAF TB by the Honorable Prime Minister. There will be a steering committee and the TWG both which the TOR will be developed and Meet bi annually. In order to disseminate and gather more inputs, the steering committee will conduct a joint ministerial meeting will once every year. The members of the committees and the TWG will be capacitated on TB control so that they can make informed policy decisions. In this line policy briefs will be developed to provide evidence.

**Expected results.**
i. Multisectoral actions on social determinants of Tuberculosis enumerated by 2024

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 6.1. Establish of the National Multisectoral Mechanism | 6.1.1. Consultative meetings with Prime Minter's office<br>6.1.2. Conduct targeted advocacy meeting with Key officials of Ministries whose activities have high predisposition to TB to create relevance on the need for multi-sectoral financial and policies investment in TB<br>6.1.3. Develop TOR for MAF TWG, MAF Steering committee | |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 6.1.4. In collaboration with PMO and Implementing partners launch MAF-TB in Tanzania<br>6.1.5. Develop policy brief/factsheet on MAF-TB with clear policy asks for key policy and decision makers (MPs, PSs, Minsters)<br>6.1.6. Conduct bi-annual MAF-TWG meetings<br>6.1.7. Conduct bi-annual steering committee<br>6.1.8. Conduct bi-annual sectorial ministerial meetings<br>6.1.9. Conduct annual joint ministerial monitoring for MAF-TB at ministerial level. | |

### *6.2 Intervention 2: Development of MAF TB*

Operationalize Multisectoral Accountability Framework

**Narrative description:**

The Multisectoral Accountability Framework for Tuberculosis response (MAF-TB) aims at supporting effective accountability of government and all stakeholders in order to accelerate progress to end the tuberculosis epidemic and to be aligned fully with the National Health Sector Strategic Plan V 2021 -2026 and TB and leprosy strategy (NSP VI 2020 - 2025), the End TB Strategy and the 2030 Agenda for Sustainable Development. Under this intervention the MAFT TB Tanzania will be developed where by commitments, actions, monitoring and reporting processes, and review mechanisms will be defined in context of TB situation in Tanzania. The components will also be tailored to fit subnational level accountability. The framework will define who is accountable, what they are accountable for, and who they are accountable to? Accountable bodies will be oriented on TB response and provided with tools to ensure committed actions are met.

The multisectoral accountability framework for tuberculosis (MAF-TB) aims at supporting effective accountability of government and all stakeholders in order to accelerate progress to end the tuberculosis epidemic and to be aligned fully with the National Health sector and hence TB and leprosy strategy (NSP VI), the End TB Strategy and the 2030 Agenda for Sustainable Development. Under this intervention the MAFT TB Tanzania will be developed where by commitments, actions, monitoring and reporting processes, and review mechanisms will be defined in context of TB situation in Tanzania. The components will also be tailored to fit subnational level accountability. The framework will define who is accountable, what they are accountable for, and who they are accountable to? Accountable bodies will be oriented on TB response and provided with tools to ensure committed actions are met.

**Expected Results**

i. A MAFTB Operational plan and its M&E in place

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 6.2. Operationalize Multisectoral Accountability Framework | 6.2.1. Develop MAF-TB guideline to lead and coordinate multi-sectoral response on TB in the country.<br>6.2.2. Develop MAF-TB Operational and M&E Plan<br>6.2.3. Orient Regional and District Authorities on MAF-TB for cascaded multi-sectoral response for TB across all levels.<br>6.2.4. Conduct bi- annual supportive supervision of multi-sectoral responses for TB at regional and district level<br>6.2.5. Review and update key TB guidelines to integrate multi-sectoral responses for TB<br>6.2.6. Conduct TB Caucus and all Member of Parliament bi-annual meeting to increase their understanding towards national end TB and MAF responses<br>6.2.7. Design, develop and disseminate IEC materials (radio spots, TV spots, digital posters, printed poster) to increase sectoral ministries and others awareness on MAF-TB response. | A MAFTB Operational plan and its M&E in place |

### *6.3. Intervention 3: Engagement with private sector, professional societies, civil society and Tuberculosis-affected communities and patient groups*

Stimulate Public and Private sector collaboration and engagement of stakeholders for increased resources to the national TB response.

**Narrative description.**

The intervention focusses on engagement with private sector, professional societies, civil society and Tuberculosis-affected communities and patient groups in the control of the disease including activities enabled and undertaken by these group.

Specifically, the intervention target on creating enabling environment for the engagement of these stakeholders. A mapping exercise will be conducted to identify the stakeholders and their possible roles in TB response. A meeting will be conducted to deliberate on how each can contribute to the response and inform the government on a batter way for their engagement

Through this strategic intervention, the Terms of Reference of the existing TB PPM taskforce team will be revised and their action plan implemented. The task force will be supported to conduct their coordinative meetings. The intervention envisions to create sustainable TB PPM agenda within the existing health and community systems.

**Expected results.**

i. Private sector TB response commitments enumerated by 2024

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 6.3. Stimulate Public and Private sector collaboration and engagement of stakeholdersfor increased resources to the national TB response. | 6.3.1. Map stakeholders such as CSOs/ NGOs, professional bodies, private companies for catalyzed multisectoral response on TB<br>6.3.2. Provide training on TB response advocacy to CSOs, professional bodies and other stakeholders<br>6.3.3. Leveraging HIV Multisectoral AIDS committee to integrate TB in committees at regional and district level<br>6.3.4. Strengthen national and sub-national TB coordination, collaboration, and accountability of TB partners in Tanzania<br>6.3.5. Engage Political leaders, religious leaders and media to catalyze implementation of and coordination of ending TB<br>6.3.6. Coordinate National and regional weeklong youth engagement on quarterly basis to raise awareness on TB<br>6.3.7. Conduct consultative meetings with between the members of parliament and the private and public bodies (academia, professional bodies) sector coalition with aim of building evidence -based advocacy capacity<br>6.3.8. Support professionals and health care workers to advocate for TB response: Meeting and develop advocacy tool presented to high level Government decision makers leaders<br>6.3.9. Conduct national and regional stakeholders' meetings for mobilizing resources for TB | Private sector TB response commitments enumerated by 2024 |

## SECTION VII: LEPROSY CONTROL.

**OBJECTIVE 7:**
To accelerate Interruption of Leprosy Transmission in all councils by 2025

***7.1 Intervention 1: Leadership, Commitment, and Partnerships***
Strengthen leadership, commitment, and partnerships

**Narrative description.**
A robust leadership and partnership are required to ensure leprosy is eliminated. Thus, in this intervention opportunities for partnerships to obtain resources for leprosy response will be created. Key activities include the dissemination of Zero Leprosy Country model & Roadmap 2023-2030, planning for establishing surveillance activities, stakeholders meeting and capacity build to care providers. Experts will be gathered to develop the leprosy research agenda.

**Expected results**
i Leprosy research agenda in place by 2024

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 7.1 Strengthen leadership commitment and partnership | 7.1.1 Collaborate with stakeholders to mobilize resources for leprosy interventions and integrate leprosy with other diseases and other national health program annually.<br>7.1.2 Training of 30 healthcare providers in each 10 endemic regions at least once in 3 years (MTR)<br>7.1.3 Disseminate and rollout of Tanzania Zero Leprosy Country model & Roadmap 2023-2030<br>7.1.4 Conduct annual stakeholders meeting to review progress of implementation of zero leprosy roadmap<br>7.1.5 Conduct annual supportive supervision in 3 endemic and 3 non-endemic leprosy regions<br>7.1.6 Conduct planning forums to rollout of AMR Surveillance activities at CTRL and zonal levels<br>7.1.7 Conduct workshops to develop and review leprosy research agenda on annual basis | Leprosy research agenda in place by 2024 |

### *7.2 Intervention 2: Leprosy Prevention and Integrated Active case detection*

Scale up leprosy prevention alongside integrated active case detection

**Narrative description**

In order to attain elimination, hotspots areas will facilitate impactful targeted preventive strategies thus through this intervention the programme aims to sustain leprosy elimination by using epidemiological and GIS methods to identify geographic clusters of leprosy cases in order to identify hidden hotspots for intensified case finding through household contact screening. The programme will also use this information to conduct targeted leprosy screening campaigns in identified councils. The campaign activities will be implemented alongside leprosy communication, advocacy, social mobilization, and operational researches.

Leprosy elimination interventions' package for endemic councils will be developed and the capacity of healthcare providers' skills in diagnosis and treatment of Leprosy will be enhanced in order to provide adequate treatment to new cases and reduction of disability grade 2 in all regions. Councils will be supported to conduct targeted active case findings campaign in selected endemic area and hot spots

**Expected results**

i. All high endemic councils and hotspots reached with leprosy screening campaigns.
ii. 100% of new leprosy cases household contacts are screened for leprosy.
iii. 50% reduction of cases with disability grade 2 among newly diagnosed leprosy patients detected.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 7.2 Scale up leprosy prevention alongside integrated active case detection | 7.2.1 Conduct localized geo-spatial analysis to Identify Leprosy high endemic councils and hidden hot spots<br>7.2.2 Support councils to conduct targeted active case findings campaign in selected endemic area and hot spots<br>7.2.3 Develop and distribute leprosy elimination interventions' package for endemic councils<br>7.2.4 Conduct planning meeting for elimination activities in endemic districts<br>7.2.5 Develop IEC materials for leprosy elimination activities<br>7.2.6 Broadcast TV and radio spots for leprosy elimination activities<br>7.2.7 Support training of HFs to scale up of household contact screening and PEP in endemic councils<br>7.2.8 Develop PEP field manual and SOP, data collection, monitoring checklist and reporting tools<br>7.2.9 Orient health management teams at both region and council levels on PEP interventions | 100% of new leprosy cases household contacts are screened for leprosy |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 7.2.10 Support CHVs to conduct household contact screening and provision of SDR during scale up of targeted PEP in endemic councils<br>7.2.11 Sensitize community leaders, CHVs and PALs, POD committees, CORPs on PEP interventions<br>7.2.12 Support region and council technical officers to conduct SS and mentorship to HFs to implementing PEP<br>7.2.13 Integrate procurement and distribution of SDR drugs along with anti-TB ordering system | |

***7.3 Intervention 3: Leprosy Complications and Disability Management***
Manage Leprosy and its complications and prevent new disability

**Narrative description.**
The programme will develop, print and distribute operational manual for POD and self-care services and formation of self-care groups. Initiatives will be made to include leprosy case finding and POD matters into community-based TB care guidelines. The R/DTLCs will support the existing self-care groups and train PALs to establish new self-care groups. As part of the empowerment process, capacity building activities will be done. PALs through leprosy association will strengthen their organizations and take active role in Leprosy prevention, treatment, care and rehabilitation. The program will continue to support referral of PALs to health zonal centers for physical rehabilitation.

Due to the high demand of the special services to PALs the program intends to procure and distribute assistive devices including special footwear, materials, prosthesis and other physical rehabilitation appliances from quality assured factories to be provided to PALs through existing rehabilitation centers and regional medical officers.

To improve care for those affected, the programme will continue to collaborate with implementing partners to provide Leprosy case management services including provision of Prevention of Disability (POD) and Self-care services, engaging more PALs. In addition, the program will expand services in the area of Community Based Rehabilitation (CBR) and provide referral packages for those who require specialized care at consultant referral hospitals including provision of shoe making materials, special protective boots and prosthesis.

**Expected results.**
i. 25% of Communities, PALs groups and leprosy survivors' association are supported in implementing Leprosy control activities by 2022.
ii. 80% of PAL have received footwear and prosthesis by 2025.
iii. 50% of all districts with PALs establish self- care groups.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 7.3 Manage Leprosy and its complications and prevent new disability | 7.3.1 Review and Develop Operational Manual for conducting POD and Self-care services at councils<br>7.3.2 Develop facilitation and training manual on self-care for PAL<br>7.3.3 Identify and formulate 2 self-care groups in each district in 20 districts<br>7.3.4 Support and Maintain 2 self-care groups in 20 leprosy endemic districts<br>7.3.5 Train persons affected by leprosy groups on POD activities<br>7.3.6 Provide Transport and allowances for patients to receive specialized rehabilitative care Integrate procurement and distribution of SDR drugs along with anti-TB ordering system<br>7.3.7 Procure and distribute protective footwear to PAL annually.<br>7.3.8 Procure and distribute special shoe making materials, Prostheses and other appliances for PALs<br>7.3.9 Develop and introduce mental health assessment tools & referral guideline to health facilities<br>7.3.10 Orient health management teams at both region and council levels on Mental health assessment tools | 80% of PAL have received footwear and prosthesis by 2025 |

### *7.4 Intervention 7.4: Stigma Reduction and Human Rights Protection*

Combat stigma and ensure human rights are respected

**Narrative description**

People affected by leprosy continue to suffer discrimination and lack of access to medical care. Tackling social vulnerability is key to reducing the transmission and prevalence of leprosy. The NSP VI and the Zero Leprosy Country model & Roadmap 2023-2030 have prioritize addressing discrimination, exclusion and disability.During this period in line with the implementation of the roadmap 2023-2025, sensitization and counselling will be offered to empower family members in the endemic councils. Integrated patient centered care will continue to be advocated to improve leprosy patients lives.

**Expected results.**

i. Proportion of Leprosy patients experience stigma at health facilities reduced

| Strategic Intervention | | Activities | | Expected Results |
|---|---|---|---|---|
| 7.4 | Combat stigma and ensure human rights are respected | 7.4.1 | Monitor availability and quality assistive devices (aids and appliances) | Proportion of Leprosy patients experience stigma at health facilities reduced |
| | | 7.4.2 | Conduct sensitization and Counselling of Leprosy affected family members on stigma reduction, advocacy, and awareness creation in endemic councils | |
| | | 7.4.3 | Advocate integration of leprosy services in routine health services including wound cares | |

## SECTION VIII: SUPPORTIVE SYSTEMS.

**OBJECTIVE 8:**
To ensure availability of supportive systems and strengthened program management and coordination for the Implementation of TB and Leprosy services by 2025.

Under this objective the program has planned to capacitate and support communities, private sectors, health products management systems and strengthen programme management to support delivery of quality TB services.

### A. PROGRAM MANAGEMENT.

***8.Intervention 8.1: Human Resource Management.***
Improve human resources capacity, planning and management for TB and Leprosy.

**Narrative description.**
In the next three year, the NTLP will continue to strengthen implementation of TB and Leprosy programme, by ensuring effective coordination and management of national programme.

The programme will develop human resource management plan, which addresses the issues of recruitment and placement of competent staff. A situation analysis to identify resources to implement the program activities will be conducted followed by a plan based on the identified needs. The programme will focus on career development to ensure that every staff is trained on issues related to TB and Leprosy control. The envisioned plan will emphasise on building staff capacity through on-job training, mentoring, coaching and supervision to enable them perform their job more efficiently and effectively.

**Expected results.**
i. 80% of programme staff trained in management by 2025
ii. NTLP Human resources gap is reduced from 24% to 10% by 2025

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 8.1 Improve human resources capacity, planning and management for TB and Leprosy | 8.1.1 Conduct situation analysis to identify man power required to implement program activities<br>8.1.2 Recruit and provide staff salaries<br>8.1.3 Support National Staff for local and International Training<br>8.1.4 To conduct in-house capacity building retreat for NTLP<br>8.1.5 Prepare NTLP training needs assessment/analysis plan<br>8.1.6 To develop human resource plan for the program<br>8.1.7 Procure office equipment, office supplies & consumables<br>8.1.8 Service and Maintenance of Office Equipment<br>8.1.9 Support Office Security and cleaning services | 80% of Programme staff trained in management<br><br>NTLP Human resources gap is reduced from 24% to 10% by 2025 |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 8.1.10 Renovate office buildings and fittings<br>8.1.11 Provide internet and ICT services at office<br>8.1.12 Procurement of various software for data analysis, office use and research purposes<br>8.1.13 Support NTLP staff to attend professional meetings | |

***8. Intervention 8.2: Programme Coordination.***
Strengthen coordination and Management of implementation of SP

**Narrative description.**
Effective implementation of the strategic plan requires effective government stewardship, political commitment and enhanced resources. This intervention will complement other activities in other objectives which focus collaboration of NTLP with the MoH units, other ministries and partners. This intervention will focus in overall high-level coordination bringing together all coordinative efforts in respective thematic areas. This will be achieved by assuring commitment in the response by developing the strategic plan, its operational plans, and annual work plans. Participation of all stakeholders will be ensured. Under the leadership of the PM , the thematic technical working groups will be conducted and monitored for the program quality assurance. The program will strategically participate in the MoH's policy and planning platforms to gain more political commitment and move the Leprosy and TB agenda to higher authorities. Annual and quarterly NTLP meetings will be conducted to discuss progress and plan for better program performance.

**Expected results.**
i. 4 annual NTLP meetings conducted by 2026.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 8.2 Strengthen coordination and Management of implementation of SP | 8.2.1 Develop Strategic Plan and associated documents for Tuberculosis and leprosy control<br>8.2.2 Participant in MoH policy, strategies and guidelines activities<br>8.2.3 Review and develop NTLP annual plan of action<br>8.2.4 Conduct bi-annual national staff general meetings<br>8.2.5 Conduct Annual NTLP Meetings<br>8.2.6 Procure and maintain motor vehicles and motorcycle for programme coordination at all levels<br>8.2.7 Maintain programme websites<br>8.2.8 Engage relevant institutions to include TB programmatic update into preservice training curriculum<br>8.2.9 Conduct Partners coordinative meetings | 4 annual NTLP meetings conducted by 2026. |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 8.2.10 Advocacy for TB and leprosy control to other Ministries and within MoH | |

***8.3 Intervention: Resource mobilization and management for NSP***
Improve resource mobilization and management for NSP

**Narrative description**
Successfully implementation of interventions requires availability of resources, however for years the implementation of the NSP has been constrained of resources both human and monetary. This intervention focus on monetary resources while the intervention 8.1 deal with human resources. A funding gap of 35% is currently existing with majority of the available resource form external sources. Hence the Program will continue to implement activities which gears towards resourcing from both external and domestic. In line with implementation of MAF TB (Objective 06) the Stop TB partnership will continue to be supported as an advocating vehicle of local support.

**Expected results**
i. NTLP resource mobilization and sustainability plan in place by 2025

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 8.3 Improve resource mobilization and management for NSP | 8.3.1 Support and develop proposal for resource mobilization<br>8.3.2 Support in cooperation of TB and leprosy activities into CCHP and DHFF.<br>8.3.3 Support establishment and functioning of Stop TB Partnership Tanzania chapter<br>8.3.4 Conduct advocacy meetings with the local government authorities<br>8.3.5 Advocate for political leaders on Sensitize TB and leprosy budget | NTLP resource mobilization and sustainability plan in place by 2025 |

***8.4 Intervention : Accountability of TB and leprosy Programme.***
Ensure accountability of TB and leprosy Programme at all levels

**Narrative description.**
While the 6th objective focuses on TB response accountability beyond the MOH, this strategic intervention is implemented strategically to address measures to ensure the Program accountability to the response. The NTLP team will conduct quarterly internal auditing, annual stocktaking for office facilities and supplies. Training NTLP staff on prevention and combating of corruption and grant oversight will also be offered.On the other hand, NTLP staff will be responsible for successfully completing the tasks and will be held accountable for failing to accomplish the tasks.

**Expected results.**
i. Auditing is timely conducted

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 8.4 Ensure accountability of TB and leprosy Programme at all levels | 8.4.1 Support Internal Auditors to provide assurance on NTLP activities<br>8.4.2 Facilitate grants oversight and management<br>8.4.3 Conduct annual inventory of programme assets and maintain asset register<br>8.4.4 Conduct annual physical stocktaking of TB and Leprosy commodities<br>8.4.5 Preparation of Annual Procurement Plan and Quarterly Review | Auditing is timely conducted |

## B. COMMUNITY SYSTEMS STRENGTHENING.

***8.5 Intervention 8. : Community linkages and coordination.***
Strengthen community linkages and coordination.

**Narrative description.**
In the previous NOSP there were two community TB Networks, MKUTA for EX-TB patients' groups and TTCN for CSOs implementing community activities. These networks supported community linkage and coordination for community TB response in the country. However there was a gap of linkage and coordination between TB –EX patients, health facilities and community authorities. Technically, the coordination has been done by Community TB - TWG. In order to realise effective community involvement there should be a presence of clear coordination for strong community response on TB control in the country.

Therefore in this NOSP the networks will be supported to strengthen the linkage and coordination through capacity building of community Led CBOs and EX-TB patients' groups in terms of resource mobilization, advocacy and monitoring for community response as part of paradigm shift from top-down efforts to control of the epidemic to a multisectoral collaboration to end TB, that is people-centered, human rights-based and Gender responsive.

Through TTCN's one impact application will provide a digitalized platform for the actors' feedback and networking to improve and scale-up community monitoring and linkage.

**Expected results.**
i. 25% increase in CSOs offering TB and leprosy services.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 8.5 Strengthen community linkages and coordination | 8.5.1 Facilitate district community health Coordinator to oversee TB and leprosy community interventions.<br>8.5.2 Support Tanzania TB Community Network (TTCN) systematic and effective community engagement and overseeing implementation of the National CRG Action Plan<br>8.5.3 Conduct quarterly community TB TWG meetings | 25% increase in CSOs offering TB and leprosy services |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 8.5.4 Support CBOs implementing TB including TB survivors' groups to participate in planning, implementation and monitoring of TB response.<br>8.5.5 Support community led CBOs and Network for community interventions<br>8.5.6 Support mobilization of EX-TB groups to improve coordination and linkages between community and formal health system.<br>8.5.7 Orient newly employed CSOs field officers in new projects on TB and Leprosy control, their roles and responsibilities and partnership with the government | |

***8.6 Intervention 8.6: Removing Human Rights and Gender Related Barriers.***
Address the underlying social determinants and barriers to TB services and leprosy services.

**Narrative description.**
Stigma and other related issues have been hindering access and utilization of TB services for years among communities especially the TB key and vulnerable populations in the country. The NSP 2020 – 2025 will increase community involvement in the fight against TB in the country by strengthening community linkages and coordination to address underlying social determinants and barriers to TB services, as well as promoting advocacy and communication for TB and leprosy control.

The country has used the results of the stigma index and the 2019 patient cost survey to develop a TB Social Protection operational plan which will begin to be implemented. The CRG Operational Plan (2020-2023) will be reviewed and continue its implementation by working with law makers, legal rights advocates, law enforcers and Community Networks to address legal and gender barriers to TB services.

Expected results.
i. TB Social protection operational plan implemented.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 8.6 Address the underlying social determinants and barriers to TB services | 8.6.1 Support community dialogue to identify gender and human right TB related issues.<br>8.6.2 Print and distribute TB patient charter in line with the revised MoH patient charter<br>8.6.3 Design and share TB related medical ethics and human rights video clips to health care providers and community Health workers, TB survivors using TB E- platform in the country. | TB Social protection operational plan implemented. |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 8.6.4 Conduct consultative meeting with Legal Reform Commission and human rights services organs on TB CRG response<br>8.6.5 Conduct consultative dialogues to brief TB caucus members on CRG response<br>8.6.6 Develop and monitor implementation of TB social protection operation plan<br>8.6.7 Develop an action plan to address community norms that drive stigma and discrimination based on the findings and recommendations from the TB Stigma assessment.<br>8.6.8 Develop TB stigma elimination communication materials for use in health facilities and the communities<br>8.6.9 Conduct training workshops for journalists and media professionals including during WTD on TB, CRG and stigma.<br>8.6.10 Develop and roll out TB gender operational plan on gender-sensitive care on TB at all levels<br>8.6.11 Conduct refresher courses on community TB, CRG and CLM to R/DTLCs and DOT nurses<br>8.6.12 Integrate CRG module into the NTLP manual and Print and distribute CRG guidelines to stakeholders<br>8.6.13 Develop CRG TB training materials for health care workers<br>8.6.14 Train Health care providers to deliver KVP friendly, gender responsive and right based TB services | |

### *8.7 Intervention 8.7: Community Led Monitoring*

Adapting and implement TB Community Led Monitoring (CLM)

**Narrative description**

After successfully development of the CRG operational plan which informed the NSP VI, CLM was identified as among important means to enhance community engagement as well as improve quality of the Program is an accountability mechanism that “empowers and engages people affected by TB to know their rights and to report the barriers that prevent them from being diagnosed, treated, and cared for. Through this intervention, the Program ensures CLM is implemented in the country by providing necessary environment, knowledge and skills of to the community. Different models will be encouraged and once information is collected it will then be used by communities and NTLP to address gaps and challenges.

**Expected results**

i. 90 District councils implementing CLM by 2026

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 8.7 Adapting and implement TB Community Led Monitoring | 8.7.1 Develop A community-led Monitoring implementation guide/framework for CSOs, Communities, IPS, regions and districts.<br>8.7.2 Support implementation of Community monitoring platform (One Impact- TB Kiganjani)<br>8.7.3 Train CSOs, IPS, regions and districts on the use of OneImpact (TB Kiganjani)<br>8.7.4 Link community-led monitoring (CLM) indicators to National M&E systems.<br>8.7.5 Conduct quarterly CLM implementer's progress review meetings to review the CLM data to improve programming.<br>8.7.6 Support utilization of CLM data to all stakeholders including decision makers. | 90 District councils implementing CLM by 2025 |

***8.8 Intervention 8.8: Advocacy communication and social mobilization.***

Promote advocacy and communication for TB and leprosy control services including

**Narrative description.**

TB and leprosy Advocacy, communication, and Social Mobilization strategy (ACSM) was launched on 2016. The revised ACSM strategy has been developed with new developments and key issues addressing TB, DR TB, TB/HIV and CRG issues. The mixed approaches for ACSM will be used to reach the targeted audiences (TV and Radio spots, Social media, print media, WTBD campaigns, Community Dialogue, Community theatre groups. The use of influential people such as political figures and national celebrities will also be emphasized.

**Expected results.**

i. Increased TB and leprosy knowledge among community members.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 8.8 Promote advocacy and communication for TB and leprosy control services | 8.8.1 Validate messages, pretest, print and distribute SBCC materials to address TB, DR TB, TB/HIV and CRG issues<br>8.8.2 Conduct community dialogue and TB screening during World TB Day commemoration<br>8.8.3 Review and update orientation package for journalists on TB and CRG issues | Increase TB and leprosy knowledge among community members |

| Strategic Intervention | | Activities | | Expected Results |
|---|---|---|---|---|
| 8.7 | Adapting and implement TB Community Led Monitoring | 8.8.4 | Conduct sensitization meeting with councilors and parliamentarians on various key on TB control issues and CRG | 90 District councils implementing CLM by 2025 |
| | | 8.8.5 | Disseminate various Advocacy and SBCC materials to address TB Related issues including CRG | |
| | | 8.8.6 | Support TB survivors' groups and CSOs to undertake advocacy and lobbying campaigns for improved availability, accessibility and quality of service and social accountability; and domestic resource mobilization | |

## C. PUBLIC PRIVATE MIX.

***8.9: Intervention 9 : Public Private Mix.***

Strengthen TB care, treatment and prevention services in private health sector including Engagement of ADDO, pharmacies, traditional healers and private labs in TB case detection.

**Narrative description.**

While objective 6 focuses in engagement with private sector, professional societies, civil society and tuberculosis-affected communities in general, this intervention is specifically targeting private sector in service delivery. There is still low number of private health facilites engaged in TB services.

APHFTA and MOH has continued to collaborate to ensure more private facilities are engaged. The MTR have recommended involving the APHFTA as an intermediary agency. The NSP will explore this by conducting assessment and stakeholders' dialogues

NTLP has also developed national guidelines for TB control at workplaces targeting high risks workplaces, through this strategy more workplaces will be reached out.

In this NSP, the program will revise its PPM plan of Action 2017 -2021 to incorporate new WHO PPM roadmap and other developments. Furthermore, sensitization meetings to private health facilities owners will be conducted in all regions.

Quarterly supportive supervision to to private health facilites providing TB services will also be conducted.

In the last NSP, program engaged drug shops in TB case detection in 20 regions. More than 1,000 drug sellers were oriented and equipped with tools to facilitate referrals of TB presumptive to the diagnostic facilities. Particularly, TUWAFIKIE project under TB REACH support implemented in Iringa and Kagera regions has shown best lessons in this regard. In this NOSP there will be expansion of these best practices to engage more ADDOs and community volunteers in order to boost TB case detection. To date NTLP has maintained engagement with 1440 ADDOs & 360 Traditional Healers using an integrated approach involving community health workers, ADDO Dispensers and diagnostic facilities.

A number of community members do seek medical attention from traditional healers. Some of them are TB presumptive cases. The situation put Traditional healers at risk for TB disease at the same time be a reservoir of the disease putting their clients and families at risk as well.

In 2018, one-month TB screening in 25 traditional healers' homes in Misungwi, Magu, Sengerema and Kwimba in Mwanza was conducted involving 28 CHWs. A total of 724 clients were screened for TB and 137 were identified as TB presumptive, all were tested for TB. Of those tested, 17 (12.4%) were confirmed with susceptible TB and two were confirmed Drug Resistant TB patients, of whom, one was a Traditional healer. This NOSP will continue to expand network of Traditional healers and herbalists to find potential TB cases.

**Expected results.**

i. 75% of all registered private health facilities which are eligible to provide TB services engaged in TB services by 2025.
ii. 5,000 ADDOs engaged in TB case detection by 2025.
iii. 50% of the traditional healers and herbalists reached out to provide TB services by 2025.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 8.9 Strengthen TB care, treatment and prevention services in private health sector including Engagement of ADDOs, pharmacies, traditional healers and private laboratories in TB | 8.9.1 Situational assessment and review and update the PPM POA 2017 – 2021 in line with WHO PPM roadmap for TB care and prevention<br>8.9.2 Conduct sensitization meetings to owners of private health facilities, APHFTA, CBOs, FBOs and NGOs on TB control and PPM engagement in 26 regions in the country.<br>8.9.3 Conduct assessment to ascertain readiness of the identified Private health facilities to provide TB and PMDT services in 26 regions.<br>8.9.4 Conduct training to 1300 health care providers from private hospitals and selected health centers on TB and TB/HIV management of TB in 26 regions.<br>8.9.5 Print and disseminate the TB workplaces guidelines to 26 regions<br>8.9.6 Facilitate National PPM task force team bi-annual meeting including review of the TOR<br>8.9.7 Conduct Supportive supervision and mentorship visits to the workplace with high TB risks including addressing the barriers and compensation mechanisms for employees<br>8.9.8 Conduct Sensitization meeting to owners of ADDOs, retail pharmacies and private laboratories on TB services. | 70% of ADDO implementing TB specific services by 2025<br><br>50% of registered traditional healers and herbalists reached out by 2025<br><br>50% of the traditional healers and herbalists reached out to provide TB services by 2025. |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 8.9.9 Conduct orientation to ADDOs dispensers on TB symptoms, sputum collection and referral system<br>8.9.10 Procure and distribute cooler boxes to facilitate sputum samples storage from ADDOs and Traditional healers<br>8.9.11 Print and distribute training and IEC materials for ADDOs<br>8.9.12 Estimate size and distribution of traditional healers in the country (compile data per council)<br>8.9.13 Conduct orientation to Traditional Healers on identification and referral of presumptive TB among their clients<br>8.9.14 Conduct joint supportive supervision and mentorship on implementation of TB and Leprosy services to private health facilities and facilitate Integration of TB agenda into the existing Regional PPP meetings and facilitate signing of Service Level agreement between DTLCs and Private Health Facilities on provision of TB screening, detection and referrals<br>8.9.15 Conduct quarterly implementation progress meetings. | |

## D. HEALTH PRODUCT MANAGEMENT SYSTEM.

***8.10 Intervention: Procurement and Supply Chain***.
Ensure uninterrupted supply of TB and Leprosy medicines, Laboratory commodities and other supplies

**Narrative description.**
To ensure uninterrupted supply of quality TB and Leprosy medicines and laboratory commodities the programme intends to continue to conduct bi-annual quantification exercise to review assumptions and update forecasts and supply plan at national level. There will also be efforts to strengthen the use of e-LMIS for TB medicines and laboratory commodities at sub-national level and orient regional and district pharmacists on quantification and forecasting of TB and Leprosy commodities. The programme will continue to ensure all commodities are procured, cleared from the port of arrival and distributed to health facilities on time.

A sub-committee for TB and Leprosy pharmaceutical management will be established to coordinate estimation of TB and Leprosy medicines needs, planning and monitoring delivery schedules and oversee implementation of related activities. TB and Leprosy stock status will be regularly monitored and estimated annual needs will be reviewed and updated on

quarterly basis to facilitate early identification of potential stock outs or possible wastage. A demand-based supply chain management system for TB and Leprosy medicines and laboratories commodities will be introduced to improve TB and Leprosy medicines documentation, ordering and reporting based on the recommendation from on-going piloting of logistic system for TB and Leprosy.

NTLP will coordinate with Global Drug Facility and partners to make sure first and second line childhood TB medicines are available, procured and distributed timely. Furthermore, the programme will train health care workers on the management of childhood TB drugs and supplies in collaboration with Pharmaceutical Supplies Unity (PSU) of the Ministry. The programme will also collaborate with Tanzania Medical and Medical Devices Authority (TMDA) and other authorities to monitor the quality of childhood TB drugs imported in the country.

To ensure appropriate use of TB and Leprosy medicines and other commodities in line with standard treatment guidelines, the program will conduct drug utilizations reviews, trainings, and supervision. NTLP will also work closely with the Tanzania Food and Drug Authority (TFDA) to strengthen monitoring system for adverse drug reactions (ADR) and product quality through rolling out trainings on ADR monitoring and reporting.

**Expected results.**

i. No stock out of TB and Leprosy medicines.
ii. ADR report on TB and leprosy medicines available.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 8.10 Ensure uninterrupted supply of TB and Leprosy medicines, Laboratory commodities and other supplies | 8.10.1 To conduct quarterly quantification review with different stakeholders and update the supply plan for TB commodities.<br>8.10.2 To eLMIS training to HCW's and rollout electronic Facility Monthly form<br>8.10.3 To review and update eLMIS SOP's, and training materials and manuals<br>8.10.4 To conduct quarterly TB commodities stock verification and reconciliation at MSD and regions<br>8.10.5 To conduct annual TBL stakeholders' meeting to strengthen performance of the logistics system.<br>8.10.6 Review DTLC and Laboratory training materials so as to incorporate the TBL logistics management system.<br>8.10.7 Train HCWs on the management of TB and Leprosy medicines, and TB laboratory commodities as per the re-designed logistics system<br>8.10.8 To conduct mentorship and on-job training to HCWs on the ordering, distribution and use of FLD and SLD pediatrics formulations. | No stock out of TB and Leprosy medicines. |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 8.10.9 Adapt WHO planning and budgeting for TB and drug resistance TB testing tools<br>8.10.10 Carry out operational research to explore factors contributing to underutilization of the FLD pediatric formulations | |

## SECTION IX: MONITORING, EVALUATION AND LEARNING.

**OBJECTIVE 9:**
To implement evidence-based interventions and decision making through institutionalized efficient Monitoring and Evaluation system and coordination of research by 2025.

***9.1 Intervention 1: TB Surveillance Systems.***
Improve the TB surveillance system's ability to accurately measure the burden of TB.

**Narrative description.**
The Programme rolled out a TB and leprosy case-based electronic system (DHIS2-ETL) in all councils in the country in 2018. In this intervention the Programme will improve the system by digitalizing community tools and TPT register, upgrade the DHIS2-ETL to WHO standards. To facilitate training of HCWs on the use of the system, the programme will develop video and audio tutorials

Furthermore, as the last PST was conducted in 2012, there is a need to conduct another PST after period of 10 years of implementation in order to understand the true TB burden at national, subnational and among Key vulnerable Population (KVPs) and thus guide resource allocation and strategies.

**Expected results.**
i. 90% of TB and leprosy key epidemiological Indicators are generated through the DHIS2-ETL.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 9.1 Improve the TB surveillance system's ability to accurately measure the burden of TB | 9.1.1 Integrate community and TPT monitoring tools with DHIS2-ETL system<br>9.1.2 Conduct routine maintenances, upgrades and updates of DHIS2-ETL system including updating of Indicators and variables.<br>9.1.3 Orient National, Regional and District TB and Leprosy Coordinators and healthcare workers on the updated DHIS2-ETL system<br>9.1.4 Procure computers and accessories for data management<br>9.1.5 Develop and Disseminate video and audio tutorial on DHIS2-ETL use for coordinators and HCWs at all levels<br>9.1.6 Conduct TB surveys including TB prevalence and Drug resistance surveys<br>9.1.7 Link laboratory data to DHIS2-ETL system and other laboratory Information systems.<br>9.1.8 Adapt WHO laboratory model in DHIS-ETL system<br>9.1.9 Update and Print TB and Leprosy recording and reporting tools | 90% of TB and leprosy key epidemiological Indicators are generated through the DHIS2-ETL. |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| | 9.1.10 Advocate coordination and collaboration with MoH ICT to ensure TB program data needs are met such as for establishment of unique ID, rollout of the vital registration ICD-10 system<br>9.1.11 Establish TB National data working group (Bi annual Data review meetings) | |

***9.2 Intervention 2: Quality of TB data***.
Improve the quality of TB and leprosy data.

**9.2.1 Narrative description.**
Both TB surveillance system assessment study and Programme review pointed out the need to improve the quality of TB and leprosy data. In order to achieve these, the programme will and print routine data management guidelines including quality assurance guidelines and checklist to accommodate DHIS2-ETL system, conduct routine data quality assessment to all levels and conduct TB inventory study to determine the TB under-reporting rate. The intervention will be implemented in collaboration with national and international stakeholders.

**Expected results.**
i. Under-reporting rate reduced to < 5%.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 9.2 Improve the quality of TB and leprosy data | 9.2.1 Revise and Print routine data management guidelines including quality assurance guidelines and checklist to accommodate DHIS-ETL system<br>9.2.2 Conduct routine data quality assessment to regions, districts and health facilities<br>9.2.3 Conduct TB inventory study to measure TB under reporting<br>9.2.4 Conduct TB Surveillance system assessment<br>9.2.5 Conduct TB epidemiology review and TB Surveillance system assessment<br>9.2.6 Conduct by bi-annual national data review Meeting at national level (IPs & Partners M&E staff) | Under-reporting rate reduced to < 5% |

***9.3 Intervention 3: Data Analysis and Use.***
Build capacity for data analysis and use at all levels.

**Narrative description.**
The Programme has a lot of data collected over the years. Studies and assessments such as evaluation of TB surveillance systems, epidemiology and impact analysis indicated a low use of data especially at lower levels.

To reverse this, the programme will conduct training to coordinators at central and subnational levels to enable them to critically review surveillance data and use them for policy adaptations and dissemination to regional and lower levels. The DHIS2-ETL dashboard adopted from the WHO TB facility data use dashboard will be utilised as a source of data.

In addition, the Program will invest in building capacity for advanced analysis of the case-based data. The data analysis plan will be developed and implemented.

**Expected results.**

i. 100% of regions produce quarterly analytical report as per nationally agreed plan and reporting format.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 9.3 Capacity building of data analysis and use at all level | 9.3.1 Finalize, print and disseminate guideline for sub-national data analysis, use and interpretation in line with WHO TB facility data use guideline<br>9.3.2 Develop video tutorial and guide on data analysis, use and interpretation<br>9.3.3 Conduct data analysis and use training to HCWs using DHIS2-ETL dashboard<br>9.3.4 Conduct annual deduplication exercise of DHIS2-ETL dataset<br>9.3.5 Develop TB and Leprosy data analysis and use workshops at all level<br>9.3.6 Procure statistical and visualization software packages e.g Tableau, STATA, and Power BI<br>9.3.7 Conduct training to RTLC and DTLC on quarterly analytical reporting template (data use training) | 100% of regions produce quarterly analytical report as per nationally agreed plan and reporting format |

***9.4 Intervention 4: Monitoring Implementation of NOPS VI.***

Monitor the implementation of the TB and Leprosy NSP VI.

**Narrative description.**

In order to monitor and evaluate the NSP, the programme will train national and sub-national staff on supervisory and mentorship skills. Regular and effective supervisions and mentoring will be conducted at all implementation levels. The national level will supervise regions at least once per year, regional level will supervise each district quarterly and districts will supervise diagnostic centres monthly and quarterly to treatment centres. The programme will conduct the end-term evaluation at the end of implementation of the Strategic Plan.

In line with MTR recommendations, this intervention will also focus on cascades analyses and impact evaluation of the implemented strategies.

**Expected results.**

i. 90% of NTLP interventions monitored and evaluated by 2025.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 9.4 Monitor the implementation of the TB and Leprosy NSP VI | 9.4.1 Conduct quarterly regional data reviewing meetings<br>9.4.2 Conduct annual stakeholder's reviewing meetings<br>9.4.3 Conduct annual Supportive supervision and mentorship visits to region by national staff<br>9.4.4 conduct quarterly regional supervisions and mentorships to districts<br>9.4.5 Conduct monthly district supervisory and mentorship to health facilities<br>9.4.6 Digitalize the supportive supervision checklist<br>9.4.7 Conduct Mid and End term Programme review<br>9.4.8 Conduct cascade analysis and Develop an impact framework for all the programmatic interventions implemented by NTLP and IPs<br>9.4.9 Orient RHMTs, CHMTs and HCWs on the updated NSP VI | 90% of NTLP interventions monitored and evaluated by 2025 |

***9.5 Intervention 5: TB and Leprosy Operational Research Agenda.***
Develop and implement TB and Leprosy Operational Research agenda.

**Narrative description.**
The program will develop TB & Leprosy agenda to guide and prioritise areas of research interest. Capacity building to coordinators at national and subnational levels will be at the heart of the implementation of these researches, such that results are used timely to improve TB and leprosy services

**Expected results.**
i. Operational Research Agenda updated, utilized and evaluated every three years.
ii. TB and Leprosy Operational Research Symposium conducted at least twice a year.

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 9.5 Develop and implement national TB and Leprosy research plan | 9.5.1 Conduct Operational Research Coordinating Committee Meetings<br>9.5.2 Conduct Operational Research TB Symposium<br>9.5.3 Conduct coordinative meeting between national and international stakeholder's<br>9.5.4 Train staff at central, regional and districts levels on research methodology | |

| Strategic Intervention | Activities | Expected Results |
|---|---|---|
| 9.5 Develop and implement national TB and Leprosy research plan | 9.5.5 Support staff and graduate students to conduct operational researches on TB and leprosy<br>9.5.6 Develop national TB and leprosy Research Repository<br>9.5.7 Conduct and coordinate 1 operational research each year<br>9.5.8 Develop and share annual bulletins on National and sub-National analytical reports | |

## SECTION X: COSTING FOR THE STRATEGIC PLAN

## BUDGET BY STRATEGIC INTERVENTIONS

| Interventions | Frequency | | | TOTAL USD |
|---|---|---|---|---|
| | 2023/2024 | 2024/2025 | 2025/2026 | |
| **Objective 1: To increase TB treatment coverage from 53% in 2018 to 90% in 2025 by innovatively addressing barriers to access, utilization and the needs of the key and vulnerable populations for TB care and prevention services** | | | | |
| Strategic Intervention 1.1: | 7,520,385 | 8,855,603 | 8,635,103 | 25,011,090 |
| Strategic Intervention 1.2 | 19,094,992 | 19,246,639 | 19,246,639 | 57,588,270 |
| Strategic Intervention 1.3 | 727,041 | 503,804 | 503,804 | 1,734,649 |
| Strategic Intervention 1.4 | 259,701 | 242,395 | 242,395 | 744,490 |
| Strategic Intervention 1.5 | 2,836,760 | 2,893,496 | 2,893,496 | 8,623,752 |
| Strategic Intervention 1.6 | 1,162,615 | 290,087 | 290,087 | 1,742,788 |
| Strategic Intervention 1.7 | 1,202,976 | 452,063 | 88,618 | 1,743,657 |
| Strategic Intervention 1.8 | 791,536 | 134,429 | 134,429 | 1,060,395 |
| **Total Objective 1** | **33,596,006** | **32,618,515** | **32,034,569** | **98,249,090** |
| **Objective 2: To expand access to quality TB diagnostic services, including the adoption of new diagnostic technologies.** | | | | |
| Strategic Intervention 2.1 | 6,176,300 | 5,745,267 | 6,769,676 | 18,691,243 |
| Strategic Intervention 2.2 | 433,019 | 533,270 | 438,857 | 1,405,146 |
| Strategic Intervention 2.3 | 2,028,909 | 67,554 | 7,729 | 2,104,191 |
| Strategic Intervention 2.4 | 232,101 | 6,000,458 | 417,246 | 6,649,805 |
| Strategic Intervention 2.5 | 157,379 | 801,374 | 138,445 | 1,097,199 |
| **Total Objective 2** | **9,027,708** | **13,147,922** | **7,771,953** | **29,947,584** |
| **Objective 3: To maintain the proportion of children and adolescent TB among the notified cases at 15%, increasing the ratio of TB incident cases for ages 0-4:5-14 to 1.5 by 2025** | | | | |
| Strategic Intervention 3.1 | 20,245 | 43,962 | - | 64,207 |
| Strategic Intervention 3.2 | 492,918 | 409,172 | 328,884 | 1,230,974 |
| Strategic Intervention 3.3 | 389,837 | 879,896 | 511,050 | 1,780,782 |
| Strategic Intervention 3.4 | 227,992 | 232,551 | 232,551 | 693,094 |
| **Total Objective 3** | **1,130,992** | **1,565,582** | **1,072,485** | **3,769,059** |
| **Objective 4: To increase RR/MDR-TB cases detected and enrolled for treatment from 54% to 90% of the estimated cases among notified cases by 2025** | | | | |
| Strategic Intervention 4.1 | 1,109,914 | 954,233 | 977,728 | 3,041,875 |
| Strategic Intervention 4.2 | 499,125 | 509,107 | 207,927 | 1,216,158 |
| Strategic Intervention 4.3 | 459,409 | 354,419 | 354,419 | 1,168,247 |
| Strategic Intervention 4.4 | 172,219 | 649,150 | 175,664 | 997,033 |
| **Total Objective 4** | **2,240,666** | **2,466,910** | **1,715,737** | **6,423,313** |
| **Objective 5: To Strengthen management of co-morbidities including Collaborative TB/HIV services** | | | | |

| Interventions | Frequency | | | TOTAL USD |
|---|---|---|---|---|
| | 2023/2024 | 2024/2025 | 2025/2026 | |
| Strategic Intervention 5.1 | 186,370 | 3,776,441 | 1,025,364 | 4,988,175 |
| Strategic Intervention 5.2 | 1,317,198 | 82,259 | 52,235 | 1,451,692 |
| Strategic Intervention 5.3 | 566,201 | 30,024 | - | 596,225 |
| Strategic Intervention 5.4 | 91,258 | 317,252 | 93,083 | 501,593 |
| Strategic Intervention 5.5 | 724,736 | 22,027 | 22,027 | 768,790 |
| Strategic Intervention 5.6 | 788,353 | 119,584 | 119,584 | 1,027,520 |
| **Total Objective 5** | **3,674,116** | **4,347,586** | **1,312,292** | **9,333,994** |
| **To Enhance Multi-Sectoral Collaboration and Action for increased, coordinated and accelerated response towards ending TB by 2030** | | | | |
| Strategic Intervention 6.1 | 354,184 | 129,674 | 129,674 | 613,532 |
| Strategic Intervention 6.2 | 610,134 | 509,334 | 552,980 | 1,672,448 |
| Strategic Intervention 6.3 | 249,885 | 254,883 | 254,883 | 759,650 |
| **Total Objective 6** | **1,214,203** | **893,891** | **937,537** | **3,045,630** |
| **Objective 7: To accelerate Interruption of Leprosy Transmission in all councils by 2025** | | | | |
| Strategic Intervention 7.1 | 176,236 | 179,761 | 139,746 | 495,742 |
| Strategic Intervention 7.2 | 645,145 | 658,048 | 658,048 | 1,961,242 |
| Strategic Intervention 7.3 | 1,117,504 | 1,139,854 | 1,103,012 | 3,360,369 |
| Strategic Intervention 7.4 | 393,170 | 400,498 | 400,498 | 1,194,166 |
| **Total Objective 7** | **2,332,055** | **2,378,160** | **2,301,304** | **7,011,519** |
| **Objective 8: To ensure availability of supportive systems and strengthened resilient Program management for the implementation of TB and Leprosy Services by 2025** | | | | |
| Strategic Intervention 8.1 | 1,233,592 | 1,196,795 | 1,197,079 | 3,627,466 |
| Strategic Intervention 8.2 | 588,766 | 733,725 | 733,725 | 2,056,216 |
| Strategic Intervention 8.3 | 381,060 | 388,682 | 388,682 | 1,158,423 |
| S<br>trategic Intervention 8.4 | 55,957 | 57,076 | 57,076 | 170,110 |
| Strategic Intervention 8.5 | 1,365,387 | 1,422,507 | 1,422,507 | 4,210,401 |
| Strategic Intervention 8.6 | 1,307,676 | 1,069,508 | 1,110,910 | 3,488,093 |
| Strategic Intervention 8.7 | 2,606,594 | 5,589,069 | 2,538,944 | 10,734,608 |
| Strategic Intervention 8.8 | 1,256,903 | 1,231,378 | 1,236,917 | 3,725,198 |
| Strategic Intervention 8.9 | 138,007 | 1,391,898 | 604,826 | 2,134,731 |
| Strategic Intervention 8.10 | 719,646 | 715,990 | 715,990 | 2,151,625 |
| **Total Objective 8** | **9,653,587** | **13,796,628** | **10,006,656** | **33,456,871** |
| **Objective 9: To implement evidence-based interventions and decision making through institutionalized efficient Monitoring and Evaluation system and coordination of research by 2025** | | | | |

| Interventions | Frequency | | | TOTAL USD |
|---|---|---|---|---|
| | 2023/2024 | 2024/2025 | 2025/2026 | |
| Strategic Intervention 9.1 | 2,208,037 | 1,789,657 | 713,801 | 4,711,494 |
| Strategic Intervention 9.2 | 1,100,092 | 1,380,209 | 1,104,196 | 3,584,496 |
| Strategic Intervention 9.3 | 841,064 | 99,290 | 36,774 | 977,129 |
| Strategic Intervention 9.4 | 3,590,881 | 3,878,237 | 3,585,407 | 11,054,525 |
| Strategic Intervention 9.5 | 462,308 | 319,223 | 319,223 | 1,100,755 |
| **Total Objective 9** | **8,202,382** | **7,466,616** | **5,759,401** | **21,428,399** |
| **GRAND TOTAL** | **71,071,715** | **78,681,810** | **62,911,935** | **212,665,460** |

**BUDGET SUMMARY BY YEAR: 2024 – 2026**

| YEAR | BUDGET -USD |
|---|---|
| 2023/2024 | 71,071,714.98 |
| 2024/2025 | 78,681,809.96 |
| 2025/2026 | 62,911,934.61 |

**BUDGET SUMMARY BY OBJECTIVES**

| OBJECTIVE | BUDGET | |
|---|---|---|
| | TSH | USD |
| Objective 1: To increase TB treatment coverage from 53% in 2018 to 90% in 2025 by innovatively addressing barriers to access, utilization and the needs of the key and vulnerable populations for TB care and prevention services | 229,098,210,432.76 | 98,249,089.95 |
| Objective 2: To expand access to quality TB diagnostic services, including the adoption of new diagnostic technologies. | 69,832,074,871.80 | 29,947,583.58 |
| Objective 3: To maintain the proportion of children and adolescent TB among the notified cases at 15%, increasing the ratio of TB incident cases for ages 0-4:5-14 to 1.5 by 2025 | 8,788,728,319.39 | 3,769,059 |
| Objective 4: To increase RR/MDR-TB cases detected and enrolled for treatment from 54% to 90% of the estimated cases among notified cases by 2025 | 14,977,945,463.74 | 6,423,313 |
| Objective 5: To Strengthen management of co-morbidities including Collaborative TB/HIV services | 21,765,101,494.40 | 9,333,994 |
| **OBJECTIVE** | **BUDGET** | |
| | **TSH** | **USD** |
| Objective 6: To Enhance Multi-Sectoral Collaboration and Action for increased, coordinated and accelerated response towards ending TB by 2030. | 7,101,831,123.65 | 3,045,630 |
| Objective 7: To accelerate Interruption of Leprosy Transmission in all councils by 2025 | 16,349,531,092.39 | 7,011,519 |
| Objective 8: To ensure availability of supportive systems and strengthened resilient Program management for the implementation of TB and Leprosy Services by 2025 | 78,015,066,620.83 | 33,456,871 |

| | | |
|---|---|---|
| Objective 9: To implement evidence-based interventions and decision making through institutionalized efficient Monitoring and Evaluation system and coordination of research by 2025 | 49,966,955,831.14 | 21,428,399.33 |
| **Grand Total** | **495,895,445,250.10** | **212,665,459.56** |

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