COUNTRY REVIEW: [UNITED REPUBLIC OF TANZANIA]

NATIONAL ASSESSMENT
TOWARDS ZERO LEPROSY

22nd NOVEMBER to 3rd December 2021

Preface

This report includes Leprosy Programme review findings from field visits to the MoHCDGEC and 5 regions (Dodoma, Singida, Zanzibar, Dar Es Salaam and Tanga). The purpose of the visit was to review the status of the National Leprosy Control Programme, review the surveillance system, validate the national reported data, and conduct interviews to assess the competency level and commitment of health personnel. During the same review, the impact of the Bangkok Declaration Fund (BDF) was assessed. The report also contains the draft Zero Leprosy Roadmap.

Acknowledgements

The review team would to appreciate the following people who participated in the field visits:

- Ministry of Health, Community Development, Gender, Elderly and Children
- Ag Director of Curative Services - Dr Paul Mhame
- NTLP Programme Manager - Dr Riziki Kisonga
- National Leprosy Coordinator – Dr Deus Kamara
- President Office - Regional Administration and Local Government Authority (PO-RALG)
- Regional Medical Officers
- Municipal Medical Officers of Health
- District Medical Officers
- Health facility In-Charges.
- Facility Health Care Workers,
- People affected by Leprosy
- Community members around the facilities visited

List of Abbreviations

Ag DCS	Acting Director of Curative Services
AMO	Assistant Medical Officer
AMR	Antimicrobial resistance
BDSF	Bangkok Declaration Special Fund
CHF	Community Health Fund
CHW	Community Health Worker
CMO	Chief Medical Officer
CSO	Civil Society Organisation
DTLC	District Tuberculosis and Leprosy Coordinator
FFP	Facility Focal Person
GLRA	German Tuberculosis and Leprosy Relief Agency
G2D	Grade-2 Disability
HC	Health Centre
HELB	**Higher Education Loan Board**
MOHCDGEC	Ministry of Health Community Development Gender Elderly and Children
MOI	Medical Officer In-Charge
NHIF	National Health Insurance Fund
NTLP	National Tuberculosis and Leprosy Programme
PAL	Persons Affected by Leprosy
PEP	Post-Exposure Prophylaxis
PM	Programme Manager
PO-RALG	President's Office Regional Administration and Local Government Authority
RTLC	Regional Tuberculosis and Leprosy Coordinator
SDR	Single Dose Rifampicin
TASAF	Tanzania Social Action Fund
TLA	Tanzania Leprosy Association
TB	Tuberculosis
WHO	World Health Organisation

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Executive Summary

Background

The National Tuberculosis and Leprosy Programme (NTLP) was launched by the government in 1977 as a single combined programme to effectively control TB and leprosy in the country. The United Republic of Tanzania has made good progress in combating the two diseases. However, efforts must be increased to ensure it achieves the global End TB targets and attain zero Leprosy status by 2030. The Global Partnership for Zero Leprosy (GPZL) envisions a world without leprosy: no disease, no disability, no discrimination and no stigma. GPZL partnered with the United Republic of Tanzania National Leprosy Programme in November 2021 to support the alignment of the current National Leprosy Strategy with the new WHO GLP Strategy and the WHO NTD Roadmap 2021-2030 and to assist with developing a resource mobilization plan using the recent GPZL country model.

Purpose of the Leprosy Program Review and road map development

The Tanzania Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) and leprosy stakeholders in partnership with GPZL conducted leprosy program review to set priorities to help in the development of a national Zero Leprosy Roadmap. As an integral part of the review process, the impact of the Bangkok Declaration Fund (BDF) was assessed. The objectives of the BDSF had been to attain the elimination of leprosy as a Public Health problem and reduce the G2D among new leprosy cases in 2 high endemic districts. This was regarded as a win-win situation as it provided additional human resources from WHO for the general review but also made available relevant local expertise for the BDF assessment. It was anticipated that the findings from the BDF impact assessment would contribute to the overall objectives of the leprosy programme review.

The process:

During the first week of the review teams comprising external reviewers, national leprosy experts and NTLP staff at different levels visited pre-selected regions, councils and health facilities and guided by GPZL Country Model tools they in health officials, programme staff, health workers, persons affected by leprosy and community members.

They also reviewed existing programme data, registers, reports and policy documents relating to leprosy control in Tanzania. They also took into account the comprehensive review of the history of leprosy control in Tanzania which was presented by the National Leprosy Coordinator during the stakeholders' conference.

Findings

Significant political ownership of the Leprosy Program exists at and below the national level. There is still ongoing transmission as evidenced by the proportion of child cases (3%), and late presentation/identification of patients as seen by the proportion of persons affected by leprosy (PALs) presenting with grade-2 disability (11%). Training materials are widely available, the overall treatment completion rate is 83%, and MDT is available at all care points. An electronic case-based surveillance system is in place and operational, however is not consistently utilized.

However, there is no dedicated budget for the Regional/District TB and Leprosy Coordinators (RTLC/DTLC). There are inadequate health care worker knowledge and skills related to leprosy diagnosis and management at all levels. The health workers knowledge was better in the districts covered by the BDF districts when compared to the others. Case finding is largely passive with minimal routine systematic contact tracing activities taking place. The characteristics of new cases detected during the BDF project

implementation in one of the targeted districts pointed to significant on-going disease transmission in Muheza District. There are data quality issues with DHIS-2. Other findings include: no country-level Zero Leprosy Roadmap, and inadequate mainstreaming of leprosy programs and services into District health programs. The policy of integrating leprosy in general healthcare services below the national level exists; In this context, the BDF project demonstrated benefits of providing MDT services in a flexible way although the flexibility was not impact on the high transport costs met by patients in order to access the services. In general, healthcare workers have very limited knowledge and expertise to carry out expected tasks.

Results

A comprehensive, and in-depth analysis of the Leprosy Programme was done. The strengths, weaknesses, opportunities, and threats of the Leprosy Programme were analysed. The ongoing process of integration of leprosy control into general health services and key issues for strengthening leprosy control were analysed. These results were used during the stakeholder's engagement to identify priorities for Zero Roadmap development.

Conclusion

The objectives of the field visit were all met and the key issues identified.

Leprosy remains a public health issue in Tanzania; the country is still is still considered a high-burden one on account of reporting more than 1000 new cases annually.

National level commitment to eliminate leprosy is illustrated by the availability of policy documents and tools to support leprosy elimination activities. However, there is insufficient funding, especially from domestic sources, to support the full range of activities necessary to implement an effective leprosy control and treatment program.

Furthermore, knowledge and skills capacity among coordinators and health care workers is low. Mapping of cases and identification of hotpots is not taking place. The observed deficiencies are core contributors to the very limited contact tracing and contact management activities being implemented as at the time of the review. The observed level and quality of self-care practices as well as interventions for leprosy related, advocacy, communication and social mobilization are deemed inadequate for producing the desired impact.

Recommendations

- There is great need to train health care workers on diagnosis and management of leprosy and its complications.
- Domestic financing for leprosy activities needs to be increased and a reasonable amount allotted to facilitate the very essential interventions of National, Regional and District Tuberculosis and Leprosy supervisors for leprosy prevention, control, and treatment.
- Existing Implementing Partners should be fully committed to support leprosy interventions.
- Engage NGOs and CSOs to participate in leprosy control activities like creation of awareness and contact tracing.
- NTLP should conduct advocacy, awareness and sensitization of communities, through mass media and radio talk shows on leprosy.
- Contact management and the use of single dose rifampicin as post-exposure prophylaxis needs to be scaled up.
- Capacity for laboratory diagnosis of leprosy by skin smear microscopy needs to be maintained/expanded and quality assured.

- NTLP should consider investing in setting up an antimicrobial resistance (AMR) surveillance system to monitor AMR to anti-leprosy medicines.
- Mapping of new cases should be upgraded to serve the purposes of identifying hot-spots and at-risk communities so that they are prioritized for community education/sensitization and intensified case-finding.
- Ensure that Contact management is implemented according to the MOHCDGEC guidelines paying due attention to the provided modification options for low burden settings.
- The complete and appropriate filling of patient record cards and registers with disability information together with repeated nerve function assessments should be ensured through regular cycles of supportive supervision from higher levels.
- MOHCDGEC to set up a system for routine collection data on persons in need of care for leprosy complications and provision of assistive devices.
- Formal links should be established between leprosy services and social support and rehabilitation programs, e.g. TASAF, NHIF, HELB.

Background

The National Tuberculosis and Leprosy Programme (NTLP) was launched by the government in 1977 as a single combined programme to effectively control TB and leprosy in the country. The mission of the programme is to provide high-quality, effective interventions for TB and leprosy care and control in Tanzania, with a focus on gender mainstreaming, equity, accessibility, and those most at risk. The Programme has a mandate to prevent and control TB and leprosy in the country, and is responsible for coordinating programme activities, policy formulation, technical guidance, planning, monitoring, evaluation, resource mobilization, and coordination of procurement and distribution of medicines and supplies. As a country, Tanzania is making good progress in combating the two diseases, however efforts must be increased to ensure it achieves the global End TB targets by 2030 and that leprosy is eliminated at all localities.

The Global Partnership for Zero Leprosy (GPZL) was launched in January 2018 by the World Health Organization (observer), the International Federation of Anti-Leprosy Associations, the Sasakawa Health Foundation, the International Association for Integration, Dignity and Economic Advancement (IDEA), and Novartis Foundation. Its leadership team includes these partners as well as leaders from the National Leprosy Programs of Brazil, Ghana and India, the International Leprosy Association, the U.N. Special Rapporteur for Leprosy and a representative of the academic community.

The GPZL envisions a world without leprosy: no disease, no disability, no discrimination and no stigma. The GPZL aims to facilitate alignment of the leprosy community and accelerate effective collaborative action towards zero leprosy through a country-by-country approach.

Rationale of the United Republic of Tanzania Leprosy Program Review

Although leprosy elimination as a public health problem was achieved in 2006, some districts are still endemic for leprosy. There is a significant proportion of new cases with Grade 2 disability (10%) which signifies delays in seeking health care services and diagnosis at health facilities. The previous national strategic plan did not achieve large enough reductions in new leprosy infections and prevention of disability to reach planned targets.

The Ministry of Health, Community Development, Gender, Elderly and Children and other leprosy stakeholders, in partnership with GPZL, conducted a Leprosy Program Review to help define priorities as well as form the foundation for development of a national Zero Leprosy Roadmap. This process is intended to supplement, and not replace, leprosy work already being done in-country.

Objectives of the Country Review

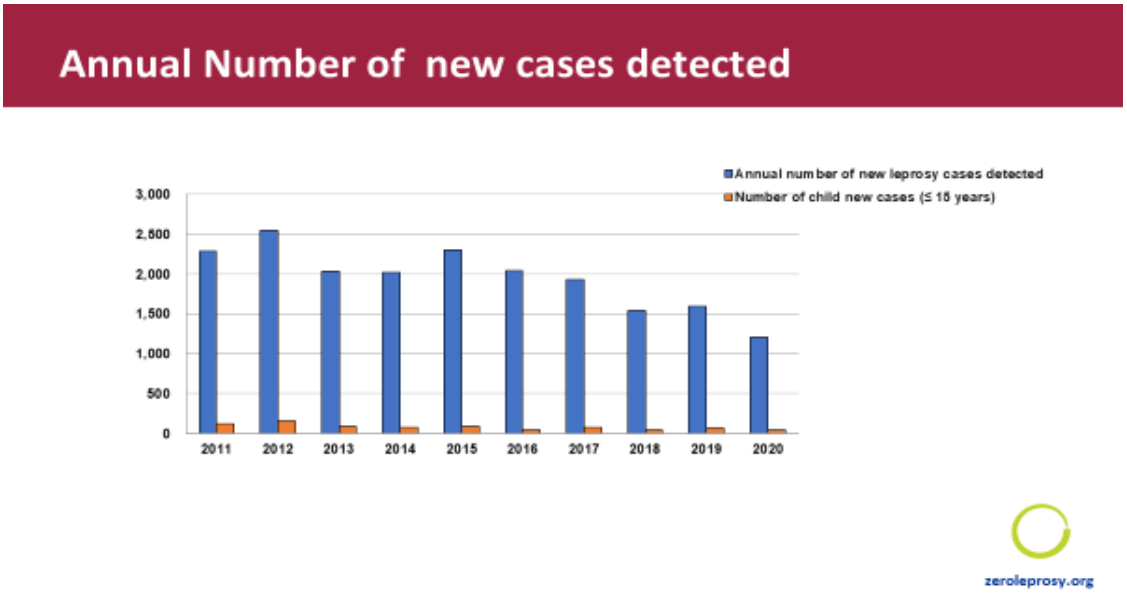
1. To make an independent, comprehensive, and in-depth analysis of the current leprosy situation in Tanzania including an assessment of the impact of the completed BDF in the targeted districts.
2. To analyse the strengths, weaknesses, opportunities, and threats of the Leprosy Control Programme
3. To evaluate the ongoing process of integration of leprosy control into general health services, especially in view of the revised WHO GLP Strategy;
4. To assess the current surveillance system and identify key issues for strengthening of leprosy surveillance;
5. To systematically explore opportunities for strengthening other facets of operation necessary for achieving zero leprosy, particularly with regards to research, inclusivity, and stigma reduction.

History of Leprosy Control in the Country

Tanzania achieved elimination of leprosy as a Public Health Problem at national level in 2006 and this has been sustained to date. However as of 2020, 13 districts had not achieved leprosy elimination status at the district level.

Leprosy Statistics

The number of registered leprosy cases in Tanzania gradually declined from 3,500 cases in 2006 to 1,279 in 2020; however, the proportion of child cases has remained essentially unchanged since 2016. In 2020, 1,279 cases were reported to the programme, representing a case detection rate of 20.9 per 1,000,000 population and prevalence rate of 0.2 per 10,000. Among the new cases, 94% were multibacillary (MB), 3% of cases were seen in children less than 15 years old, 35% of cases were diagnosed in females, and 10% of cases presented with grade 2 disability (G2D).



Current Policies (formal documents and reports)

Reviewed documents includes:

- National TB and Leprosy Strategic Plan VI (2021-2025)
- NTLP Annual Report -2019
- TB and leprosy data collection tools
- eTL-DHIS-2 reports
- NTLP Manual for Management of TB and Leprosy 7th edition 2020/2021
- Programme Review Report 2020

There is a comprehensive manual for management of TB and leprosy which has been updated recently. The NTLP supervision tools are integrated with leprosy indicators and cover all the key areas for leprosy control activities. The electronic TB and leprosy register -DHIS-2 reports do not include indicators for children less than 15 years for leprosy.

The National Strategic Plan (2021-2025) for TB and Leprosy is still in draft with only one strategic objective for Leprosy (Objective 7: To reduce leprosy prevalence in all endemic councils by 2025). The objective may need to be re-written to align with WHO/Global Leprosy Programme Strategy and ensure that it is measurable.

Indicator	Baseline (2015)	Target (2020)	Status (2019)	Status (2020)
Percentage of patients with disability grade 2 among newly diagnosed leprosy patients	11%	7%	14%	9.1%
Percentage of children notified among new cases	4.5%	2.0%	3.5%	3%
Percentage of districts providing leprosy services that report no stock outs of leprosy commodities	100%	100%	100%	100%

Integration of Leprosy Activities into Other Health Programs

NTLP is a program with twin diseases TB & leprosy. The Ministry has a strategy to increase access to healthcare services throughout the country (population of approximately 60 million). Among activities to achieve this increase in access is to have a primary health care facility (dispensary) in each village, a health centre in each ward and hospital in every council. Diagnosis of leprosy is made at some health centres and at council (district) hospitals or higher-level facilities. The lower-level facilities (dispensaries and health centres) all are involved in screening and refer suspect patients to council (district) hospitals for diagnosis.

Other activities include case finding through outreach programmes organized by departments in the ministry (NHIF, TB) where HCWs are sent to rural and hard-to-reach communities and people are invited for general medical care including leprosy screening. Leprosy curative services are also included as a part of Dermatological Health. Wherever a Skin Camp is set for public screening of skin conditions, leprosy is among the conditions screened for; if diagnosed, treatment is initiated through TB and Leprosy clinic.

Main Stakeholders

The following are the main stakeholders relevant for leprosy control participated in the Leprosy Programme Review meeting.
MoHCDGEC/NTLP
PO-RALG
WHO
Novartis Foundation representative
GLRA
CHEP
GPZL
Dermatologists
PALs
Tanzania Leprosy Association (TLA)
Other Implementing partners and CSOs

Methods Used

The review was carried out in Dodoma/Central and 5 other regions (Dar es Salaam, Morogoro, Singida, Tanga, and Zanzibar) with visits to a total of 15 districts* (facilities and district office for each district). Two of the districts, Mkinga and Muheza in Tanga Region had been implementation districts for the BDF.

Interviews were conducted with MoHCDGEC, Regional and District Medical Officers, Regional and District TB and Leprosy Coordinators, Health Facility In-Charges, health care workers, PALs, and community members. In addition, community focus group discussions were held in all of the regions visited. Policy documents and facility records were reviewed during the visits as well.

Some pictures taken during the field visits

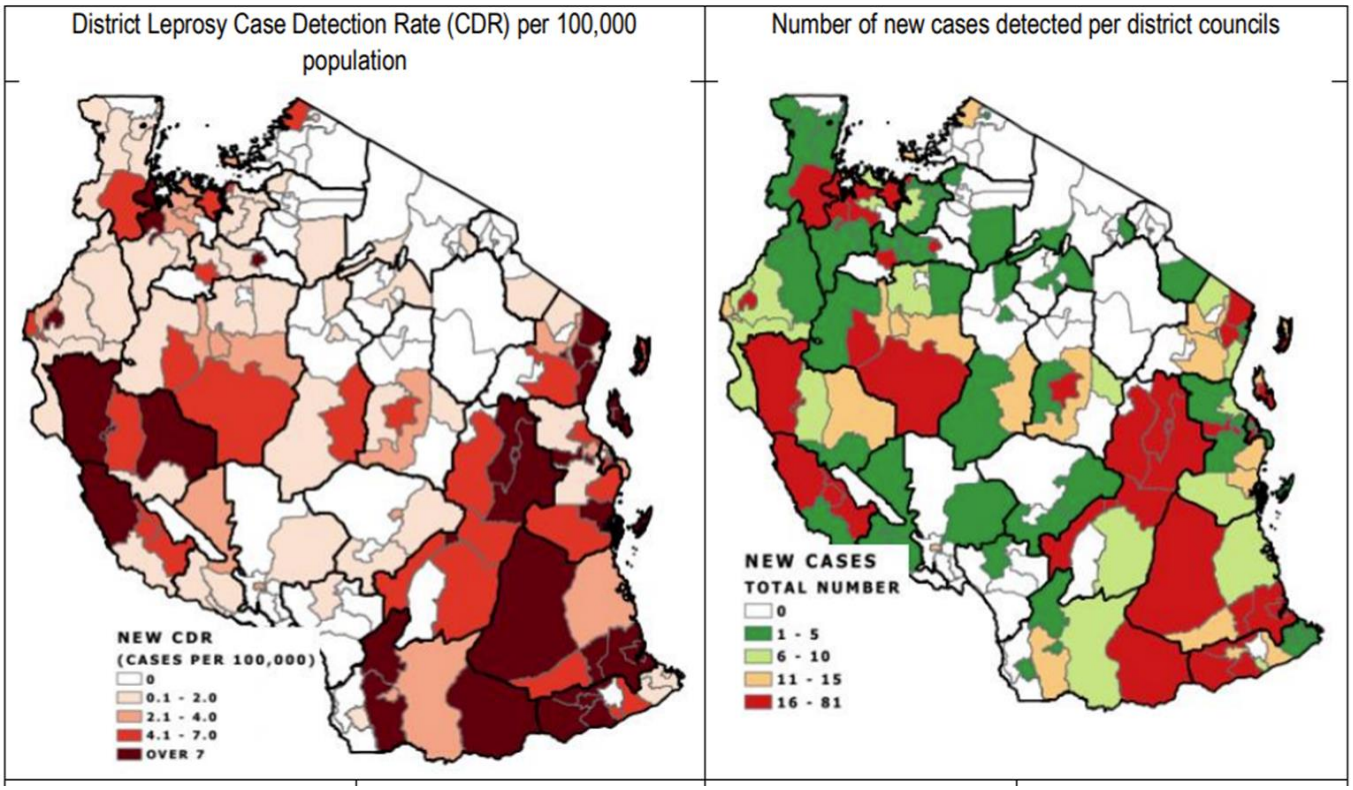
* Regions/facilities visited:

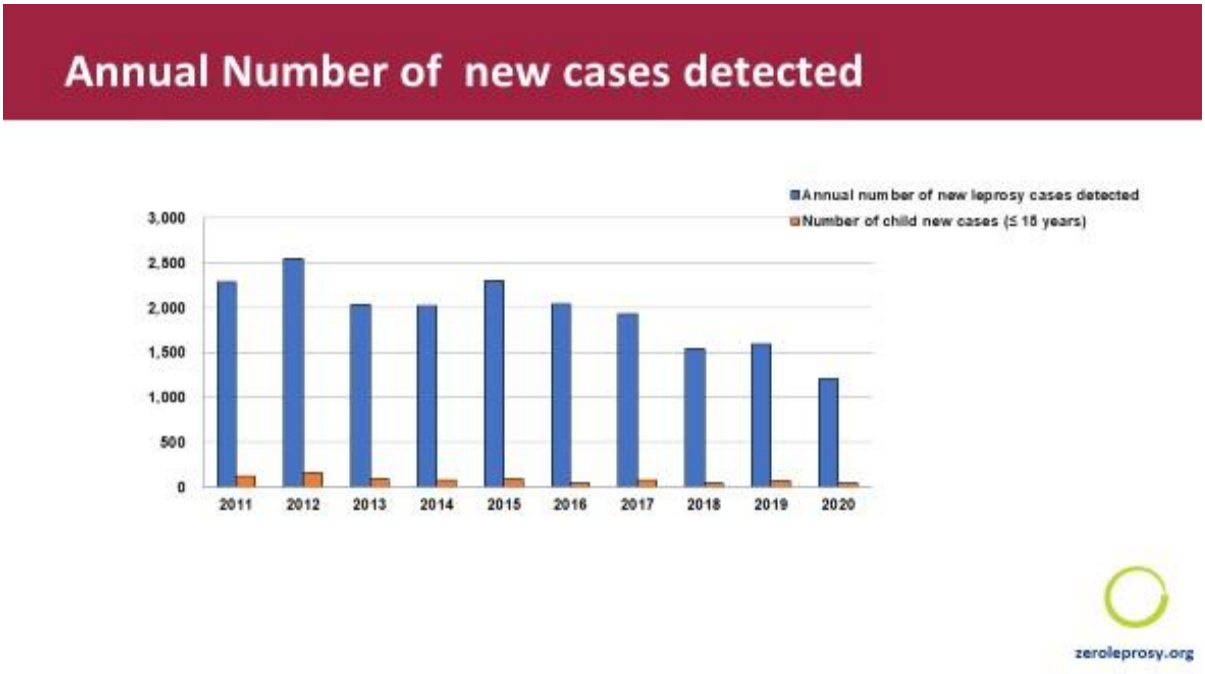
- Dar es Salaam: Temeke (Wailes TMK RRH, Kizuiani Disp, RaniTatu Hosp)
- Dodoma: Dodoma City (Makole HC), Bahi (Bahi HC)
- Morogoro: Morogoro Municipality Sabasba HC, Mvomero (Chazi HC), Morogoro DC (Mvuah HC)
- Singida: Singida Municipality (SRRH), Singida DC (Dispensary), Ikungi HC
- Tanga: Tanga City (Ngamiani HC), MKinga DC (Maramba HC), Muheza DC (Muheza DDH)
- Zanzibar Unguja: Kusini Unguja (Kizimkazi Mkunguni PHCU+, Dimbani PHCU+), Kaskazini Unguja (Kaskazini A Nungwi PCHU+), Mjini Magharibi (Mnazi Mmoga NRH)

Historical Program Performance

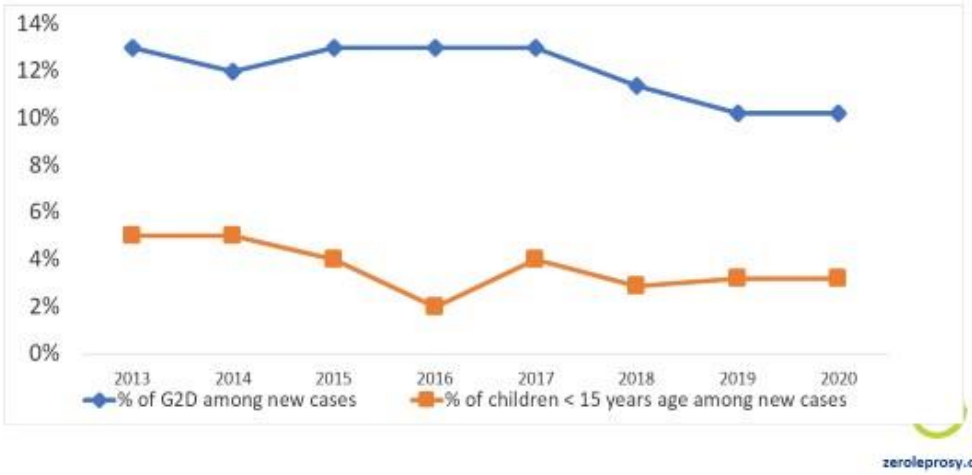
i) Country leprosy control situation

The map below summarises the programme performance as assessed against targets included in the concluded NTLP Strategic plan.





Epidemiological profile



ii) Leprosy Programme Performance

The table below summarises the programme performance over the past ten years.

The proportion of Grade 2 disability is at 12% while the proportion of Children among the new leprosy cases in 2020 was 3%.

Implementation dashboard

Indicator	Baseline (2015)	Target (2020)	Status (2020)
Percentage of patients with disability grade 2 among newly diagnosed leprosy patients by 2020	11%	7%	10%
Percentage of children notified among new cases by 2020	4.5%	2%	3%
Percentage of districts providing leprosy services that report no stock outs of leprosy commodities	100%	100%	100%

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Country Review Findings Summary, Based on the Four Global Leprosy Programme Strategic Pillars

Pillar 1: Implement integrated, country-owned zero leprosy road maps in all endemic countries

1.1 Political commitment

- High commitment to leprosy control at all levels (national, regional, district, local)
- Low domestic funding at all levels
- Inadequate mainstreaming of leprosy activities into District programmes
- Inadequate program management capacity among the Regional and District Tuberculosis and Leprosy coordinators and facility focal persons for tuberculosis and leprosy
- Persons with leprosy not included in Leprosy Programme planning and development

1.2 Zero Leprosy Roadmaps

- No Zero Leprosy Roadmaps at any level
- The country has an integrated TB and Leprosy Strategic plan with little visibility for leprosy
- Follow up of strategic plan in Regions and Districts not evident

1.3 Capacity building

- All DTLCs have been trained on electronic case-based surveillance and data management tools
- Majority of staff interviewed have not been oriented/trained on leprosy in the last five years
- Most of the staff (DTLCs, MOIs and health care workers) interviewed were new/high staff turnover
- Inconsistent availability of transportation for Leprosy Program Coordinators

1.4 Surveillance and data management

- Treatment registers are available in all health facilities visited
- Some of the tools are available (MDT, Disability and Contact tracing registers)
- Paper-based and electronic case-based surveillance are both in use; slow adoption of electronic system with limited roll-out and inconsistent use
- Proper filling of primary data collection tools is not done
- No mapping of cases and hotspots

1.5 Monitoring of AMR & adverse drug reactions

- Monitoring of adverse drug reactions is integrated in the routine reporting system
- No monitoring mechanisms for antimicrobial resistance

PILLAR 2: Scale up leprosy prevention alongside integrated active case detection

2.1 Contact tracing

- Systematic contact tracing is not done
- No SOP for contact tracing

2.2 Preventive chemotherapy

- Currently no preventive chemotherapy is being implemented at the national program level; has been implemented in 5 districts in the country as a part of a pilot study

2.3 Active case-finding

- Case finding is integrated **i**n the routine health campaigns, e.g. Dodoma health festival week, use of mobile vans, and World Leprosy Day commemorations
- No door-to-door contact tracing except in districts where the pilot study using single dose rifampicin is taking place

PILLAR 3: Manage leprosy and its complications and prevent new disability

3.1 Early detection, diagnosis and treatment

- MDT blisters were available and in good condition in all facilities visited
- The high grade 2 disability proportion at 10% (national) and 11% (Dodoma region) points to late diagnosis
- High rates of child cases in Zanzibar region points to high levels of ongoing transmission
- Most community members not aware that they could get care for leprosy in the nearby facility, or the treatment is free
- Majority of community members not aware of early signs and symptoms for leprosy
- There are still myths about leprosy, e.g. leprosy is hereditary disease

3.2 Access to referral facilities

- Referral system exists, but support for patients to access the facilities is not provided (transport, food)

3.3 Management of reactions, neuritis & disabilities

- Nerve function assessment is not being routinely performed
- Supplies for managing leprosy complications (prednisolone and sandals) are available but some patients did not have appropriate footwear and had bad wounds
- Some patients interviewed did not have MCR sandals; all were wearing inappropriate footwear

3.4 Self-care

- It was evident that the cost of care was acting as significant barrier for care among PALs
- Self-care groups have disbanded due to lack of support and supplies

Photo below: Coaching the family member on self-care for a patient with foot ulcers

3.5 Mental well-being

- Health care workers are enthusiastic and ready to provide mental health and well-being support

- Limited mental health counselling training and capacity exists

PILLAR 4: Combat stigma and ensure human rights are respected

4.1 Adoption of Principles and Guidelines

- There are no laws or cultural norms that discriminate against PALs
- Most public facilities has disability friendly access

4.2 Inclusion of persons affected by leprosy

- No report of PALs being excluded from cultural and recreational activities

4.3 Stigma reduction

- No stigma reported from health care workers, patients and community

4.4 Social support and rehabilitation

- Some PALs are able to access social and economic support, e.g. housing and money
- High transport costs incurred by patients for travelling to facilities where MDT services are available.

Limitations of the Country Review

During the field visits we were unable to meet and interview some planned participants (DMOs, CMO, DCSs) and under such circumstances we only managed to interview their representatives.

Conclusions and Recommendations

Leprosy remains a public health issue with Tanzania; Tanzania is still considered a high-burden country with high case detection rates and substantial transmission including new cases among children.

There is high level of commitment at the national level with availability of policy documents and tools to support leprosy elimination activities. However, there is insufficient domestic funding to support the full range of activities necessary to implement an effective leprosy control and treatment program.

Furthermore, knowledge and skills capacity among coordinators and health care workers is low, and only very limited contact tracing and contact management activities are being done. Mapping of cases and identification of hotpots is not taking place. There is need for strengthening of self-care practices and support, and a need to strengthen advocacy, communication, and social mobilization.

Recommendations

- The leprosy related strategic objective in the current NSP (2021-2025) may need to be revisited in order to ensure alignment to both the WHO GLP strategy and the national zero-leprosy roadmap.
- There is great need to train health care workers on diagnosis and management of leprosy and its complications, and other skin conditions.
- Domestic financing for leprosy activities needs to be increased and financial support to National, Regional and District Tuberculosis and Leprosy supervisors is needed to implement leprosy prevention, control, and treatment activities.

- NTLP should conduct advocacy, awareness and sensitization of communities, through mass media and radio talk shows on leprosy.
- Contact management and the use of single dose rifampicin as post-exposure prophylaxis needs to be scaled up.
- NTLP should establish an antimicrobial resistance (AMR) surveillance system to monitor AMR to leprosy antimicrobials
- Capacity for laboratory diagnosis of leprosy by skin smear microscopy needs to be maintained/expanded.
- Consider mapping of cases to identify hot-spots and at-risk communities and to target community education/sensitization.
- IPs should be fully committed to support leprosy interventions.
- Advocate for political commitment for leprosy (potentially among TB caucus) – MoH, Stakeholders – Short and Mid Term.
- Engage NGOs and CSOs to assist in leprosy control activities, provision of awareness and education, contact tracing.
- Implement contact management according to guidelines – MoH – Short and Mid Term
- Scale up post-exposure prophylaxis (LPEP) – MoH, Stakeholders – Mid Ter
- MOH needs to routinely collect data of persons in need of care for complications and provision of assistive devices.
- The complete and appropriate filling of patient record cards and registers with disability information together with repeated nerve function assessments should be ensured through regular cycles of supportive supervision from higher levels.
- Link leprosy services with social support programs, e.g. TASAF, NHIF, HELB, rehabilitation services – MoH, Stakeholders –
- Ministry of Health to produce awareness sensitization material in the form of posters and flyers for use at health facilities and in communities.
- There is need to develop a research agenda addressing, among others, developing a system for monitoring leprosy related stigma.

Recommendations by Pillar

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Pillar 1: Implement integrated Zero Leprosy Roadmaps

Short Term

1. Revisit the NSP VI (2021-2025) to ensure alignment to the Zero leprosy road-map.
2. Set up a Zero-Leprosy Partnership including all relevant stakeholders for high level advocacy in support of the zero-leprosy agenda
3. MOHCDGEC should ensure new DTLCs and FFP are trained
4. The NTLP should progressively ensure that the opportunities for integrating resources for leprosy and TB are fully realized within the programme and with other sectors
5. NTLP should establish an AMR surveillance system built on the maintenance of adequate capacity and skills for laboratory diagnosis

Pillar 2: Scale up leprosy prevention & active case detection

Short term

1. NTLP should implement contact management including SDR-PEP as a routine programme package available following each diagnosis.
2. NTLP should increase the level of active case-finding including the use of skin-camps, CHWs, door-to-door approach in identified high endemic clusters, and facility screening as done with TB

Medium term

1. Implement mapping of cases and contacts to facilitate identification of hotspots and other locations where activities should be escalated

Pillar 3: Manage leprosy, complications & prevent disability

Short Term

1. NTLP needs to routinely collect data of persons in need of care for complications and provision of assistive devices
2. The complete and appropriate filling of patient record cards and registers with disability information together with repeated nerve function assessments should be ensured through regular cycles of supportive supervision from higher levels

Medium term

1. The Zero Leprosy Partnership should advocate for the existing council funds to be extended to cover disability prevention and management care, including making available prednisolone at the quantities required for reaction management

Pillar 4: Combat stigma & ensure human rights are respected

Short Term

1. NTLP to produce awareness sensitization material in the form of posters and flyers for use at health facilities and in communities.
2. NTLP to implement integration and other approaches to ensure easy access to treatment and care facilities.

Long Term

1. NTLP should work on developing stigma index for both TB and Leprosy

THE ZERO LEPROSY ROADMAP FOR TANZANIA

During the stakeholder engagement, participants selected priority sub-pillars from a list presented in the work-sheet. From the subsequent logic model discussions, the indicators and timelines were determined. Participants were made aware of being at liberty to include additional sub-pillars in case they identified important areas that had been left out.

Below is a summary of the Zero Leprosy Road map

	PRIORITY ISSUES	**INDICATOR**	**TYPE OF INDICATOR**	**Who is responsible for implementation**	**2022 Milestones**	**2025 Milestones**	**2030 Goals)**
		Pillar 1: Implement integrated, country-owned zero leprosy road maps in all endemic countries					
Political commitment	Increasing share of budget financed by domestic funding	Proportion of leprosy budget covered with domestic funds	Process	Govt and Stakeholders	domestic funding of leprosy budget increased to 5%	Domestic funding of leprosy budget increased up to 15%	Domestic funding of leprosy budget increased to 50%
National partnerships for zero leprosy,	Establishment of a national partnership for zero leprosy			Govt and Stakeholders	MOU for zero leprosy partnership signed	Functional national partnerships for zero leprosy, incorporating government, development partners and persons affected by leprosy	Strengthened Zero leprosy Partnership
Capacity building among health staff	Ensure capacity of front-line and referral-level	% frontline Health	Performance	Govt and Stakeholders	20% of frontline health care workers oriented on	50% of HCW oriented on	89% of HCW oriented on Leprosy

	staff in screening, case-finding and treatment Ensure capacity of regional referral hospitals to handle leprosy complications	Workers oriented Or % of health facilities with trained health workers % of regional referral hospitals with staff able to handle leprosy complications	process	Govt and stake-holders	Leprosy diagnosis and management 20% H facilities with at least one trained front-line health workers 20% RRH with capacity to handle leprosy complications	leprosy management 50% 100%	80% 100%
Surveillance and data management	Effective epidemiological and post-treatment surveillance systems functioning	% using electronic case-based reporting systems for leprosy	Process	NTLP	Post treatment surveillance incorporated into electronic case based reporting 20% of districts using electronic case based reporting for leprosy	100% of districts using electronic case base reporting for leprosy	100% of districts using electronic case based reporting for leprosy
		PILLAR 2: Scale up leprosy prevention alongside integrated active case detection					
Contact tracing	Average number of contacts screened per index case Screening all contacts of index cases identified.	Proportion of listed contacts of index cases screened	performance	NTLP PO-RALG Stakeholders	20% of index cases have contacts screened	50% Index contacts traced	95% Contacts traced
Preventive chemotherapy for contacts	Swiftly implement ~~new~~ post-exposure chemoprophylaxis with SDR	Proportion of eligible contacts received PEP	performance	NTLP PO-RALG Stakeholders	20%of eligible contacts received PEP	50% of eligible contacts received PEP	75% of contacts received PEP

Active case-finding	Active case-finding programmes in target populations		performance	NTLP PO-RALG Stakeholders	Active case-finding programmes in all endemic districts	Active case finding programmes in all endemic districts	Active case finding programmes in all endemic districts
		PILLAR 3: Manage leprosy and its complications and prevent new disability					
Improved timeliness of case detection	High Number and proportion of new cases with G2D at the time of diagnosis	% of new cases with G2D at diagnosis	performance	NTLP PO-RALG Stakeholders	grade 2 disability proportion of new cases at 10%	proportion of grade2 Disability at 5%	proportion of grade 2 disability at 2%
	Number of new child cases~~,~~	% of new cases that are children Proportion of new child leprosy cases / million children	performance	NTLP PO-RALG Stakeholders	Proportion of child cases among new cases3% Proportion of child cases / million children	proportion of child cases at 2%	proportion of child leprosy cases at 0%
Improved quality of care for detected patients	Number of patients with deteriorated disability status at the end of MDT	DG and /or EHF score at beginning and end of MDT % with same or better status at end MB MDT treatment outcomes	performance		Need a baseline (even if based on review sample) of % with DG at the end _____ Over 90%	100% 50% Over 95%	100% 80% Over 95% 100%
		Pillar 4: Combat stigma and ensure human rights are respected					

Awareness of the extent of stigma and discrimination Awareness of "missed opportunities " for inclusion and rehabilitation	Lack of local evidence to support stigma related interventions Implementation research:	Quantification of the extent of stigma and discrimination Listing of opportunities for inclusion	process	NTLP PO-RALG Stakeholders Academic institutions CBR organizations TLA	Research project proposal and implementation Establishment of existence and extent of stigma and discrimination	Implementation of research projects: stigma reduction and inclusion. Roll out to all regions of the evidence based stigma reduction interventions	Zero stigma
Increased social participation of persons affected by leprosy in the community (by using relevant tools	Encourage and support opportunities for self-employment, the formation of cooperatives and vocational training for persons affected	Number of selfcare groups Number and proportion of registered PAL participating in selfcare groups.	process	NTLP PO-RALG TLA The ministry responsible for rehabilitation Stakeholders	Inventory of number and composition of existing selfcare groups Mobilising resources for new groups could think of formation of new Self-care groups by the TLA	20 SCG formed	40 SCG formed
4.4 Social support and rehabilitation	Poor access to opportunities for Social Economic Rehabilitation and social support systems	PAL not accessing social support systems	Number of PAL accessing social support systems No and proportion of districts providing support	Ministry for rehabilitation Local Government TLA IPs	Inventory development Lobby at district level Established M&E system for this	PAL accessing support systems at 20% of registered 25% of districts with social support systems that include leprosy affected persons	

			systems that include PAL				

References

- National TB and Leprosy Strategic Plan VI (2021-2025)
- NTLP annual report -2019
- TB and Leprosy data collection tools
- eTL-DHIS-2 reports
- NTLP manual for management of TB and Leprosy 7th edition 2020/2021
- Programme Review report 2020