### Summary Sheet

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<th>Agenda Nr. 1.08-4.0D</th>
<th>Subject</th>
<th>ROUNDTABLE WITH COUNTRIES: COUNTRY REPORT ON THE GLOBAL PLAN</th>
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<tr>
<td>TANZANIA</td>
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### Rationale

To inform the Coordinating Board on the implementation of The Global Plan - of progress made and the challenges faced by four countries - Afghanistan, India, South Africa and Tanzania.

### Summary

1. **Tanzania** achieved 100% DOTS coverage by 1986 and the case detection rate (all forms) was less than 80 per 100,000. By 2007, TB case detection rate all forms has doubled to 158/100,000 despite having a strong well functioning programme. The reported case notification rate is only 50% of the WHO estimates. Case detection rate for smear positive TB cases stands at around 56/100,000 which is about 45% of WHO estimates. However, treatment success rate for smear positive TB cases has increased from 79% in 2000 to 84.8% for cohort notified in 2006.

2. In 2006, with support from the Global Drug Facility (GDF) and Novartis Foundation for Sustainable Development (NFSD), Tanzania changed the treatment regimen for TB from 8 months to 6 months by introducing Fixed – Dose Combination (FDC) anti-TB drugs containing rifampicin in the continuation phase. At the same time, community members were empowered to supervise TB patients take their drugs at home. The results of that new policy are increased treatment success from 82% in 2005 and less defaulters.

3. To address the HIV epidemic, Tanzania has adopted the Global Policy on collaborative TB/HIV and since 2006 over 80% of the country is actively implementing collaborative activities. A national TB/HIV policy has been adopted, printed and distributed to all stakeholders. Today, more than 60% of all TB patients are being screened for HIV within the TB clinics, over 70% of those with TB/HIV co-infection are using co-trimoxazole preventive therapy unfortunately, only 28% of them are on ARVs. Similarly efforts are underway to screen all HIV/AIDS patients for TB infection within the HIV clinics using a locally adopted questionnaire containing 5 key signs and symptoms of TB. The target is to ensure that over 80% of all TB clinics are screened for HIV and vice versa and at least 60% of them put on ARVs to save their lives.

4. Tanzania has just completed country wide TB drug resistance survey with financial and technical support from WHO, KNCV Foundation and Institute of Tropical Medicine (ITM) in Antwerp. The preliminary results suggest a low level of MDR-TB (below 1% of all TB cases) in the country. However, there is concern because of the close economical collaboration with other countries in the SADC block of which some have worrisome levels of MDR-TB and XDR-TB. Routine MDR-TB surveillance to monitor the level especially among TB cases will continue.

At the same time, Tanzania is initiating MDR-TB treatment starting this year in one of the National TB hospital with funding from the Global Drug Facility round 6. The Green Light Committee approved the proposal to purchase drugs for 50 patients at a reduced price early this year and we will negotiate for future expansion as we accumulate the necessary experience.

5. Health care services in Tanzania are provided through public-private mix strategy, of which 60% of the services are provided by public health facilities and the remaining 40% by NGOS and private sector including faith-based organisations. TB services are being provided free of charge by all providers both in public and private sector. The government gives anti-TB drugs and laboratory supplies free of charge to all providers. Additional support to the private sector include...
recruitment and training of health workers in an effort to increase access to TB services especially in rural areas and people with low income.

6. The Government is committed to the control of diseases of public health importance including malaria, HIV/AIDS and TB. Each of these diseases has a separate budget line and dedicated personnel especially at the national, regional and district levels. However, service delivery at the health facility level is fully integrated into the general health system. The government seeks to increase resource allocation to increase number of health facilities to be available in each village in the country and improve quality of care to meet the expectation of patients. Furthermore, the Government declared TB as an emergence in August, 2006 in line with the Maputo declaration of Health Ministers in 2005.

7. The country is using all opportunities to raise community awareness on signs and symptoms of TB through local theatres, mass media such radio, TV and newspapers and by commemorating world TB days. The Global Fund is supporting the country to raise community awareness and a 36 districts – about a quarter of the country for the next five years. Despite these efforts, community awareness is still low – about 38%

Challenges

1. The biggest challenge is to increase case detection from the current 45% to reach 70% in line with the Global Targets.
2. Coordination of the different partners and stakeholders involved in TB control.
3. Scaling up collaborative TB/HIV activities to reach all those who need them timely all the time.
4. Scaling up and sustaining MDR-TB surveillance and treatment to reach all those who need them thus avoid future TB epidemic.
5. Raising community awareness on the signs and symptoms of TB and to encourage early health seeking.
6. Improving diagnosis of TB especially at the point of care by introducing new technologies such fluorescent microscopes and scaling up culture and drug susceptibility testing capacity to reach all regional hospitals and below.
7. Mobilizing financial resources to scale up TB activities to meet the MDGs by 2015.

Decisions requested (from the Stop TB Coordinating Board)

1. Work with GF to simplify proposal development and other related procedures to meet country needs
2. Provide technical assistance to countries to provide successful proposals for GF funding
3. Request the Coordinating Board to consider providing technical assistance especially in EQA and introduction of new laboratory technologies to improve case detection
4. Mobilise other sources of funding to meet the funding gap
5. Coordination of TB related research activities at country level by different partners
6. Provide technical assistance to develop a new 5 year strategic plan in line with the Global Plan.

Implications (political/financial/staffing etc):
Lack of funding may stall implementation of TB and TB/HIV activities in line with Millennium Development Goals 2015

Next Steps

Action Required: N/A
Focal Point: N/A
Timeframe: N/A
COUNTRY PROFILE

United Republic of Tanzania

In 2008 the United Republic of Tanzania will benefit from a massive increase in the budget for TB control that is almost met by a corresponding increase in available funding. The planned expansion of collaborative TB/HIV activities to the whole country in 2007, use of community-based TB care in more districts and formal collaboration with private practitioners should improve both the case detection rate and treatment success. The provision of ART to HIV-positive TB patients is likely to reduce the currently high death rate, and plans to improve the recording and reporting system may help reduce the number of patients lost to follow up after transfer. Management of MDR-TB was begun in 2007; preparations began in 2006 with the construction of laboratories and hospital wards and the recruitment of personnel.

SURVEILLANCE AND EPIDEMIOLOGY, 2006

Population (thousands) 39,469

Estimates of epidemiological burden

- Incidence (all cases/100,000 pop/yr) 312
- Mortality (deaths/100,000 pop/yr) 66
- Of new TB cases, % HIV+ 18
- Of previously treated TB cases, % MDR-TB (2007) 1.1
- Of new TB cases, % MDR-TB (2007) 0.0

Surveillance and DOTS implementation

- Notification rate (new and relapse/100,000 pop/yr) 150
- DOTS case detection rate (new ss+ 46
- DOTS treatment success (new ss+, 2005 cohort, %) 82
- Of new pulmonary cases notified under DOTS, % ss+ 55
- Of new cases notified under DOTS, % extrapulmonary 22
- Of new ss+ cases notified under DOTS, % in women 37
- Of sub-national reports expected, % received at next reporting level 100

Laboratory services

- Number of laboratories performing smear microscopy 690
- Number of laboratories performing culture 3
- Number of laboratories performing DST 1
- Of laboratories performing smear microscopy, % covered by EQA 100

Management of MDR-TB

- Of new cases notified, % receiving DST at start of treatment 0.6
- Of new cases receiving DST at start of treatment, % MDR-TB 1
- Of re-treatment cases notified, % receiving DST 3.7
- Of re-treatment cases receiving DST, % MDR-TB 5.3

Collaborative TB/HIV activities

- National policy of counselling and testing TB patients for HIV? Yes
- Of TB patients (new and re-treatment) notified, % tested for HIV 11
- Of TB patients tested for HIV, % HIV+ 50
- Of HIV+ TB patients detected, % receiving CPT 57
- Of HIV+ TB patients detected, % receiving ART 26

DOTS expansion and enhancement

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<td>DOTS coverage (%)</td>
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<td>DOTS case detection rate (all cases, %)</td>
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<td>DOTS case detection rate (new ss+, %)</td>
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<td>DOTS treatment success (new ss+, %)</td>
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<td>DOTS re-treatment success (ss+, %)</td>
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IMPLEMENTING THE STOP TB STRATEGY
DOTS EXPANSION AND ENHANCEMENT

Political commitment, standardized treatment, and monitoring and evaluation system

Achievements
- Declared TB a national emergency in August 2006
- Changed TB treatment regimen nationwide from 8 to 6 months by introducing rifampicin in the continuation phase
- Set up quarterly meetings to computerize district TB recording and reporting nationwide, with support from CDC
- Revised TB reporting and recording forms and TB register in line with WHO recommendations
- Produced 11th annual report of NTP activities

Planned activities
- Develop strategic plan, including component on national TB emergency
- Monitor treatment outcomes and adverse drug reactions nationally
- Monitor accuracy and completeness of TB data by development of specific indicators

Quality-assured bacteriology

Achievements
- Completed national DRS

Drug supply and management system

Achievements
- Introduced DFCs in priority areas, with support from GDF
- Distributed anti-TB drugs free of charge to all collaborating service providers, including NGOs and major private-for-profit health facilities

Planned activities
- Pilot test use of liquid culture media and introduce LED microscopy in 3 regions: Dar es Salaam, Mwanza and Tanga
- Conduct physical inspection of drugs and drug stores in health facilities

TB/HIV, MDR-TB AND OTHER CHALLENGES

Collaborative TB/HIV activities

Achievements
- Developed national guidelines for collaborative TB/HIV activities
- Trained more than 1500 health workers to implement collaborative TB/HIV activities
- Scaled up HIV testing and counseling for TB patients, and provided ART and IPT to identified HIV-infected TB patients

Planned activities
- Provide CPT to 80% of HIV-positive TB patients
- Provide ART in TB clinics in 31 out of 156 districts
- Train 700 health workers at district level to implement collaborative TB/HIV activities

Diagnosis and treatment of multidrug-resistant TB

Achievements
- Built new TB wards and laboratory unit for management of MDR-TB
- Recruited 6 medical officers, 16 nurses, 1 pharmacist and 2 laboratory technologists for management of MDR-TB
- Strengthened laboratories in order to perform culture and DST

Planned activities
- Apply for second-line drugs for treatment of MDR-TB through GLC
- Train 26 clinicians, nurses and laboratory staff in management of MDR-TB
- Introduce drug resistance surveillance by providing DST for all previously treated cases and 10% of new cases
- Introduce EQA for culture and DST

High-risk groups and special situations

Achievements
- Initiated screening for TB in prisons and among refugee populations

Planned activities
- None reported

HEALTH SYSTEM STRENGTHENING, INCLUDING HUMAN RESOURCE DEVELOPMENT

Achievements
- Collaborated with planning department of MoH, ministries of justice and of defence, NAP and NGOs in planning for TB control
- Trained over 4000 general health workers in clinical management of TB and TB/Leprosy (1 health centre established in each village)
- Renovated 12 TB diagnostic centres in 7 districts
- Provided 50 microscopes and other laboratory supplies to diagnostic centres and to public and private health facilities in 18 districts, as part of FIDELEIS programme
- Developed draft modules on TB control for inclusion in curricula for medical doctors and nurses of 4 medical schools

Planned activities
- Continue to renovate health infrastructure and increase supply of microscopes
- Develop long-term HRD plan for TB, with technical support from partners
- Train additional 500 general health workers

1 Unless otherwise specified, achievements are for financial year 2006; planned activities are for financial year 2007.
UNITED REPUBLIC OF TANZANIA

ENGAGING ALL CARE PROVIDERS

Achievements
- Carried out national assessment of involvement of non-NTP providers in diagnosis and treatment of TB, with WHO technical support
- Supplied anti-TB drugs free of charge to private health centres

Planned activities
- Introduce patient-centred treatment approach to all districts, in close collaboration with PATH
- Strengthen PPM by involving major private providers in urban areas in TB control
- Introduce ISTC in medical school curriculum

EMPOWERING PEOPLE WITH TB, AND COMMUNITIES

Advocacy, communication and social mobilization

Achievements
- Collaborated with NGOs and influential community leaders in advocacy and sensitization about TB
- Developed new ACSM messages for TB/HIV

Planned activities
- Conduct social marketing of TB

Community participation in TB care

Achievements
- Involved communities in TB control in 11 districts
- Introduced patient-centred treatment and community-based DOT
- Supported creation of club for former TB patients
- Introduced community-based TB control activities in 3 districts with nomadic populations

Planned activities
- Involve former TB patients in TB centres in 31 districts
- Recruit focal persons at central level to coordinate community and empowerment activities
- Support creation of additional associations for former TB patients
- Monitor community-based DOTS in nomadic populations

Patients' Charter

Achievements
- Distributed 500 copies of Patient's Charter to districts

Planned activities
- Develop mechanisms to involve TB patients and former TB patients, recognizing their potential to contribute to TB control activities

RESEARCH, INCLUDING SPECIAL SURVEYS AND IMPACT MEASUREMENT

Achievements
- Conducted national DRS
- Began research projects on treatment of HIV in TB patients
- Initiated national survey of prevalence of infection (3 health workers attended workshops in Botswana and Latvia) and began preparations for national prevalence of disease survey

Planned activities
- Continue preparation for prevalence of disease survey
FINANCING THE STOP TB STRATEGY

NTP budget by source of funding
NTP has developed plan and budget for 2008-2012 that covers all elements of the Stop TB Strategy; funding needs now much higher than previous years; while funding has grown, mostly from external donors and Global Fund, funding gaps remain.

NTP budget by line item
Increased budget for DOTS component, mainly for supervision activities and training at peripheral level; 95% of TB/HIV budget is for activities conducted by the NAP.

Total TB control costs by line item
NTP budget will account for largest share of total TB control costs in 2008 if fully funded, whereas the use of general health services by TB patients accounts for the largest share of total TB control costs 2003-2005.

Comparison of country report and Global Plan
Total TB control costs, 2003-2008

Per patient costs, budgets and expenditures
Substantial increase in cost and budget per patient as TB control broadened in line with the Stop TB Strategy; increase in available funding per patient.

NTP budget and funding gap by Stop TB Strategy component

SOURCES, METHODS AND ADDENDA

1. Incidence, prevalence and mortality estimates include patients infected with HIV. Incidence estimate originally based on an assumption of 50% sputum case detection rate in 1997 (DOTS and non-DOTS). Trend in incidence estimated from 5-year moving average of notification rate (new and relapse; DOTS and non-DOTS).
2. MDC and STB Partnership indicators shown in bold. Targets are 75% case detection, 80% link to care, 75% of cases on treatment, 75% at least one laboratory providing smear microscopy per 10,000 population. To provide culture for diagnosis of drug-resistant, extrapulmonary and sputum smear-negative patients, as well as DOTS for re-treatment and failure cases, most countries will need one culture facility per 5 million population and one DST facility per 10 million population.
3. Proportions are shown for the first time in a line chart. This figure shows the distribution of costs by category for the year 2008.
4. Funding channelled through the NAP is mostly external financing, e.g. other donors or Global Fund. The split of these funds between Global Fund and other donors is not known. This figure shows the distribution of costs by category for the year 2008.
5. Total TB control costs for 2008 are based on available funding, whereas these for 2004-2006 are based on expenditure. Estimates of the costs of clinical visits and hospitalization on HIV/AIDS estimates based on data provided by the NAP and from other sources. See Methods for further details.
6. NTP available budget for 2001-2005 is based on the amount of funding actually received, using retrospective data; available funding for 2002-2003, 2005 and 2006 is based on prospectively reported budget data, and estimated as the total budget minus any reported funding gap.

Data not available.