THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

STRATEGIC MASTER PLAN FOR THE NEGLECTED TROPICAL DISEASES CONTROL PROGRAM JULY 2021 – JUNE 2026

TANZANIA MAINLAND

"Sustain the Gains for Control and Elimination of NTDs"

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FOREWORD

Neglected Tropical Diseases (NTDs) are communicable diseases linked with poverty and prevalent in areas with poor sanitation, inadequate safe water supply and substandard housing conditions. NTDs are estimated to affect over one billion people in the world, majority being in developing countries. These diseases include Lymphatic Filariasis (LF), Onchocerciasis, Schistosomiasis, Soil Transmitted Helminths (STH), Human African Trypanosomiasis, Trachoma, Leprosy, Dengue fever, Rabies among others and have been confirmed to be endemic in Tanzania. NTDs are known to debilitate, deform, blind and kill sizeable proportions of the Tanzanian population. However, the focus of NTD Programme-Tanzania- had been on the main 5-PC NTDs (LF, STH, schistosomiasis, trachoma and onchocerciasis).

The first national NTD master plan for the control and elimination of targeted NTDs in Tanzania was launched in 2012. Since the launch, significant achievements have been made in understanding the burden of the diseases and the planning and implementation of subsequent control interventions. In addition, NTDs have given attention in the Health Sector Strategic Plan 2015/16 – 2019/20 (HSSP IV) and increased more emphasize in the HSSP V 2021-2026, which targets reaching all households with quality health care in Tanzania, promoting equity, gender, health promotion and social determinants for health in NTDs, to ensure no one is left behind.

This national NTD master plan (2021-2026) builds on the structure of the first master plan to provide strategic direction for the implementation of the elimination Lymphatic filariaisis, Trachoma, Onchocerciasis, schistosomiasis, and Soil Transmitted Helminthiasis. Although midterm and final evaluation of the previous master plan was not done due financial constrains, routine monitoring of the program activities highlighted several achievements attained and gaps to be adressed. Moreover, the document updates the estimates of the burden of NTDs, based on the mapping and impact data which was collected over the past 5 years. It is a comprehensive and valuable document that serves as a road map for NTD elimination in Tanzania.

The control and elimination of the NTDs will be a major contribution to poverty alleviation and attainment of the Sustainable Development Goals (SDGs) as stipulated in the SDG goal 3, target 3.3 (WHO 2016). This document will assist programme implementation and thereby alleviate the impact of these diseases. The document has been developed by various stakeholders and will be made available to all LGAs, health professionals, programme managers working on NTDs, as well as development partners.

The MOHCDGEC appreciates the contributions of all stakeholders involved in revision of this Multi-Year Strategic Plan. It is highly anticipated that all partners will make concerted efforts to the successful implementation of this plan in a collaborative manner to achieve the goal of the NTDs Programme.

Prof Abel N. Makubi
PERMANENT SECRETARY

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To all of you we say; thank you so much.

Dr. Aifello W. Sichalwe
CHIEF MEDICAL OFFICER

ABBREVIATIONS

AIDS	Acquired immunodeficiency Syndrome
APOC	African Programme for Onchocerciasis Control
BAKWATA	Baraza Kuu la Waislamu Tanzania (National Council of Muslims in Tanzania)
BCC	Behaviour Change Communication
CBOs	Community Based Organization(s)
CBR	Community Based Rehabilitation
CCHP	Comprehensive Council Health Plan
CDTI	Community Directed Treatment with Ivermectin
CHMT	Council Health Management Team
CSSC	Christian Social Services Commission
DBL	Danish Bilharziasis Laboratory
DED	District Executive Director
DFID	Department for International Development
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DMO	District Medical Office
DP(s)	Development Partners
DPS	Director (ate) of Preventive Services
DRC	Democratic Republic of Congo
DTLC	District Tuberculosis and Leprosy Coordinator
FAO	Food and Agriculture Organization
FBOs	Faith Based Organizations
GAELF	Global Alliance for Elimination of Lymphatic Filariasis
GDP	Gross Domestic Product
GLRA	German Leprosy and Tuberculosis Relief Association
GoT	Government of Tanzania
GSK	GlaxoSmithKline
HAT	Human African Trypanosomiasis
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
IEC	Information, Education and Communication
IHI	Ifakara Health Institute
IMA	Interchurch Medical Assistance
IMR	Infant Mortality Rate
ITI	International Trachoma Initiative
IVM	Integrated Vector Management
JHU	Johns Hopkins University
LF	Lymphatic Filariasis

LGAs	Local Government Authority(s)
MB	MultiBacillary (Leprosy)
MDA	Mass Drug Administration
MDGs	Millennium Development Goals
MDT	Multidrug Therapy
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMAM	Mpango wa Maendeleo ya Afya ya Msingi
MMP	Monitoring Master Plan
MMR	Maternal Mortality Ratio
MOFEA	Ministry of Finance and Economic Affairs
MOEVT	Ministry of Education and Vocational Training
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and children
MR	Mortality Rate
MSD	Medical Stores Department
MSU	Michigan state University
MTEF	Mid Term Expenditure Framework
MUHAS	Muhimbili University of Health and Allied Sciences
NECP	National Eye Care Programme
NFSD	Novartis Foundation for Sustainable Development
NGDO	Non-Governmental and Development Organisation
NIMR	National Institute for Medical Research
NLFEP	National Lymphatic Filariasis Elimination Programme
NOCP	National Onchocerciasis Control Programme
NSGRP	National Strategy for Growth and Reduction of Poverty
NSSCP	National Schistosomiasis and Soil Transmitted Control Programme
NTDs	Neglected Tropical Diseases
NTLP	National Tuberculosis and Leprosy Program
OIE	Office International des Epizooties (World Organization for Animal Health)
PB	Pauci bacillary (leprosy)
PCT	Preventive Chemotherapy
PHC	Primary Health Care
PHCSDP	Primary Health Care Service Development Programme
PHDR	Poverty and Human Development Report
PO-RALG	President's office-Regional Administration and Local Government
POD	Prevention of Disability
PPP	Public Private Partnership
PPRA	Public Procurement Regulatory Act Authority
PZQ	Praziquantel
RCHS	Reproductive and Child Health Services Section
REMO	Rapid Epidemiological Mapping of Onchocerciasis

RSs	Regional Secretariat
RTLC	Regional Tuberculosis and Leprosy Coordinator
SAFE	Surgery, Antibiotic, Face washing and Environmental Improvement
SCH	Schistosomiasis
SCHi	Intestinal Schistosomiasis
SCHu	Urinary Schistosomiasis
SCI	Schistosomiasis Control Initiative
SER	Social Economic Rehabilitation
SIDA	Swedish International Development Agency
SPRS	Septic Preventive and Reconstructive Surgery
SSI	Sightsavers International
STH	Soil Transmitted Helminthiasis
SUA	Sokoine University of Agriculture
TBRF	Tick Borne Relapsing Fevers
TMDA	Tanzania Medicines and Medical Devices Authority
TFNC	Tanzania Food and Nutrition Centre
TLA	Tanzania Leprosy Association
TPRI	Tanzania Tropical Pesticides Research Institute
TT	Trachomatous Trichiasis
UCLAS	University College of Lands and Architectural Studies
UDSM	University of Dar es Salaam
UNICEF	The United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization

KEY DEFINITIONS OF TERMS

Control: Reduction of disease incidence, prevalence, morbidity and/or mortality to a locally acceptable level as a result of deliberate efforts; continued interventions are required to maintain the reduction. Control may or may not be related to global targets set by WHO.

Elimination (interruption of transmission): Reduction to zero of the incidence of infection caused by a specific pathogen in a defined geographical area, with minimal risk of reintroduction, as a result of deliberate efforts; continued action to prevent re-establishment of transmission may be required. Documentation of elimination of transmission is called verification.

Elimination as a public health problem: A term related to both infection and disease, defined by achievement of measurable targets set by WHO in relation to a specific disease. When reached, continued action is required to maintain the targets and/or to advance interruption of transmission. Documentation of elimination as a public health problem is called validation.

Eradication: Permanent reduction to zero of the worldwide incidence of infection caused by a specific pathogen, as a result of deliberate efforts, with no risk of reintroduction.
Hygiene: Conditions or practices conducive to maintaining health and preventing disability.
Integrated vector management: A rational decision-making process to optimize the use of resources for vector control.

Mass drug administration: Distribution of medicines to the entire population of a given administrative setting (for instance, state, region, province, district, sub district or village), irrespective of the presence of symptoms or infection; however, exclusion criteria may apply. (In this document, the terms mass drug administration and preventive chemotherapy are used interchangeably.)

Morbidity: Detectable, measurable clinical consequences of infections and disease that adversely affect the health of individuals. Evidence of morbidity may be overt (such as the presence of blood in the urine, anaemia, chronic pain or fatigue) or subtle (such as stunted growth, impeded school or work performance or increased susceptibility to other diseases).
Monitoring and evaluation: Processes for improving performance and measuring results in order to improve management of outputs, outcomes and impact.

Platform: Structure through which public health programmes or interventions are delivered.

Preventive chemotherapy: Large-scale use of medicines, either alone or in combination, in public health interventions. Mass drug administration is one form of preventive chemotherapy; other forms could be limited to specific population groups such as school- aged children and women of childbearing age. (In this document, the terms preventive chemotherapy and mass drug administration are used interchangeably.)

INTRODUCTION

The vision of the Ministry of Health Tanzania is to have a healthy and prosperous society that contributes fully to the development of individuals and the nation. To realise this vision, the national health policy and other policies strive to provide a conducive environment for health services delivery that consider socio-economic changes, global strategies, other national strategic priorities and advancement in science and technology.

Tanzania is endemic with five Preventive Chemotherapy (PCT) targeted NTDs, namely, Schistosomiasis, Soil-transmitted Helminths, Lymphatic Filariasis, Onchocerciasis and Trachoma, as well as case management diseases such as Human African Trypanosomiasis (HAT), Rabies, Tick borne Relapsing fevers, Echinococcosis (hydatid), Taeniasis (cysticercosis), Brucellosis, Plague, Leprosy and Snake bite. A large part of the population is at risk of co-infection with two or more of these diseases. The control and/or elimination of these NTDs have been on-going for several years.

Integrated NTD Control program has been in operation since 2009 and was guided by the first NTD Master Plan which started from 2012 to 2017. The Master Plan served as an essential tool in ensuring effective plans are set forth for the implementation of sustainable NTD control programme in the whole country. It includes strategies for financial sustainability that link to the health sector budgeting and planning cycles and encourages strong linkages with other interventions within and beyond the primary health care context.

The Master plan addresses 5 PCT targeted NTDs as guided by HSSP V 2021 - 2026. The HSSP V 2021-2026 states application of Mass Drug Administration (MDA), Environmental Interventions and Case and Co-morbidities management, for for Lymphoedema, Hydrocele and Trachomatous Trichiasis as the key interventions for implementation of control and elimination of 5 PC-NTDs under the NTD Programme. The main goal of the previous plan was to reduce morbidity due to NTDs in Tanzania to a level that they are no longer a public health problem by 2017 through community and school-based delivery mechanisms.

1. Significant achievements have been realized in the past eleven years since the launching of the integrated NTD control program. These achievements have come due to collaborative effort of local communities, government, partners and implementing team. Some of these successes include Establishing and implementing integrated NTD control. Tanzania is one of the first WHO African region countries to integrate the coordination and implementation of 5 PC-NTDs diseases control /elimination activities, including MDA, health education and morbidity management.
2. Inclusion of NTD in the Health Strategic Plans and its budget tools. NTDs was included in the HSSPIV (2016-2020) and the Council Comprehensive health plans (CCHP).
3. Attainment of full (100%) geographical coverage for MDA in all councils. MDA for onchocerciasis reached full coverage by 2009, for LF in 2014 and for STH and SCH in 2015/16. In 2013 over 19 million people were treated with 45 million treatments and in 2014, over 23 million people were reached with 55 million treatments of Ivermectin, Albendazole, Praziquantel and Zithromax. In 2016/17, over 17.4 million people were reached with 34.9 million treatments of the same medicines.

4. Scaling down of MDA for LF and trachoma: For Lymphatic Filariasis the country scaled down from the previous 119 endemic districts that needed MDA to 24 (80% reduction) in 2019 and for Trachoma the country scaled down from the previous 71 districts that needed MDA to 6 (92% reduction) districts that needed MDA in 2019.

The priority areas for this term is establishing sustainable NTD implementation programme with focus in monitoring & evaluation and establishing NTD surveillance mechanisms. The goal of this second NTD strategic masterplan (2021-2026) is to continue and sustain implementation of NTD elimination and control efforts in all endemic areas, and to scale up disease monitoring and surveillance in areas that have attained reduction of morbidity due to NTDs and make them no longer a public health problem by 2026.

This master plan also highlights the lessons learnt and challenges encountered, and solutions applied during the implementation of the previous master plan.

Four priority areas have been outlined in the plan to guide future implementation.

1. Strengthen Government Ownership, Advocacy, Coordination and Partnership
2. Enhance planning for results, resource mobilization and financial sustainability
3. Scale up access to interventions, treatment and system capacity building
4. Enhance NTD monitoring and evaluation, surveillance and operational research

The following day to day activities of NTD programme will be guided by the four priority areas: -

1. Capacity building activities for NTD control and elimination, including trainings to be conducted at national, regional and district levels.
2. NTD control and overall program advocacy, social mobilization and community mobilization.
3. Mass Drug Administration for all preventive chemotherapy targeted NTDs. Administered medicines are Ivermectin, Albendazole, Praziquantel, and Zithromax.
4. Morbidity management activities including hydrocele and Trachomatous Trichiasis (TT) surgeries and Lymphoedema management.
5. Implementation of Program and disease monitoring and evaluations including coverage surveys, Data Quality Assurance (DQA) and disease specific assessments

PART ONE: SITUATION ANALYSIS

1.1. Country Profile

1.1.1. Administrative, demography and community health care

Administrative Structure

Tanzania Mainland has 26 regions with 139 administrative districts and 184 councils. The districts are further sub-divided into divisions, wards, villages/streets and sub-villages (Hamlets). The country has 4,263 streets and 12,369 villages of which all are divided into 64,384 sub-village. In rural areas such sub villages consist of natural sentiments of up to a few hundred households. Administratively, each sub village (hamlet) and village/street has a chairperson elected by the community and ward has a Councillors elected by the community and ward executive officer employed by the government. A ward has gained more importance as a functional unit than divisions at the local government as it plays an overall significant role at the district level.

Figure 1: Administrative structure in the country

Local Government Authorities are headed by Council Directors. The present system of decentralization of powers gives more emphasis on the local government authorities where they also handle political matters (Councillors). This set-up has elective representation starting from the village/street governments to the ward and ultimately to the council. council are the most important functional unit concerning community development and social service delivery, including primary health care.

Community Health Care

In history, Primary Health care in Tanzania was often referred to and sold as "Afya ya Msingi "(Basic Health Care) and was primarily considered to be the first step towards ensuring access to care for all citizens. The Tanzania health policy describes the health services to be offered at all levels. The role of communities is described as "taking responsibility of their own health and contributing to health service". The health sector strategic plan identifies CBOs and NGOs as the entities responsible for empowering families and engaging in home-based care. The Primary Health Care Services Development Plan (PHCSD) of 2007 popularly referred to as MMAM – Mpango wa Maendeleo ya Afya ya Msingi was one of key new strategies laid to re-address community health systems as important and the key to the health development of all Tanzanians.

One Health and Universal Coverage; the national health sector strategic plan for 2021 – 2026; is a living document, developed using a multi-sectoral approach to create and

maintain active collaboration between the sectors for the prevention and control of Neglected Tropical Diseases and ensure that there is timely preparedness, and a consistent and coordinated response in the event of an occurrence of NTD.

National Community based health program and Community health workers cadre initiative

The National Community Based Health Program (CBHP) policy guidelines (March 2014) provides a coordinative and integrative framework to enable Local Government Authorities (LGA) to put in place sound community health practice as an extension of MMAM benefits beyond First Line Health Facilities (FLHFs). The aim is to empower communities by building capacity through sustainable and integrated CBHP to respond to local health needs.

Historical trends for community-based health initiatives in Tanzania indicate several gaps which need to be addressed. These gaps include:

- Absence of a formalized community-based health cadre,
- Inadequate mechanisms for community-based health services,
- Inadequate linkages between community and facility,
- Poor community participation in health care.

Despite efforts by the Government and various stakeholders, these gaps have continued to be observed, leading to health benefits not being fully realized.

Community Drug distributors and related cadres are recognized in different Ministry of health strategy documents though not in the scheme of Service (Note: VHWs on the other hand are legally recognized and established by government act of July 1975). Sustainability and remuneration of community health distributors at ground level has been a stumbling bottleneck in motivating and sustaining the growing community distribution programme adopted by NTDCP.

Under the new community-based health program policy (2014), the policy statements are.
The Ministry of health, community development, gender, elderly and children in collaboration with relevant ministries shall:

- Support delivery of integrated services in a continuum of care at both facility and community levels.
- Establish an essential health service package for CHW and ensure that package is fully operational in communities.
- Ensure resources to support this initiative.

Following this policy, the Ministry in collaboration with partners and other relevant stakeholders harmonized and standardized a training curriculum for CHWs. In addition, they shall facilitate accreditation of the training curriculum for CHWs, formalize a CHW cadre with selection criteria, competency based national training, and ensure deployment of CHWs.

CHWs and other community level service providers shall contribute to mortality reduction by supporting care and treatment at home, detecting and following up HIV and other clients with chronic illnesses, providing TB Directly Observed Treatment (DOT), NTDs Mass

Drug Administration through house-to-house DOT approach and ensuring early and effective referrals.
The referrals follows the health care pyramid in Tanzania as highlighted in the figure below.

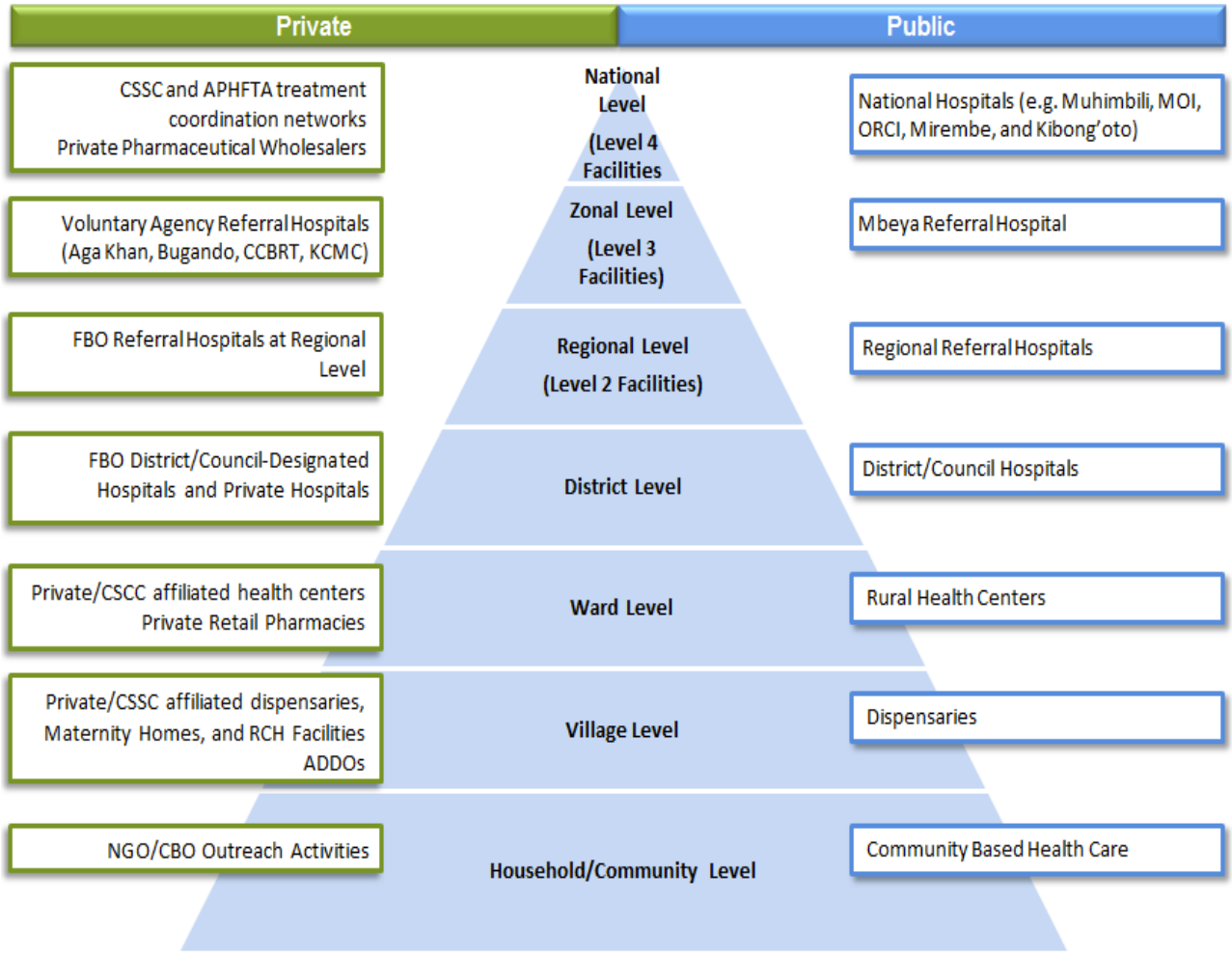


Figure 2: The Health Care Pyramid in Tanzania (Private & Public)

Demography

In 2020 the projected population was 57.6 million where by males are 28.2 million while females are 29.4 millions The population of Tanzania has continued to be predominantly rural despite the increase in proportion of urban residents over time, from 6 per cent in 1967 to 30 per cent in 2016.
NTD program has been using population figures in activities implementation e.g., drugs distribution and assessment surveys.

Geographical characteristics

The United Republic of Tanzania covers 940,000 square kilometres, 60,000 of which are inland water. Tanzania lies south of the equator and shares borders with eight countries: Kenya and Uganda to the north; Rwanda, Burundi, the Democratic Republic of Congo, and Zambia to the west; and Malawi and Mozambique to the south (figure 1). Tanzania lies 200 metres or more above sea level, and much of the country is higher than 1,000 meters. In the north, Mount Kilimanjaro rises to 5,895 meters—the highest point in Africa.

Figure 3: Geography of Tanzania (based on district administration)

Lakes and the Drainage Pattern

Tanzania has an abundance of inland water, with several lakes and rivers. The country's physical geography and associated drainage patterns are largely influenced by the Great Rift Valley that runs northwards from near the mouth of the Zambezi River, through Tanzania, Kenya, Ethiopia and across the Red Sea. Tanzania has two branches of the valley, one running along the western branch, which holds Lakes Tanganyika, Rukwa, and Nyasa, while the eastern branch, which ends in northern Tanzania, includes Lakes Natron, Manyara, and Eyasi. Lake Tanganyika runs along the western border of the country and is Africa's deepest and longest freshwater lake. It is also the world's second deepest lake. Lake Victoria, the world's second largest lake, drains into the Nile River, which flows to the Mediterranean Sea. There are two internal drainage basins, that of lake Eyasi in the northern-central plateau and Lake Rukwa in the southwest, a relatively small area.

High plateau and mountains in the country are drained by many fast-flowing streams, both permanent as well as seasonal; with the latter flowing only in rainy season. Although there are many rivers, only the Rufiji and the Kagera, which empties into Lake Victoria, are navigable by anything larger than a canoe. Important rivers which directly flow into the Indian Ocean include (from north to south) the Pangani, Wami, Ruvu, Rufiji (whose major tributaries include the great Ruaha, Kilombero, Luhombero and Luwengu), Matandu, Mbwemkuru, Lukuledi and Ruvuma.

All the smaller rivers such as the Ruhuhu, Lumbira, Lufilyo, and Kiwira etc. which flow into Lake Nyasa finally reaching the Indian Ocean are important Onchocerciasis vector habitats in the south and southwest of Tanzania.

Forests, National Parks and Game Reserves

About a quarter of Tanzania's land area is covered by forest reserves, national parks and game reserves. The forests offer habitat for wildlife, beekeeping, unique natural

ecosystems and genetic resources. They are also an important economic base for the country's development.
Tourism is one of the biggest exports earning industries in the country and accounts for about 10% of GDP and nearly 40% of the total foreign exchange earnings from the export of goods and services (Ministry of Natural Resources and Tourism 2002). Human's activities like those related to agricultural expansion, livestock grazing, wildfires and over-exploitation increase ones contact with vectors and animals likely to be carrying NTDs like rabies and the Human African Trypanosomiasis.

Meteorology
The main climatic feature for most of the country is tropical in nature, with high average temperature, low wind speeds and high air humidity in the lowlands. The Indian Ocean coastal plain is hot and more humid, with average day temperatures of 30^{o}c and very little annual mean temperature differences. Long dry spells are from May to October followed by a period of rainfall between November and April. The main rainy season is from March to May, along the coast and around Mount Kilimanjaro, with short periods of rain arriving between October and December. In the western part of the country, around Lake Victoria, rainfall is well distributed throughout the year, with the peak period falling between March and May.

Socio-Economic Situation and Indicators

The Tanzanian economy depends heavily on agriculture, provides 85% of exports, and employs 80% of the work force (National Bureau of Statistics, 2012). Topography and climatic conditions, however, limit cultivated crops to only 4% of the land area. Cash crops including coffee (its largest export), tea, cotton, cashews, sisal, cloves, and pyrethrum, account for the vast majority of export earnings. Poor pricing and unreliable cash flow to farmers continue to frustrate the agricultural sector. Tanzania's industrial sector is one of the fastest growing in Africa and it accounts for 22.6% of GDP.

Tanzania Gross Domestic Product (GDP) at constant 1992 prices recorded an average of real growth rate of 4.0 per cent per annum during 1996-1999. Given the annual population growth rate of 2.7 per cent, per capita real growth rate was around 1.2 per cent (National Bureau of Statistics, 2012). The composition of GDP is such that, agricultural sector accounts for around 50.0 per cent, followed by trade sector which accounts for around 16.0 per cent. Financial and business services rank third at the tune of 10 per cent, followed by the industrial sector by around 8.0 per cent. The mining sector has been contributing around 2.0 per cent, but there is a bright future for the sector as foreign investments continue to flow in.

Tanzania's estimate for 2010 Human Development Index was at 0.398 HDI reflecting a low pace towards improved country's wellbeing: in terms of child welfare, life expectancy, literacy, education and standards of living. Most of the population (74%) resides in rural areas. About half of the population is in the economically productive age range of between 15-64 years; 43.2% are under 15 years of age and a further 2.5% aged over 65 years. The primary school enrolment rate in the year 2012 was 92% and the age was 7-13years (National Bureau of Statistics, 2012). The labour market is still constrained with more unemployed youths than adults. According to WHO statistics in 2015 the life expectancy at birth is 60 years for males and 64 years for female (WHO, 2016). The maternal mortality ratio is of 398 per 100,000 live births. UNICEF maternal and child health data reported there is a considerable progress in the reduction of child mortality (UNICEF

2019). Under-five mortality rates continue to drop from 112 deaths per 1,000 live births in 2005 to 81 in 2010. The deaths of infants under one year also decreased from 68 to 51 per 1,000 live births over the same period.

According to Water Aid, 23 million people in Tanzania do not have access to safe water. Typically, women and children spend over two hours a day collecting water. Sanitation coverage in urban and rural areas is 97.7% and 90.4% respectively (National Bureau of Statistics 2012). The median time to a water source is 27 minutes. Pit latrines account for the bulk of sanitation coverage, typically around 80 per cent, followed by open defecation. Flush latrines and VIP represented a very small fraction of latrines found in rural areas. Improved rural household sanitation coverage for Tanzania is 23% and 27% for rural and urban areas respectively (National Bureau of Statistics 2012). With the inclusion of the shared latrines, the coverage stands at 42%. According to the World Bank collection of development indicators, 32.8% of the population have access to electricity (Trading Economics, 2019).

Transport and Communication

Tarmac roads connect all regions in Tanzania. Most of the roads within the districts are passable all seasons. There are also two main railway lines: the central lines and Tanzania-Zambia railway line. Central line is to be upgraded to Standard Gauge Railway from Dar-es-salaam to Dodoma (Makutupora) through Morogoro with 541 Km of main truck and 184 of exchange lines (TCRA, 2019). This project expected to be completed 2020. The road network provides the main means of transport to various regions and districts; the main implementation units (IU) for NTD control activities. Since most of the IUs do not have tarmac roads to lower level, i.e. villages and hamlets, delivery of drugs and supplies, and actual MDA and DSAs, have to be implemented during relatively dry seasons of year when roads are passable. The use of motorcycle at district and sub-district level and the use of bicycles have proved to be helpful and cost effective given the condition of the roads and the large sizes of IUs. (See: Annex 1-Tanzania Distance Chart).

Communication

With the growing economic state of the country, the number of landline phone users has been degrading gradually while mobile phone users have been increasing (TCRA, 2019). The figure below shows the number of landline users versus mobile phone users in the period 2011-2016.

Figure 4:The number of landline users versus mobile phone users.

According to Tanzania Communications Regulatory Authority (TCRA, 2019) more than 40 million mobile phone subscriptions were recorded by June 2017. With this, communication has become easier especially in reaching health and other related messages to communities. Overall, the high use of mobile phones in both rural and urban households gives room for scale up on mobile communication for the NTD programme.

Other modes of communication include letters (through post and parcels through buses) railway services, Television and Radio systems, use of posters, local village gatherings and meetings, public criers and road shows. Communication by telephone, fax and electronic mail services are available in all districts. National and local radios are available in all communities. NTDCP has adopted these modes of communication to convey messages to communities prior to MDA activities.

The number of internet users has been increasing gradually from 2011 (TCRA, 2019) (see figure below) with the number increasing to 20 million users in 2016. Currently the government is constructing the National Fibre Optic Cable network named as National ICT Broadband Backbone (NICTBB) with a view to achieve its' ICT vision. The Backbone is managed and operated by the Tanzania Telecommunications Company Ltd (TTCL) on behalf of the government, through the ministry of Communication Science and Technology (MCST).

The infrastructure will enhance usage of ICT applications for sustainable socio-economic development including implementation of e-government, e-learning, e-health, e-commerce and much more locally and globally. Overall, advanced technology in telecommunication industry has allowed communication available up to the village level. This has eased NTD implementation to all levels.

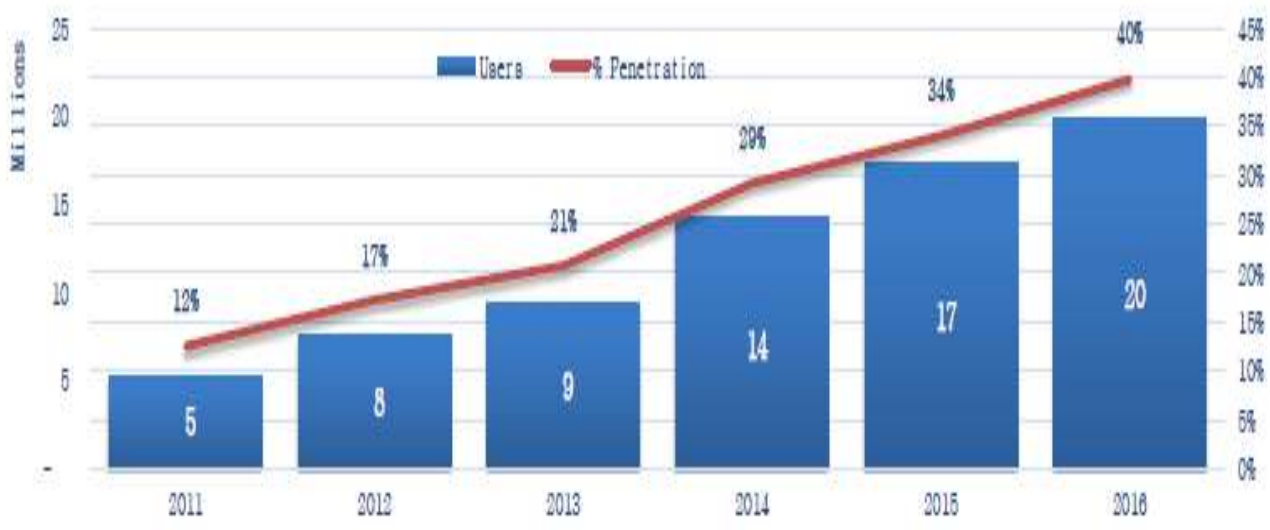


Figure 5:The number of internet users

Health System Situation Analysis

Health System in Tanzania, Goals and Priorities

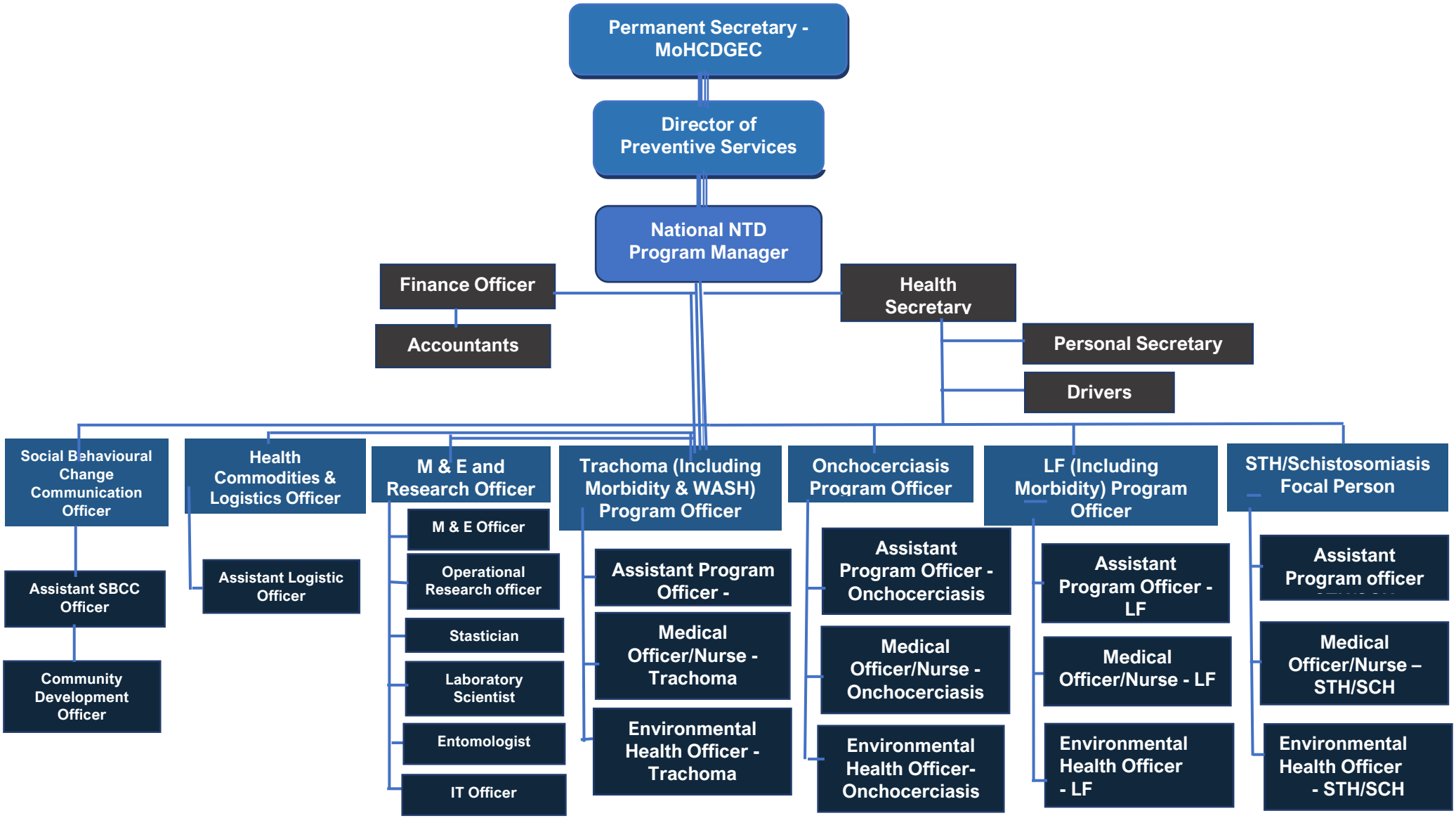
The Ministry of Health, Community Development, Gender, Elderly and Children is responsible for the provision of health services and the overall stewardship of the health sector. The vision of the MoHCDGEC is to be the centre of excellence in promoting community's pro-activeness, confidence, commitment and culture of hard working in striving for better livelihood embracing gender equality and children's rights.

The mission of the MoHCDGEC is to promote community development, gender equality, equity and children's rights through formulation of policies, strategies and guidelines in collaboration with stakeholders active in the country. Core values of the MoHCDGEC include discipline and commitment, creativeness, results oriented, integrity, customer's focus, team spirit, transparency, impartiality, responsibility and accountability.

Top 10 diseases in Tanzania include diarrheal disease, neonatal disorders, HIV/AIDS, TB, NTDs and malaria, cardiovascular diseases, other non-communicable diseases, nutritional deficiencies, unintentional injuries, neoplasms and mental disorders.

NTDCP is monitored under the Director of Preventive Services; below is the detailed organogram of the Program.

Figure 6: Organogram of the NTDCP



Analysis of the Overall Health System

Service Delivery

Local Government Authorities (LGAs) are responsible for delivering public services in local health services. Primary Health Care services form the basis of the pyramidal structure of health care services. Both public and private providers are working in dispensaries, health centres and at least one hospital at the district level. About 90% of population live within five kilometres of a primary health care facility.

The distribution of Health Facilities has a heavy rural emphasis. Plans for the establishment of health facilities have in the past taken into consideration the facility/population ratio, but with time this has, in some areas, been seriously overwhelmed by the high population growth-rates. Approximately, two thirds of the total population cannot access health facility within 5 kms.

The health referral system assumes a pyramidal pattern recommended by health planners that is from dispensary to National and specialized Hospitals. As of 30th of June 2021, the country has 380 hospitals 930 health centres, 6,964 dispensaries and 571 clinics. (Source : http://hfrportal.ehealth.go.tz/index.php?r=site/index). These are owned by the Government, Faith Based Organizations and private sector).

The lowest level of health care delivery home-based care service is provided by community health care workers followed by dispensary. The dispensary can cater for up to 10,000 people and a health centre can serve approximately 50,000 people in one administrative division or ward. Districts are very important levels in provision of health services in the country. Each district has a district hospital and Council Health Management Team (CHMT), which determines the priorities for the health needs.

Every region has a hospital which offers similar services to those provided at district level; however, some regional hospitals have specialists. The zonal referral hospitals serve as the referral facilities from regional hospitals. There are four in the country; namely, the Muhimbili National Hospital which serve as a zonal referral hospital and national hospital caters for the eastern zone; Kilimanjaro Christian Medical Centre which caters for the northern zone, Bugando Hospital which caters for the western zone; and Mbeya Hospital which serves the southern Highlands. Muhimbili National Hospital and specialized hospitals (Ocen road, Kibong'oto, MOI and JKCI) serve as the highest level of service delivery

NTDs are endemic all over the country. Patients get treatment at the nearest health facilities. Case Management for hydrocoele, Lymphoedema as well as trichiasis are managed at the Health Facility with support from the councils. Due to stigmatization some patients do not seek the services. Such patients are identified by the CDDs during pre-MDA census.

Whenever possible, the programme in collaboration with partners organizes a camp to cater for the big backlog of patients in an endemic area. Non PCT disease patients do seek treatment and are always treated on routine basis in the health facility expect for the epidemic prone diseases like Plague whereby a surveillance mechanism is in place.

For LF, Trachoma, Onchocerciasis, STH and Schistosomiasis, MDA campaign is done at least once a year whereby the targeted population get Prevention of the named diseases

with Ivermectin & Albendazole, Zithromax, and Praziquantel Distribution of these drugs follow a Community Directed Treatment Initiative (CDTI) approach whereby the community chooses their own Drug distributor. The Community Drug Distributors (CDDs) are responsible for distributing drugs house to house and sometimes in booth (schools, markets, bus stands etc). CDDs and teachers (for Praziquantel) are trained pre-MDA on drugs importance, dosage and data recording. Supervision of CDDs and teachers is done by the local health facility workers.

Health Workforce

Health sector has been facing a huge problem of shortage of human resources despite measures by the Government to fill the gap. The shortage has a negative impact on provisional of quality health services including NTDs. Recent statistics show that there are only 2 doctors available for every 100,000 people in the population. Regional and District NTD Coordinators and respective secretariat members are nominated from the existing health staff. They are trained as trainers and provide training to lower cadres in cascade manner. However, there is a need to empower them beyond NTD MDA to skill sets like program and data management.

Front line health care facilities provide leadership and supportive supervision at community level. In each health facility two staffs are trained on NTD MDA including SAE management. Community-owned resource persons (CDDs, VHW) provide a formidable workforce at the lowest level of implementation, i.e., the hamlet, to distribute drugs House to House. Teachers do the same for school-based distribution.

Health Information

Health information that reflects the burden and magnitude of diseases in the country is collected in two different systems: HMIS and IDSR. HMIS collect information from all health facilities in the country and is disseminated through annual health abstract. IDSR is an adopted strategy from WHO AFRO which collects information of disease which needs immediate action. Some of the NTD programme data and indicators are integrated and available in HMIS.

Medical Products

The MoHCDGEC has been prioritising the adequate and timely disbursement of financial resources for provision of essential medicines, medical supplies, equipment and vaccines at all levels according to the drug allocation formula in place. It ensures constant and adequate availability of pharmaceuticals, medical supplies and equipment of acceptable quality in the supply chain system for public health facilities and accredited private facilities.

The country has a centralized system of handling all medical products such as medicines, laboratory consumables, equipment and supplies. Procurement, supply and distribution is done through the Medical Stores Department (MSD) which receives orders from the Regional, District and Faith Based Organisations. The department has extensions to the zonal level where distribution of these products to the regions, districts and health facilities take place.

The pharmacy council ensures provision of quality and efficient pharmaceutical services in the public and private sectors. Rational use of medicines is promoted through introduction of up-to-date standard treatment guidelines and dispensing guidelines. In

hospitals, Drugs and Therapeutic Committees have been introduced as part of quality improvement. The essential medicines list is regularly reviewed and adapted to new treatment insights and distributed on time to health workers. Donors are stimulated to comply with the Tanzanian procurement systems and donation guidelines, rather than providing non- requested medicines and medical devices in kind.

NTD medicines are applied at the National Program by the NTD Secretariat staff through the WHO Joint Request for Selected Medicines application form (for Ivermectin tabs, Albendazole tabs, Praziquantel tabs) as well as the ITI application form (for Zithromax tabs and Zithromax POS) after having the data (population, drug inventory) from the district and lower level. All donated PCT medicines are handled, stored and distributed by MSD.

In efforts to effectively manage NTD medicines, the NTDCP received support from PATH and managed to develop supply chain management booklets for Pharmacists (English), Front Line Health Workers (English and Swahili) and Community Drug Distributors (English and Swahili). The materials, the NTD Control Program will train all health care workers on the management of NTD medicines. Supply chain management on NTD medicines is important because management of NTD medicines is a bit different from other programs. Medicines are required back at the district pharmacy after the campaign for proper management before the next campaign.

Pharmacovigilance System

The government, through TMDA has step up control of quality, safety and efficacy of pharmaceuticals, medical supplies, medical equipment, traditional and alternative medicines in both public and private sectors. TMDA regulates various aspects of pharmaceutical sector activities, food, cosmetics and medical products. The authority prescribes standards of quality, safety and effectiveness for the above areas of responsibility.

Adverse drug reactions (ADRs) monitoring and reporting system is also under TMDA. It is well known that all drugs carry the potential to produce both desirable and undesirable effects. Guideline for monitoring and reporting ADR is available since 2006 in which the implementation of the law obligates the Authority to carry out effectively ADR monitoring and reporting activities which essentially embraces detection, assessment, understanding and prevention of ADRs. This exercise necessitates cooperation among all healthcare providers, drug registrants and manufacturers in the country. Some serious and mild ADRs tend to go unreported. The MoHCDGEC has also been working with other partners such as MSH and JSI to strengthen the pharmacovigilance system in the country. There is an existing system for monitoring and reporting ADR which requires submitting the filled forms to the designated centres by post or online.

In 2010-2011 TMDA in collaboration with the WHO and NTD Control Programme developed the pharmacovigilance guide for PCT NTDs. This guide stipulates all aspects of SAE and its management. Moreover, the working tool for SAE is the same as for routine medicines and it is provided by TMDA to all health facilities. NTD program will continue to operate in collaboration with the existing system to strengthen detection, assessment, monitoring and reporting of ADRs.

Health Financing
The HSSPV spelt out different mechanism for health financing for health service delivery. MOHCDGEC has adopted the Sector Wide Approach (SWAPs) which provides the framework for collaboration among stakeholders, MoHCDGEC, PO-RALG, Ministry of Finance and Planning, Civil Societies, Private sectors and DPs including UN Agencies active in Health.

Financing of the NTD activities takes note of the critical shortage of resources facing developing countries. It also recognizes the existence of non-discretionary resources, which are mostly found outside the Government budget frame. The approach, therefore, is planning service provision based on the package of essential health interventions that are cost-effective, with the view that the off-budget resources are gradually captured in the Government budget and will provide flexibility for funding NTD priorities.

The Health Basket Fund (HBF) is one of mechanism for health financing. It consists of two elements; central basket, which funds the MoHCDGEC headquarters and other central, organizations with central support functions, and the district basket, which funds the running costs for council health services based on the CCHPs. The council basket aims at providing a stable and predictable resource base for local councils, complementing the council Health Block Grant and own sources including cost sharing. It also provides funds for PO-RALG and RHMTs to oversee implementation of the district health services including NTDs. The Basket Funding (BF) comprises of source from Government MOHCDGEC, PO-RALG, MOF and basket-donors. The BF follows a set of financial, administrative and management procedures as laid down in the government financial regulations and procedures.

It is expected that funding from domestic resources will gradually increase in the coming periods, since health sector is and continues to be one of the priority areas. It is also expected that funding from foreign resources will decrease as globally the country ownership and domestic funding to NTD Program is among the NTD 2030 Roadmap goals on NTDs.

Leadership and Governance
The Ministry of Health, Community Development, Gender, Elderly and Children is responsible for provision of health services and the overall stewardship of the health sector. Service delivery, leadership and governance are decentralized with key roles and responsibility divided in four levels.

National level
The MoHCDGEC is responsible for policy and policy guideline development, strategic planning, resource mobilization and overall monitoring quality control and evaluation.

Regional Level
The RHMT does policy interpretation and provides overall technical supportive supervision to the CHMTs.

Council Level
Council is the implementation level. Health plans are developed at this level following identified local and national priorities. The CHMT develops budgets and carries out

implementation of the budgets. Monitoring and evaluation of the impact of the plans is also done by CHMT.

Community Level

The lowest level of health system is the community. Activities incorporated into the council health plan are derived from community needs identified through village/street health committees. In 2020 Tanzania had 184 councils that are responsible for planning and execution of local health plans.

NTDCP is largely integrated into the existing primary health care system and works with local communities, CHMTs, and RHMTs to plan and implement NTD control activities. Program implementation follows the existing structure and is led by National, Regional and Council coordinators respectively. At community level, there are community drug distributors-CDDs, case finders, and cascade leaders/zonal coordinators who provides the front health facilities with supportive supervision and aids in data collection.

Intersectoral Collaboration

Control of NTDs is through multisectoral approach. NTD activities are planned and implemented at the Council level by the CHMT. All partners-local, national and international- contributions and activities by other related departments, e.g., department of education, department of agriculture, department of livestock and social work, are reflected in the council plans. The plans are approved by the Council Health Services Board (CHSB) and checked by RHMT. Final review and approval are done by PO-RALG and MOHCDGEC before funds are disbursed to councils for implementation.

The program also works in partnership with research institutions like the NIMR, universities like SUA, and government institutions and ministries like Tanzania Food and Drug Administration Authority, Medical Stores Department, Tanzania Bureau of Standards, National Bureau of Statistics, Ministry of Education, Ministry of livestock Development, Ministry of Water, and Tanzania Food and Nutrition Centre and other Ministry of Health and Social Welfare departments.

Neglected Tropical Disease Situational Analysis

Epidemiology and burden of diseases

Parasitic infections are widespread in the country due to several factors including the low socio-economic status of rural populations. Schistosomiasis, soil-transmitted Helminths, Lymphatic Filariasis, Onchocerciasis and Trachoma are endemic in many areas as well as zoonotic diseases such as Human African Trypanosomiasis (HAT), Rabies, Tick borne Relapsing fevers, Plague, Echinococcosis (hydatid), Taeniasis (cysticercosis) and Brucellosis with a large part of the population being at risk of co-infection with two or more of these diseases.

DALYS due to NTDs and Malaria 2,902 DALYs in 100,000 people as per GBD report 2016. The most recent national survey revealed stunting or chronic malnutrition in 34.7% (33.7-35.7; 95% CI) of children 0-59 months of age which is a high rate according to WHO classification. Among women aged 15-49 years of age, 5.5% were considered being in thinness (Government of the United Republic of Tanzania, 2014).

Schistosomiasis

Schistosomiasis is a parasitic disease caused by infection with trematode flatworms of the genus Schistosoma. Infections are acquired when people come into contact with infested waters. Transmission occurs when infected people contaminate waterbodies with excreta containing eggs of the parasite, which hatch in the water. Schistosoma species include S. mansoni, S. mekongi, S. japonicum and S. intercalatum which cause intestinal schistosomiasis and S. haematobium which causes urinary schistosomiasis.

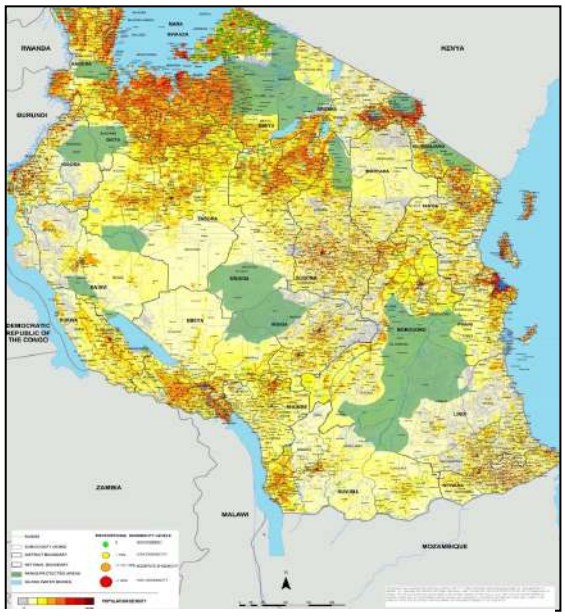


Figure 7: Schistosomiasis endemicity map

In Tanzania, schistosomiasis is known to be highly endemic across the country (figure 7), with published data suggesting that all regions have some level of infection. This can range from 12.7% to 87.6% prevalence in the entire population. Data published in 2008 from a baseline mapping survey for urinary schistosomiasis indicated a heavier infection burden in the lake zone (along Lake Victoria basin) but also in isolated pockets of favourable transmission condition across the country. Although it was clear that transmission was focal, the level of infection was very high in so many communities which engage in irrigation, fishing, rice farming or any water related economic activities. S. haematobium and S. mansoni are the common species causing acute and chronic Schistosoma infections in Tanzania.

The major contributory factors to such high levels of infection are limited access to safe water and lack of or poor environmental sanitation. Individuals are therefore continually exposed to the parasites and re-infection levels are high.

Ongoing control efforts by the NTDCP include provision of at least once-a-year Praziquantel treatments to SAC in the affected communities as well as health education with focus on prevention. There has been some success in reduction of overall intensity of infection but due to high re-infection rates; prevalence levels are still high.

In 2016 survey conducted in Lake Zone found prevalence level ranging from 0% to 63% in sentinel schools. Communities along Lake Victoria basin and related islands have some of the highest infections of S. haematobium in the country. Further away from the lake, in Kigoma and Serengeti, S. mansoni of up 67% in sentinel sites has been reported. These findings show a slight reduction in prevalence compared to studied in Ukerewe that document over 87% prevalence of S. mansoni and severe morbidity (Kardoff et al. 1997).

Soil-Transmitted Helminths (STH)

Soil-Transmitted Helminthiasis (STH) is caused by infection with nematodes Ascaris lumbricoides (roundworm), Ancylostoma duodenale and Necator americanus (hookworm) and Trichuris trichura (whipworm). STHs are known to be highly endemic across Tanzania with hospital records suggesting that all regions have some level of infection. This could

be up to 100% for STH in certain ecological settings. The major contributory factors to such high levels of infection are limited access to safe water and lack of or poor environmental sanitation. For example, 33.6% of mothers admit to disposing of their children's stools within the immediate vicinity of their dwelling thus encouraging the transmission of STH's.

Throughout 2004, a nationwide epidemiological survey in schools with Schistosomiasis and STH was conducted to prioritize areas for control as a prerequisite for implementation. All 26 regions across the country were found to require some level of intervention according to WHO guidelines. Intervention has been provided in two major ways. First, people in all LF endemic districts, receive Ivermectin + Albendazole package. Secondly, SAC in primary schools receive Albendazole (at least once a year) as Albendazole alone or Albendazole + Praziquantel.

As a result of these PC interventions, heath education and environmental sanitation, there has been moderate reduction in overall prevalence of STH, with a significant reduction in intensity of infection. Data collected as part of routine program monitoring from sentinel sites indicate a decline in overall prevalence. For instance, in 2016, a survey in 40 primary schools for STH found infection ranging from 0 to 82% among SAC but with 0% of heavy intensity of infection.

Lymphatic Filariasis (Elephantiasis)

Lymphatic Filariasis is the parasitic disease caused by infection with nematodes Wuchereria bancrofti, Brugia malayi and Brugia timori and is a leading cause of disability due to parasitic infections in Tanzania. The clinical manifestations of the disease are horrific, including hydrocoele, lymphoedema, orchitis, adenolymphangitis and elephantiasis and such acute and chronic pathologies impose a significant impediment to socio-economic development, and an extremely poor quality of life.

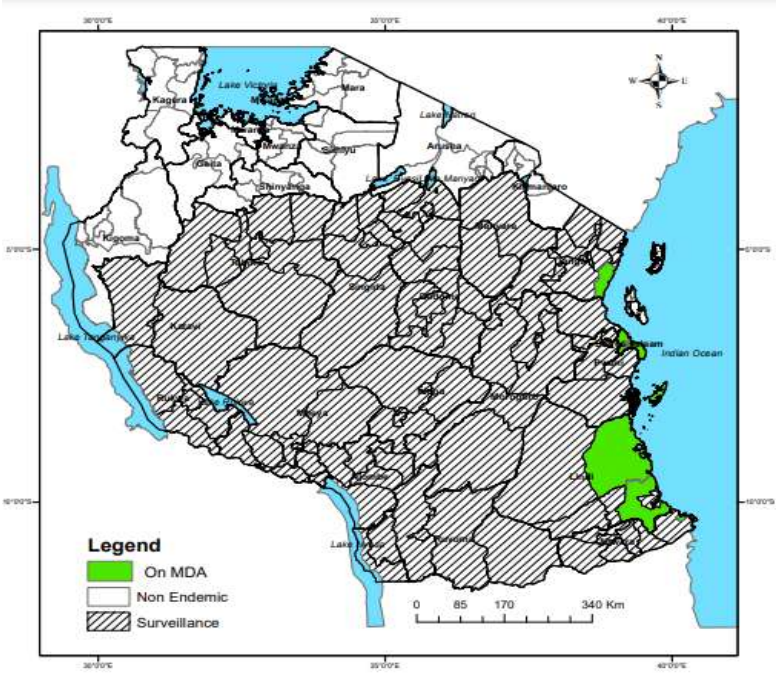


Figure 8: Endemicity of LF as of 2020

Mapping for lymphatic Filariasis (LF) was conducted between 1998-2004 where LF was found to be endemic in the whole country, and co endemic with other NTDs. By the year of mapping the threshold above which mass treatment for lymphatic Filariasis is indicated in a community (Mf prevalence above or equal to 1%);120 district councils were found to have the criteria for starting Mass Drug Administration (MDA) of Ivermectin and Albendazole. MDA was started in 2001 in Mafia Island and scaled up to all endemic districts by 2015. Management of LF cases has been conducted in five regions along the coast which had the highest prevalence rates of up to 16% circulating filarial antigen (CFA).

Onchocerciasis (River-Blindness)

Onchocerciasis is caused by infection with nematodes Onchocerca volvulus. It has also long been associated with a high incidence of detrimental effects on socioeconomic development and public health in endemic areas due to the severe disabilities. The disease is transmitted by the black fly- Simulium damnosum. Prevalence can be as high as 63.6% in certain focal endemic areas. In Tanzania Onchocerciasis is present in 28 districts. There are 7 known Oncho Foci namely: Tanga Focus, Tukuyu Focus, Mahenge Focus, Ruvuma Focus, Morogoro Focus, Kilosa Focus, Tunduru Focus and Mufindi-Njombe focus. Approximately, seven million people are at risk of infection. Morbidity characteristics include dermatologic, lymphatic, ophthalmologic, and systemic manifestations.

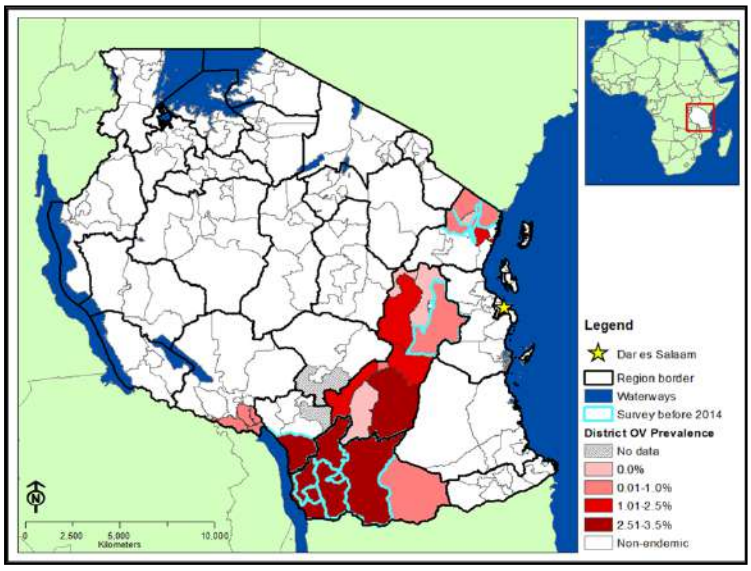


Figure 9:Endemicity of Onchocerciasis as of 2020

Trachoma

Trachoma is the leading infectious cause of blindness worldwide. It is caused by an obligate intracellular bacterium called *Chlamydia trachomatis*. The infection is transmitted by direct or indirect transfer of eye and nose discharges of infected people, particularly young children who harbor the principal reservoir of infection. These discharges can be spread by species of flies. Environmental risk factors influencing the transmission of the disease include inadequate hygiene, crowded households, inadequate access to water and inadequate access to and use of sanitation.

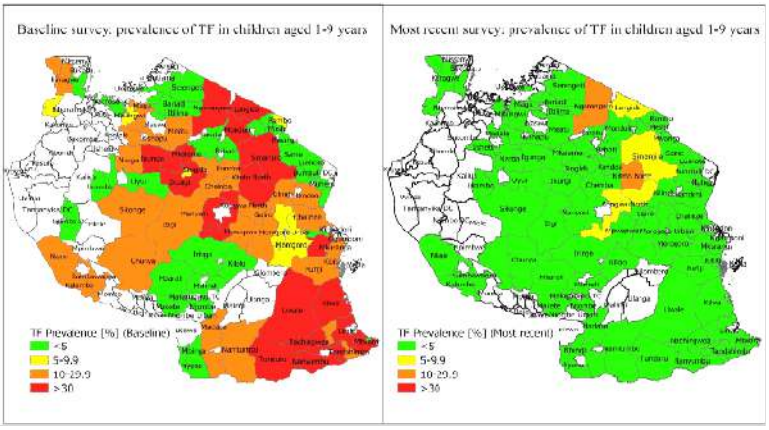


Figure 10: TF prevalence change (2004 to 2020)

Following National wide baseline surveys between 2004 and 2006 in 50 districts considered most at risk for trachoma, 43 districts were found to have active trachoma above 10%. The mean prevalence of active trachoma was 25.4%, whereas the mean prevalence of Trachomatous Trichiasis (TT) was found to be 2.7% with TT backlog estimate of 167,000 cases countrywide. In total Tanzania was estimated to have 12.5 million people at risk for trachoma. The highest prevalence among children 1-9 years was in the southern parts of the country, where active disease rates as high as 69% have been documented. Currently, in Tanzania mainland, trachoma mapping has been completed, with a total of 71 Trachoma endemic District councils. Accounting for splitting of administrative areas, there were a total of 95 districts known to be endemic for trachoma

Tanzania has been implementing the SAFE strategy since 1999, at first on a pilot basis in a few districts. Implementation of SAFE was expanded to cover a total of 43 districts that had TF prevalence ≥10% among 1-9 years old according to the 2006 WHO guidelines for MDA. Currently the country remains with only 6 districts needing A, F & E interventions. The remaining 65 districts have stopped Zithromax distribution, and are continuing with surveillance. The current Trichiasis backlog has declined to 34,000. The figure below shows baseline survey of TF and TT in the country versus the current status.

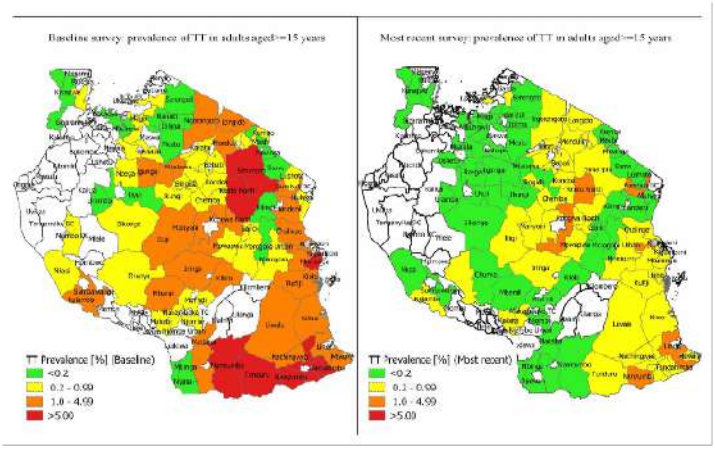


Figure 11: TT prevalence change (2004 to 2020)

As part of SAFE Strategy, TT surgeries (S-component) services are provided in district councils with prevalence of unmanaged Trachomatous Trichiasis (TT) of greater than 0.2% in population aged 15 years and above. TT surgeries started effective in 2004 in 46 councils which were found to have huge TT backlog. From 2009 to December 2020, a total of 38,684 TT patients were operated through the National NTDs control Program. The current Trichiasis backlog has declined to 34,000

PCT Targeted NTDs Co-endemicity

In Tanzania 5 PCT targeted NTD are co-endemic in various districts. The Map below illustrates the types of overlap which are 5 as of year 2020. Some districts have two to three PCT NTDs.

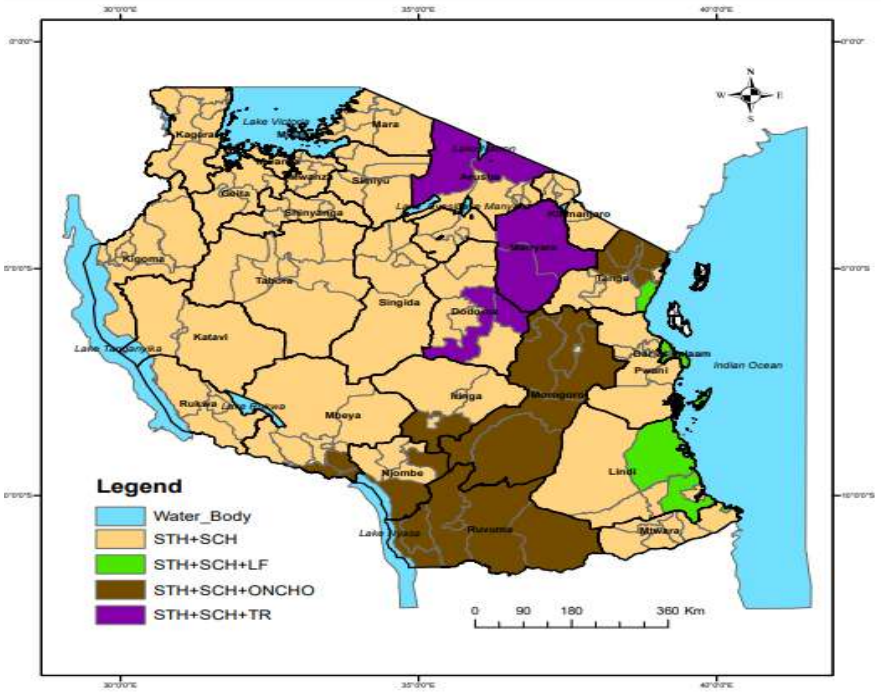


Figure 12: NTD Co-endemicity

NTD Programme implementation/interventions

PCT Diseases Interventions - GoT Initiatives 2012-2017

Ever since the start of integration, the GoT has been committed in addressing NTDs through elimination and control efforts countrywide. From 2011 to 2015, the program scaled up MDA interventions to reach all endemic districts with at least once a year WHO recommended PCT package. This was made possible through financial support from USAID & DFID.

In 2015, over 61.5 million treatments of ivermectin, Albendazole, Praziquantel, and Zithromax were distributed to 25 million people. This marked the climax of the MDA program. Thereafter, the program has been gradually scaling down PCT interventions as districts achieve criteria for stopping MDA. As of December 2020, 96 out of 119 districts had stopped IVM+ALB MDA for LF; hence, 21 million people are no longer at risk of LF infection. Furthermore, 65 of 71 trachoma endemic districts had achieved criteria for stopping Zithromax MDA. Thus, about 17 million people live in areas that are no longer endemic for blinding Trachoma. STH and SCH interventions are geared towards control of infection and to reduce related morbidity. There has been marked reduction in intensity of STH/SCHISTO infections and overall prevalence in all districts, but re-infection rates remain high, mainly due to limited availability and use of proper sanitation. The figure below shows the scaling down of MDA interventions over the years.

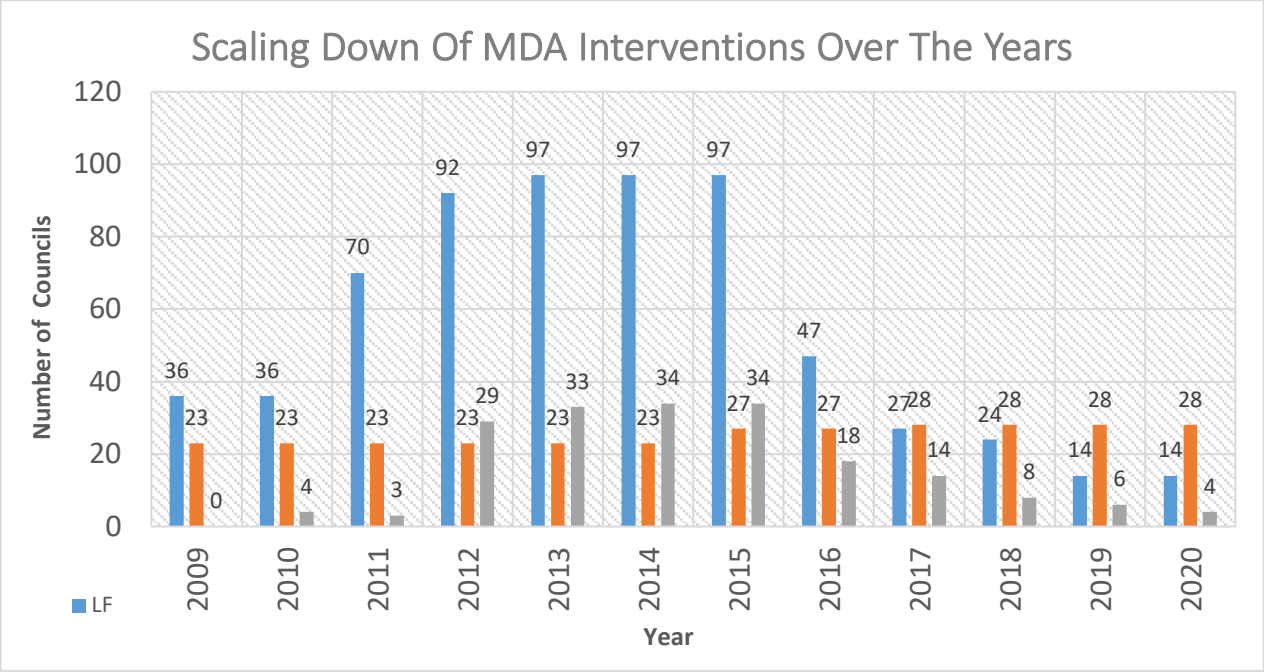


Figure 13: Scaling down of MDA intervention for Onchocerciasis, LF and Trachoma

The table below provides a summary of the existing preventive chemotherapy programmes.

Table 1: Information on Existing Preventive Chemotherapy and MMDP Programmes

NTD	Year of Program Up/Down scalling	Total Number of councils Targeted	No. Of councils Covered (Geographic Coverage)	Total Population in Target Districts	No of Population Covered (%)	Types of Interventions	Key Partners
TRACHOMA	2020	6	71	1.8 million	100%	SAFE, Health Education and Promotion	IMA, ITI, SS, CROWN AGENTS, HKI, PFIZER, WHO
SCH	2020	184	184	51.5 million	100%	MDA, Health Education and Promotion	IMA, SCI, CROWN AGENTS WHO, RTI
STH	2020	184	184	51.5 million	100%	MDA, Health Education and Promotion	IMA, SCI, CROWN AGENTS GSK, WHO
LF	2020	14	119	9.8 million	100%	MDA, MMDP,Health Education and Promotion	IMA, RTI, MERK, ENDFUND, CROWN AGENTS, WHO
ONCHO	2020	28	184	6.3 million	100%	MDA, Health Education and Promotion	IMA, RTI, MERCK, WHO

Schistosomiasis and Soil Transmitted Helminthiasis Control

Control efforts of Schistosomiasis and STH started under the NSSCP by targeting primary school-age children (5-14 years) who are the most high-risk group. The main intervention is drug delivery to pupils by trained schoolteachers supported by health personnel, which should be complemented by school health education and environmental sanitation. The program under MOHCDGEC worked in partnership with the, Ministry of Education and Vocational Training (MOEVT) and Local Government Authorities (LGAs).

Between 2005-2016 Schistosomiasis control implementation scaling up was ongoing until all highly endemic populations in 26 regions were covered, making approximately 4 million enrolled and non-enrolled school-aged children treatment with Praziquantel and Albendazole. In the year 2017 the Country managed to treat approximately 9.4 million SAC which makes a more than 75% of all SAC in the country.

Lymphatic Filariasis control/ Elimination Efforts

From 2009, LF elimination activities are implemented through NTD control program. The focus is mainly on interrupting transmission (via MDA) and disability management (lymphoedema management and hydrocelectomy). Mass drug distribution has been conducted in all endemic districts through a phased approach depending on availability of funding.

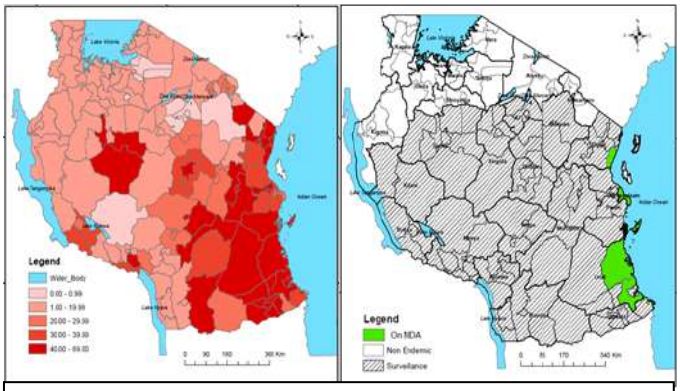


Figure 14:: LF endemicity in 2004 (left) and 2020 (right).

All endemic districts have been under annual mass treatment with Ivermectin and Albendazole. By December 2020, 105 districts out of 119 had stopped LF treatment after five or more rounds of effective mass

treatment. Transmission assessment surveys were conducted to determine LF prevalence after five or more rounds of Mass treatment, and it was found to be less than 2% in those districts. There are only 14 districts remaining, which require MDA for LF. The reduction in LF endemicity is as shown in the maps above, the first map is the baseline prevalence situation before MDA intervention by NTDCP and the second map is the current prevalence situation as of the year 2020.

Onchocerciasis (River-Blindness) Control Efforts

The control of Onchocerciasis was established in Tanzania since 1994, when large-scale community-based distribution of Ivermectin commenced in the Tukuyu focus of disease transmission. With support from WHO/APOC, Tanzania started implementing Ivermectin MDA in seven CDTI projects. In addition, some implementation units received support from Non-governmental Development Organization (NGO) partners like Helen Keller International (HKI), IMA World Health, Sight Savers International (SSI) and Rotary International. From 2009 to date, all control activities are implemented through the integrated NTD control program. Currently Ivermectin is distributed in combination with Albendazole as one drug package for LF and Oncho in Pangani where there is overlap. To-date all meso and hyper endemic communities in the 19 districts are implementing MDA (i.e.100 percentage geographic coverage).

LF MDA in overlap areas started in 2004 in Tanga and 2007 in Morogoro and the remaining districts in Ruvuma, Mbeya and Iringa in 2009. Through this integrated approach Oncho hypo endemic communities have received Ivermectin treatment. Epidemiological surveys in Tanga- 2010 and Tukuyu in 2011 have indicated the transmission interruption after 10 years of Ivermectin distribution. Further Epidemiological and Entomology studies are planned to confirm the results obtained in 2012. The program has planned to remap/ validate endemicity levels in all districts neighbouring endemic countries-particularly Burundi, Mozambique and Uganda.

Trachoma Elimination Efforts

Trachoma control activities in Tanzania started way back in 1970s. Trachoma control efforts through MoHCDGEC were further enhanced by support from ITI in 1999 through Public Private Partnership (PPP). The main aim was to expand trachoma control activities using WHO recommended strategy known as SAFE - Surgery, Antibiotic, Face washing and Environmental improvement. Alongside the SAFE is utilization of Pfizer donated Zithromax for treatment of active infection.

The implementation structure of trachoma control encompasses national, regional, and district and community levels. At all these levels, a PPP approach is maintained. The program extended from six districts to 40 districts between 1999 and 2005. In the year, 2008 program expansion through scaling up of SAFE strategy reached 50 endemic districts.

In accordance with World Health Organization (WHO), Mass Drug Administration (MDA) with Zithromax was required in the 43 districts that have active disease. MDA scale up to all endemic districts was not possible due to financial constraints. However, due to financial support through Envision program, by the year 2015 program expansion through scaling up of SAFE strategy reached all 71-district councils, thus making a 100% geographic coverage. For elimination, SAFE strategy is to be implemented for 3 to 5 years

(depending on baseline prevalence) before impact assessment. MDA Coverage of 80% or above is required for desired impact.

To date, Trachoma elimination activities are implemented in an integrated approach under the NTDCP. Different districts are at different stages of SAFE strategy implementation. To date the numbers of districts implementing Zithromax MDA have scaled down from 71 to 6. The 65 have stopped MDA having achieved TF prevalence of <5% as per WHO threshold. The remaining endemic districts are implementing only S, F & E components. Elimination efforts have been supported by GoT and other NGDOs like IMA-world health (Envision), HKI, ITI, Sightsavers, and Pfizer that provides Zithromax used for MDA through International Trachoma Initiative (ITI).

Integrated PCT Interventions 2012 to 2017

The initiative to integrate the Implementation of Neglected Tropical Diseases through Preventive Chemotherapy and Transmission Control in Tanzania in 2015 -16 has paved way to up scaling in other 16 regions in 108 districts. By 2017, the program has managed to scale up to all 26 regions in 184 implementation units. Mass drug administration (MDA) is the main key strategy through CDDs where 119 co-endemic Councils continue distributing four drugs (Albendazole, Ivermectin, Zithromax and Praziquantel) for the control of onchocerciasis, Trachoma, SCHISTO, STH and Lymphatic Filariasis.

Control of Neglected diseases has been intensified in the past ten years with co-implementation activities fully embarked in all IUs from 2015 to 2016. In 2013/2016, USAID through RTI/IMA joined to extend integrated approach of NTD Control Program support to 7 regions. In early 2012 PCT activities resumed in coast regions under the support of USAID through IMA. Upscaling to megacities (Dar es Salaam and Mwanza) was extended in 2013 through the support of DFID under SCI and FPSU. PCT activities to full geographical coverage were extended in 2015/2016 in 8 more regions of Kagera, Shinyanga, Kigoma, Mara, Simiyu, Geita, Kilimanjaro and Arusha DFID/SCI and USAID/RTI/Envision/IMA. In addition to the PCT activities, Trachoma control through the SAFE strategy and LF control through MWANGA strategy (combining drug treatment with hygiene and environmental management) will have direct impact to helminths control interventions.

Case Management Interventions

Table 2: Case Management Diseases (2012-2020)

NTD	Target area (councils)	No. of councils covered	Cases	Key Stategies	Drug Used	No. Treated	Fatality rate	Funding sources	Key Partners
LF	40	119	16,260 (7,025 hydrocele, 108 lymphoedema)	Lymphoedema management hydrocelectomies	ALB IVM	7,133	NDA	MTEF, CCHP, DFID, GATES PRESIDENT FUND	IMA, MUHAS, , END FUND, EQUINOR, CROWN AGENTS
TRACHOMA	89	89	80,000	SAFE	Zithromax & TEO	42,000	NDA	DFID, Q/TRUST, USAID	IMA, ITI, SS, KTP, KCCO, HKI, MUHAS, KCMC, WHO, RTI, CROWN AGENTS

Gaps and Priorities

SWOT Analysis

Table 3: SWOT Analysis of NTDs Programme

Strengths	Weakness	Measures to counteract identified weaknesses	Opportunities	Threats	Measures to counteract identified threats
Advocacy, coordination, and partnerships					
NTD incorporated in the existing national Policies (HSSP IV and V, CCHP guidelines).	Inadequate resource allocation in CCHP for NTD elimination activities	Implementation of policy guidelines/ SOPs at all levels to guide elimination strategies and activities	Political will at all levels and acceptance at all levels Implementation of policy guidelines/ SOPs at all levels to guide elimination strategies and activities	Competing needs for the available limited resources	Advocate for more funding from donors, private sectors and the Government
	Over-emphasis on NTD as a whole and not disease focused emphasis commensurate to burden in the respective district	Strong disease specific programs as basis at community level Sensitization/advocacy materials to focus on what's specific to the community Encourage involvement of policy makers in setting priorities	Use existing strategic projects to increase awareness among policy makers and community depending on disease focus		
BCC strategy developed and in use	Limited Roll out/dissemination of strategy at IUs level	Ensure strong NTD coordination at all levels to facilitate the dissemination	Introduction of CHW cadres at village level to assist in raising awareness	Potential failure of CHW in being fully involved due to other programs competing for time	Use of awareness information through mass media campaigns in roll out to help in the dissemination
	Non continuous Health education campaigns at all levels Inadequate social behavioural communication	Involvement of partners and organization working at community level who can do the roll out Increase community SBCC awareness in relation to NTD	Widespread use of social networks and mobile phones to reach to community members Work with the existing national sanitation campaign (CLTS)		Use the existing media focal persons in the regions and districts and councils to facilitate the dissemination and awareness health education and planned program activities

	among community members BCC does not cover vector control interventions	Avail funds to support BCC for diseases that do not have MDA	Work with the existing schools WASH programs		
Targeted advocacy at district level	High turnover of administrative authorities	Continue conducting continuous advocacy in areas of known high turnover	In most cases the administrative authorities are already familiar with the program Maximise on the existing political will to increase impact of advocacy	Increasing need for time and resources in advocacy when new administrative authorities take office	Money allocated for advocacy budget should put this into consideration
Existence of NTD coordinators at all levels	Divided commitment on NTD activities due to multiple roles	TOR given to region and district authorities to guide nomination of coordinators	Increase the use of NTD secretariat at the district level and regional level to monitor and facilitate program activities in their regions and districts Existence of CHMT and RHMT to support and ensure implementation at their levels	Adherence of TOR's is beyond program's control or/and influence	Continuous advocacy and sensitization on the need for adherence to the TOR and its use in nominating coordinators
Increased number of partners supporting control/elimination efforts	More partners tend to support PCT interventions	To advocate for more partners to come on board and support current partners in increasing focus on more Case Management Interventions and Vector Control Interventions	The annual country joint plan is shared with the donors/partners/stakeholders to align their funding to the country needs Attendance and networking at local and international conferences Existing collaboration with research institutes and universities	Some partners already have their own preferences on desired areas of support/funding	Flexibility in accommodating partners' preferences, provided, it aligns with the country needs
Planning for results, resource mobilization and financial sustainability					
Joint planning for NTD control and elimination strategies	Multiple planning and budgeting tools from different partners	Regular planning and review meetings	Existence of program planning tools at national and sub national levels	Partner preference on vertical approach for example, some partners already have their own	Development of an integrated master plan

				preferences on desired areas of support/funding	
	Different planning cycles between the program and partners affect the program	Flexibility in accommodating partners'/donors' planning cycles by having an extended plan Regular meetings within the program to review the program and the budget	Availability of technical assistants from partners to assist in planning and implementation	Partners dominance in planning/supporting NTD activities because of pre-existing plans/priorities	Continuous advocacy and sensitization on the country need for ownership and leadership in planning and prioritization of NTDs
	Less fund allocation and delays in funds release	Advocate for more funding from donors, private sectors & the Government Increasing government resource allocation for NTD control and elimination especially at councils level Existence of project coordinators and disease focus people to assist in marrying program activities in other programs or activities running in their areas			
	No funding allocated for Vector Control interventions	Integration of program activities to get the most out of the limited resources	Existence of Vector Control program and Officers in some Councils	Priorities of vector control program not including NTDs	Having thematic areas /technical exchange meeting between NTD and Vector control programs
Strong collaborations and partnerships with various local and international stakeholders	Strict donor/partner conditions, e.g. yearly contracting	Flexibility in accommodating donors/partners by having regular meetings to reach a consensus	Availability of signed multiyear contracts from some partners Existing collaboration with research institutes and universities	Instances where particular donor support ends before the program has reached the predetermined goals	Having transitioning plans to attract more partners to ensure continuity of the program activities

	Donor dependency	Having sustainability plans for continuity of program activities Increasing government resources allocation to NTD elimination	Availability of NTD activities in the budget guidelines at national, regional and council levels (MTEF, CCHP, Regional Health Plans)	Change in global policies and politics	Advocate for more resource mobilization by key government policy and decision makers Advocate for more support from other sources including the private sector
Scale up access to interventions, including treatment & service delivery, drug supply, logistics & capacity building					
MDA program established in all endemic districts in Tanzania (100% geographical coverage)	Low epidemiological coverage in some districts and sub districts	Improve strategies for advocacy and community mobilization to increase MDA uptake Improve supportive supervision at all levels	Availability of donated NTD PCT medicines (IVM, ALB, PZQ, ZITH) Availability of Health staff at all levels	Crushing of MDA activities with other council activities/events	Flexibility in implementing program activities to accommodate unexpected council activities/events
Control/elimination program established in all areas in the country	Limited support for morbidity management	Donor support established Participation of councils in morbidity management (e.g in LF and trachoma)	Existence of well organised structures for example, CHMT and RHMT	Recurrence of infections previously interrupted due to lack of surveillance measures especially at the council levels Cross border transmission of NTD diseases	Institute sustainable surveillance measures Multi-sectoral collaboration Cross-border collaboration
	Limited support for Case Management NTD interventions Reduced support for STH/SCH Lack of a complete morbidity mapping	Solicit more funds to support Case Management NTDs Existing of school health program that can be used for SAC MDA delivery	Inclusion of NTD activities into CCHP Existence of available facilities and capacities for morbidity management	Low knowledge of prevalence and impact of NTDs by Councils and Health facilities	Conduct quarterly data review meetings Promote NTDs awareness to planners, health governing committees Advocacy on importance of NTD control and elimination to political leaders at council and region levels especially councillors

NTDS monitoring, evaluation, surveillance & operations research					
Existence of M&E component in the programme priorities Existence of research and development Institutions	Lack of entomological support Incomplete mapping for Oncho		Strong Research institutions e.g. NIMR. Strong health system	Lack of financial resources	
	Limited surveillance activities where MDA is stopped No vector surveillance implemented		Competent researchers/scientists to conduct research on NTDs		
Existence of NTD database	Incorporation of historical, MMDP and Survey data		Expertise available and database already in place to start the process		
Improved disease guidelines and diagnostics	Slow adaptation of new methods			Lack of relevant expertise and tools (e.g. ELISA and PCR) Limited case definition and understanding of cases	Train and procure tools/materials/supplies
NTDs incorporated in HMIS and IDSR	Poor definition of variables in the IDSR and HMIS		Electronic HMIS and IDSR	Limited case definition and understanding of cases	Training of CHW Electronic IDSR and HMIS

PART TWO: NTD STRATEGIC AGENDA

Tanzania's NTD Strategic Agenda has been formulated through a gradual analysis of the prevalence of different NTDs and alignment of policy documents the HSSP V 2021-2026 and WHO NTD Roadmap 2021- 2030. It has been formulated in collaboration between the Government of Tanzania, Development partners and other stakeholders who critically worked on the plan and reviewed the National NTD strategic plan and various national documents.

The agenda has articulated the overall programme to formulate the mission and vision statements, overall goal, strategic objectives and activities. Progress of the plan will be outlined through the operational framework for each level of implementation.

Overall NTD Programme Mission and Goals

Vision

To have a healthy society free of debilitating, stigmatizing and other Neglected Tropical Diseases, that can contribute effectively to individual and national development.

Mission

To promote community centred NTDs control, elimination, and preventive interventions that affordable, sustainable and gender sensitive.

Goal

To accelerate the reduction of 5 PCTs NTDs burden and sustain the gains of integrated NTD elimination measures in all endemic councils in Tanzania through multi-sectoral approach.

Master Plan Targets, Milestones and Indicators

Overarching Programme Targets

Indicator	2026
Percentage reduction in people requiring interventions against neglected tropical diseases	50%
Number of councils having eliminated at least one neglected tropical disease	115

Cross – cutting Targets

Indicator		2026
INTEGRATED APPROACHES	Integrated treatment coverage index for preventive chemotherapy	100%
	Number of councils that adopt and implement integrated neglected tropical disease interventions	184
MULTISECTORAL COORDINATION	Number of councils with access to at least basic water supply, sanitation and hygiene in areas endemic for neglected tropical diseases – to achieve targets 6.1 and 6.2 of Sustainable Development Goal 6	184
	% of the population at risk protected against out-of-pocket health expenditure due to neglected tropical diseases morbidity – to achieve target 3.8 of Sustainable Development Goal 3	80%
	# of councils with neglected tropical diseases integrated NTD interventions into councils health plans / CCHPs, budgeted and allocated funds at least 60%	92
UNIVERSAL HEALTH COVERAGE	# of neglected tropical disease interventions included in national package of essential health services	5
	# of councils with guidelines for management of neglected tropical disease-related interventions within national health systems	184
COUNTRY OWNERSHIP	# of councils reporting on all relevant endemic neglected tropical diseases indicators	184
	# of councils collecting, analyses and reporting data on neglected tropical diseases interventions and disaggregated by gender	184

Impact of the Integrated Approaches on Disease – specific Targets

Disease	Indicator	2021/22	2022/23	2023/24	2024/25	2025/26
TARGETED FOR ELIMINATION AS A PUBLIC HEALTH PROBLEM						
Lymphatic filariasis	Number of councils validated for elimination as a public health problem defined as:- infection sustained below transmission assessment survey thresholds for at least four years after stopping mass drug administration availability of essential package of care in all areas of known patients	88	98	98	112	115
Trachoma	Number of councils validated for elimination as a public health problem defined as;					
	i) A prevalence of trachomatous trichiasis "unknown to the health system" of <0.2% in ≥15-year-olds in each formerly endemic district;	38	47	74	79	84
	ii) A prevalence of trachomatous inflammation—follicular in children aged 1–9 years of <5% in each formerly endemic district; and	63	66	68	68	68

	iii) Written evidence that the health system is able to identify and manage incident cases of trachomatous trichiasis, using defined strategies, with evidence of appropriate financial resources to implement those strategies	38	47	79	89	89
Schistosomiasis	Number of councils validated to eliminate as a public health problem (currently defined as <1% proportion of heavy intensity schistosomiasis infections)	0	12	22	34	58
Soil-transmitted helminthiases	Number of councils validated to eliminate as a public health problem (defined as < 2% proportion of soil-transmitted helminth infections of moderate and heavy intensity due to *Ascaris lumbricoides*, *Trichuris trichuria*, *Necator americanus* and *Ancylostoma duodenale*)	0	12	22	34	58

Disease	Indicator	2021/22	2022/23	2023/24	2024/25	2025/26
TARGETED FOR ELIMINATION (INTERRUPTION OF TRANSMISSION)						
Onchocerciasis	Number of Councils verified for interruption of transmissions	0	4	4	9	17

Milestones Set for Specific Disease

To achieve the overarching, cross-cutting and disease-specific targets as set forth in this master plan and given the progress so far made as elucidated in the fore-going sections a number of milestones should be undertaken. These disease specific milestones are reflected in Table 7 and 8 (Strategic goals, objectives of the specific diseases)

Milestones for Targeted NTDs

Table 4: Milestones for targeted Lymphatic Filariasis

Indicators	2021/22	2022/23	2023/24	2024/25	2025/26
Lymphatic filariasis					
Completed mapping of LF and determined LF endemic areas and the population at risk	184	184	184	184	184
Continue implement LF MDA in IUs requiring LF MDA	7	4	4	1	1
Geographical coverage in LF of LF MDA %	100	100	100	100	100
Major urban areas with evidence of LF transmission under adequate MDA	3	3	3	1	1
Number of IUs conducted more than 5 rounds of with coverage more than 65%	7	4	4	1	1
Number of IUs conducted first TAS activities after at least 5 rounds of MDA.	1	3	0	3	0
Number of IUs conducted and passed at least 2 TAS activities.	0	14	4	3	0
Number of IUs started passive surveillance and vector control activities.	0	2	3	4	5
Proportion and number of IUs where there is full coverage of morbidity-management services and access to basic care	0	0	5	10	16
Proportion and number of IUs where 75% of hydrocele cases benefitted from appropriate surgery	0	0	5	5	7

Table 5: Milestone for targeted Trachoma

Indicators	2021/22	2022/23	2023/24	2024/25	2025/26
Trachoma					
Completed mapping of trachoma and determined trachoma endemic areas and the population at risk	115	120	120	120	120
Continue implement trachoma MDA in IUs requiring trachoma MDA	8	5	3	3	3
Geographical coverage in trachoma of trachoma	100%	100%	100%	100%	100%

MDA					
Major rural areas with evidence of trachoma transmission under adequate MDA	8	5	3	3	3
Number of IUs conducted more than 5 rounds of MDA with coverage more than 65%	8	5	3	3	3
Number of IUs conducted first TSS activities after at least 5 rounds of MDA.	0	0	0	2	1
Proportion and number of IUs where there is full coverage of morbidity- management services and access to basic care	100%	100%	100%	100%	100%
Proportion and number of IUs where 75% of TT cases benefitted from appropriate surgery	100%	100%	100%	100%	100%

Table 6: Milestone for targeted Onchocerciasis

Indicators	2021/22	2022/23	2023/24	2024/25	2025/26
Onchocerciasis					
Completed mapping of Oncho and determined Oncho endemic areas and the population at risk	183	183	184	184	184
Continue implement Oncho MDA in IUs requiring Oncho MDA including co-endemic areas	28	24	24	19	11
Geographical coverage in Oncho of Oncho MDA	100%	100%	100%	100%	100%
Major spot areas with evidence of Oncho transmission under adequate MDA	28	24	24	19	11
Number of IUs conducted more than 5 rounds of with coverage more than 80%	28	24	24	19	11
Number of councils conducted first stop MDA survey	4	0	5	8	7
Number of councils conducted and passed for Epi and Oncho	4	5	8	7	4
Number of councils started conducting Monitoring surveys	28	28	28	28	28

Table 7: Milestone for Targeted Schistosomiasis

Indicators	2021/22	2022/23	2023/24	2024/25	2025/26
Schistosomiasis					
Continue to conduct mapping of Schisto and determined Schisto endemic areas after and the population at risk	30	39	40	34	30
Begun implement Schisto MDA in IUs	184	172	152	150	126

requiring Schisto MDA at ward level					
Geographical coverage in Schisto of Schisto MDA	100%	100%	100%	100%	100%
Major urban areas with evidence of Schisto transmission under adequate MDA	7	7	3	0	0
Number of IUs conducted more than 5 rounds of with coverage more than 80%	184	172	152	150	126
Number of Councils conducted first evaluation of prevalence activities after at least 5 rounds of MDA.	30	39	40	34	30
Number of councils conducted precision mapping and passed	0	12	22	34	58
Number of IUs started passive surveillance and vector control activities.	0	73	73	73	73

Table 8: Milestone for targeted Soil-transmitted helminthiases

Indicators	2021/22	2022/23	2023/24	2024/25	2025/26
Soil-transmitted helminthiases					
Completed mapping of STH and determined STH endemic areas and the population at risk	30	39	40	34	30
Begun implement STH MDA in IUs requiring STH MDA at ward level	184	172	152	150	126
Geographical coverage in STH of STH MDA	100%	100%	100%	100%	100%
Major urban areas with evidence of STH transmission under adequate MDA	0	0	0	0	0
Number of Councils conducted more than 5 rounds of MDA with coverage more than 80%	184	172	152	150	126
Number of Councils conducted first Prevalence Evaluation activities after at least 5 rounds of MDA.	30	39	40	34	30
Number of Councils conducted impact assesment and passed	0	12	22	34	58

Table 9: Milestone for NTD Health System StrengtheningTable

Indicators	2021/22	2022/23	2023/24	2024/25	2025/26
NTD Health System Strengthening					

Number of councils trained for 5PCTs diagnostics and Treatment	20	42	52	61	73
Number of facilities performing 5PCTS diagnostics using rapid test methods	0	350	1,256	3,775	4,913
Number of Councils advocated to plan and allocated budget for NTD interventions	30	60	120	160	184
Number of Councils plan and allocated budget for 5PCTs NTDs interventions at least by 60%	15%	20%	35%	50%	60%
	30	60	120	160	184
Number of Councils conducting Co-morbidity management (surgeries of TT, hydrocele and lymphoedema)	7	14	28	35	36
Number of Councils oriented on NTD interventions planning.	30	69	109	143	184
Annual funds amount targets established and secured	15%	20%	35%	50%	60%
Number of Councils received support supervision on 5PCTS NTDs planning and budget allocation	30	39	40	34	30
Number of councils conducted NTD data collection, processes and interpretation for use	25	50	75	80	92
Number of health governing committees received 5PCTs NTDs advocacy on planning	0	350	1,256	3,775	4,913
Number of local private sector partners secured to finance / support 5PCTs NTDs	1	2	3	4	5
M&E framework for master plan established	100%	100%	100%	100%	100%
Number of Annual progress reports of 5PCTS interventions developed	1	2	3	4	5
Number of 5PCTs NTDs indicators review sessions conducted and updated to DHIS2	1	2	3	4	4
Implementation and Promotion of 5PCTs NTDs values (Gender, Social determinant for health, socio-economic and demographic patterns) documented	1	2	3	4	5
Number of Universal Health Coverage interventions for 5PCTs NTDs promoted and implemented	5	5	5	5	5

Guiding Principles, Values and Strategic Priorities

Tanzania embarked on an integrated approach to control NTD in 2009. NTD control programme was designed to limit duplication, maximize use of resources and work with the community through a holistic approach. It is increasingly being recognized that, co-occurring diseases need to be tackled in an integrated manner, since the interaction between co-existing pathogens, affect the transmission of individual diseases and the overall morbidity in the community.

The master plan is the roadmap by which, the vision of "Tanzania free of NTD's" can be achieved. This plan is guided by the WHO road map for NTD 2030, Health Policy (2017) and the Health Sector Strategic Plan V (2021-2026). The plan is based on the principles of organizational integration of health services as well as wider intersectoral integration between other ministries, both in planning and implementation. The community is very central to the programme right from the planning stage until implementation, and hence making them own the programme for the sustainability. In additional to that the master plan is emphasizing taking special consideration of other life practices factors that contributes to improvement of living standards, best use of environments and knowledge of NTD that in return will stimulate a sustainable control and elimination of NTDs. This will be possible through addressing equity,gender and social determinants of health.

Equity

NTD master plan aims to reach vulnerable groups

Health promotion and behavioral change communication will be enhanced to all communities receiving NTD interventions and those beyond the endemic councils. Health education will enable vulnerable groups to access to MDAs and morbidity management, sanitation and treatment services. Health education and community awareness will be directed to the vulnerable groups, especially women, pastoralist communities, out of school children and disables. The integration of NTD interventions to roles of Community Health Workers will be advocated to increase the scale of community reached by the NTD programme especially at grassroot level. This will help improve programme to reach to community timely and also improve the monitoring and community surveillance by empowering CHW through trainings and provision of tools to use.

Master plan will address geographic, socio-economic inequities

Master plan will address the gaps of information especially NTD confirmation re-mapping for 5PCs NTD to effectively address issues of geographic and socio-economic inequities, through generating information that will confirm the NTD status in the country especially to the hotspots such as villages, wards, councils and regions reaching those in needs of services through health facilities and or programme interventions. This will take into consideration issues affecting geographic and socio-economic inequalities like climate change.

Gender

Master plan will enhance gender equality throughout its implementation

The sustainability plan which is part of this master plan has emphasized the consideration for Gender in all aspects of NTD planned interventions, SOP's development, Behavioural change communication delivery strategy, trainings and health facility governing committees empowerment. Health promotion and health education will address social

values and norms within the community on gender issues and promote gender equity at grassroot level where the beneficiaries of NTD interventions are found.

Health in All Policies to address social determinants of health

Master plan is promoting collaboration with other sectors and ministries applying total approach that have impact on the health of the endemic population.
Main areas that have an impact on determinants of health are water and sanitation, nutrition and food safety, education and training, environment (including climate change), occupational conditions, social protection and community development, infrastructure, road security.

Activities for collaboration with other sectors are reinforcing the national sector-wide approach and take forward the actions, creating a platform mechanism to include the participation of all other sectors, also at the level of a decentralised SWAP at regional and Council level. LGAs will create exchange platforms at ward and community levels.

Priorities in Strengthening Control of NTDs

NTD programme Priorities are *Planning, Coordination and Management, Partnerships, Implementation of interventions,* and *Surveillance, Monitoring and Evaluation*

Planning and resource Mobilization:

- Plan and implement joint annual NTD planning meeting on yearly basis, aimed at ensuring good use of identified resources and identifying existing gaps, challenges and weaknesses in implementing NTD activities. This also creates an avenue for sharing the lessons learnt
- Ensure NTD Control sustainability through inclusion of NTD control activities into MTEF, Regional HPs and CCHPs and other budgets
- Emphasize vector control and WASH strategies to reduce burden in NTDs
- Funds mobilization for Integrated NTD implementation including vector control
- Emphasize One Health approach in all plans for control of NTDs

Coordination and Management:

- Strengthen NTD Coordination units at all levels
- Develop a comprehensive, harmonized Standard Operating Guideline for implementing NTD Programme interventions.
-

Partnerships:

- Foster partnerships on NTDs locally and internationally
- Have MOU or MoA with various partners for NTD control and advocate for involvement of more partners into NTD control
- Strengthen linkages with line Ministries e.g., MOEVT, PO-RALG, MOW

Implementation of interventions:

- Continue with Disease Specific assessments of 5 PCTs
- Close support and supervision for NTD interventions; MDA and morbidity management and disease prevention.

- Strengthening pharmaco-vigilance in NTD program
- Disseminate program's good practices, experiences and success stories to all levels and stakeholders in NTD control
- Continue with MDAs, Case management, water and sanitation hygiene activities and improve coverage
- Strengthening the use of Community Based Health Program in delivering the NTD interventions

Surveillance, Monitoring and Evaluation:

- Update an integrated Monitoring Information System (MIS) for NTDs and link NTD MIS with DHIS2
- Build capacity to national, regional, district and health facilities on DHIS2 in collecting, compiling and producing data on NTDs
- Collaborate and conduct operational research studies on integrated NTD for evidence-based decisions

Summary of Programme Strategic Priorities and Framework

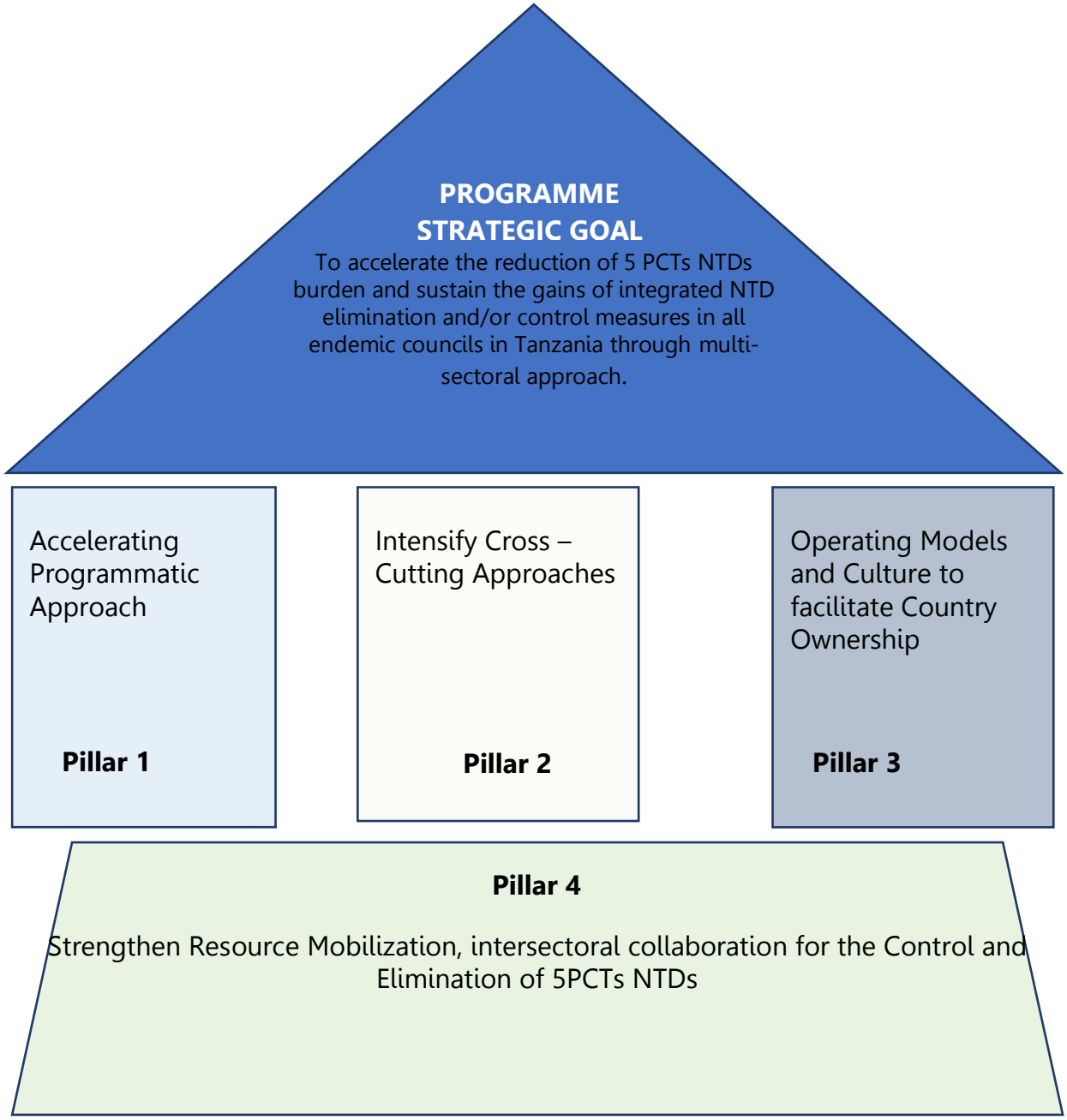
This master plan is guided by main two documents the HSSP V and WHO NTD Roadmap 2020 - 2030. The strategic direction of the two documents is interlinked by the formulated four (4) Strategic Priorities and strategic pillars. Where the Strategic pillars reflects global direction as guided by WHO NTD Roadmap 2020 – 2030 and Strategic Priorities are the programme direction that reflects the National context decended from strategic pillars and the set of objectives proposed presents a pool of activities that will actualize both the Strategic pillars and Strategic priorities. This means the Control and Elimination of NTDs will be managed in accordance with the four strategic priorities as outlined in the table below:

Table 10: Summary of Programme Strategic framework

STRATEGIC PRIORITIES	STRATEGIC OBJECTIVES
Strategic Priority 1: Strengthen Government Ownership, Advocacy, Coordination and Partnership	1. Promote and strengthen country ownership and leadership through organizational structures at national and local government with dedicated funding 2. Strengthen coordination mechanisms for the NTD control at national, regional and district levels 3. Strengthen and foster partnerships for NTDs at all levels. 4. Enhance NTD programme performance reviews and use for decision making 5. Strengthen advocacy, visibility and profile of NTD control programmes 6. Promote community involvement and ownership of the program for optimal use of available resources 7. Promote improved communication and awareness at the community level for a successful elimination of the endemic NTDs.

Strategic Priority 2: Enhance planning for results, Resource mobilization and financial sustainability	1. Support regions and districts to develop integrated annual plans and budgets for NTD control 2. Enhance resource mobilization approaches and strategies at National, Regional and district levels 3. Strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms 4. Develop and update national NTD guidelines and tools for operationalization of NTD interventions
Strategic Priority 3: Scale up access to interventions, treatment and system capacity building	1. Scale up integrated preventive chemotherapy to achieve 100% geographic coverage and treatment access to 5 PCTs NTD 2. Scale up integrated case-management-based diseases interventions, including MMDP services for LF and Trachoma 3. Strengthen identified platforms with similar delivery strategies and interventions (MDAs, skin NTDs, Morbidity management, SBCC, WASH etc) for integrated approaches across NTDs 4. Strengthening integrated vector management and WASH activities for targeted NTDs 5. Strengthening pharmaco-vigilance in NTD program and ensure timely effective supply chain management of quality-assured NTD Medicines and other products up to the last mile 6. Strengthen capacity for NTD programme management and implementation & accelerate disease burden assessments and integrated mapping of NTDs 7. Empower local government and authorities in social mobilization, behavioural change and building local support for NTD interventions.
Strategic Priority 4: Enhance NTD monitoring and evaluation, surveillance and operational research	1. Enhance monitoring of national NTD programme performance and outcome 2. Strengthen surveillance of NTDs and response to epidemic prone NTDs. 3. Support operational research, documentation and evidence to guide innovative approaches to NTDs programmes interventions 4. Establish integrated data management system (Monitoring Information System, MIS, for NTDs and link NTD MIS with DHIS2) and support impact analysis of NTD in Tanzania as part of WHO Africa region and global NTD data management system

WHO PROGRAMME STRATEGIC PILLARS



National 5PCTs NTD Goals, Objectives, Strategies, Targets, and Milestones

The plan has taken into consideration the importance of maintaining 5 PCTs diseases specific focus goals, objectives and strategies. We foresee integration as the most cost-effective approach to maximize on the limited resources we have in the country. Table 7 below provides a summary of disease specific global goals, objectives, strategies, national targets, and indicators for the targeted NTDs in Tanzania. Contents of this table have been used to guide activity implementation. In the subsequent sections, Key program indicators with their milestones are summarised in table 12.

Table 11: Program Summary components of Strategies for control endemic NTDs

PROGRAMME AND GLOBAL GOAL	NATIONAL GOALS	OBJECTIVES	INTERVENTIONS	DELIVERY CHANNELS	TARGET POPULATION (at Risk)
LF To eliminate Lymphatic Filariasis as a public health problem by 2030	To eliminate lymphatic Filariasis as a public health problem by 2030	To ensure that the population at risk is covered by treatment with Ivermectin and Albendazole by the year 2026 To ensure that all people identified with LF are provided with Morbidity management and Disability Prevention by the year 2026 To conduct a Coverage surveys To ensure culex mosquito control interventions in all affected areas. To ensure that mapping of LF morbidity is conducted to 46 endemic councils To conduct health promotion and behavioural change communication (BCC) To strengthen domestic resource mobilization and utilization To support continued operational research To conduct Monitoring and Evaluation to ensure that decisions are evidence based To conduct Surveys (such as impact surveys, SSA and TAS).	MDA and Disease alleviation (surgeries and Lymphoedema management, promotional of vector management (IVM) and Health promotion) Conduct SSA and TAS surveys Mosquito control to reduce transmission	Community based and facility based National guidelines targeting community participation	**31mil**
Schistosomiasis Eliminate Schistosomiasis by 2030	eliminate Schistosomiasis as a public health problem (currently defined as <1% proportion of heavy intensity schistosomiasis infections) by 2030	To treat all (100%) primary school age children regularly in all endemic communities. To treat at least 75% of High Risk Adults (HRA) to all Councils proved to have HRA populations. To conduct Coverage surveys To conduct mapping to all areas with high risk of transmission. To conduct a scientific study on best options for snails control interventions. To conduct health promotion and behavioural change	MDA. Morbidity Control. Behavioural Change Communication for transmission control and Health promotion. Control of snail's programmes. Conduct surveys	School and Community based Health Facilities based Multisectoral engagement (eg WASH)	**12.2mil**

PROGRAMME AND GLOBAL GOAL	NATIONAL GOALS	OBJECTIVES	INTERVENTIONS	DELIVERY CHANNELS	TARGET POPULATION (at Risk)
		communication (BCC) To strengthen domestic resource mobilization and utilization To promote water and sanitation hygiene (WASH). To support continued operational research. To conduct Monitoring & Evaluation to ensure that decisions are evidence based. To conduct parasitological surveys (precision mapping, sentinel site assessment). .			
STH elimination as a public health problem by 2030	eliminate STH as a public health problem (defined as < 2% proportion of soil-transmitted helminth infections of moderate and heavy intensity due to *Ascaris lumbricoides*, *Trichuris trichuria*, *Necator americanus* and *Ancylostoma duodenale*) by 2030 Increase domestic financial support to Preventive Chemotherapy for STH to enhance sustainability.	To treat all (100%) SAC children in endemic areas. To conduct Coverage surveys To promote access and use of water and sanitation hygiene (WASH). To conduct health promotion and behavioural change communication (BCC) To monitor disease trends by conducting Parasitological surveys. To strengthen domestic resource mobilization and utilization To support continued operational research to enhance evidence based decisions. To conduct Monitoring & Evaluation to ensure that decisions are evidence based	MDA. Behavioural Change Communication for transmission control and Health promotion. Environmental interventions. Morbidity management. Conduct surveys	School and Community based. Health facility based. 3. Multisectoral engagement (eg WASH)	**12.2 mil**
Onchocerciasis Elimination (interruption of transmission) by 2030	To eliminate Onchocerciasis as a public health problem by 2030 Sustain 100% geographical coverage of 28 endemic councils. Sustain 80% therapeutic coverage of the at-risk	To reach all 28 Endemic Councils (100% geographical coverage). To sustain at least 80% therapeutic coverage to 28 Councils. To conduct stop MDA surveys in all qualifying foci. To conduct IVM MDA in oncho areas twice a year to 9 Council. To conduct health promotion and behavioural change communication (BCC) To strengthen domestic resource mobilization and utilization	MDA. Behavioural Change Communication for transmission control and Health promotion. Integrated Vector Management control. Conduct survey	Community based. Health Facility based Local Government Multisectoral engagement	**6.8 mil**

PROGRAMME AND GLOBAL GOAL	NATIONAL GOALS	OBJECTIVES	INTERVENTIONS	DELIVERY CHANNELS	TARGET POPULATION (at Risk)
	population by 2026.	Establish Vector control in 50% endemic councils. To support continued operational research. To conduct Monitoring & Evaluation to ensure that decisions are evidence based (Epidemiology & Entomology). To conduct Oncho elimination mapping in 15 councils to determine endemic of Oncho			
Trachoma Elimination of blinding trachoma as a public health problem by 2030	Elimination of blinding trachoma as a public health problem by 2030 Sustain 100% geographic coverage to all endemic Councils. Sustain at least 80% therapeutic coverage.	To conduct surveys (TIS, TSS and TT only) To Reduce TT backlog by 80% to all councils with TT backlog by 2026. To reduce active disease by ensuring >80% therapeutic coverage through mass drug administration (Zithromax) in all endemic councils by 2026. To reduce trachoma prevalence to a level of below 5% TF among children 1-9 years old by 2026 in 71 endemic councils. To conduct health promotion and behavioural change communication (BCC) To strengthen domestic resource mobilization and utilization To promote water and sanitation hygiene (WASH). To support continued operational research. Monitoring & Evaluation to ensure that decisions are evidence based (impact and surveillance surveys).	MDA, Surgery, Environmental and hygiene Improvement, Face washing. Behavioural change Communication for transmission control and Health promotion. Collaborate with Ministry of water and other partners to increase availability of clean water in affected communities Surveys	Community based Health Facility based Local Government Multisectoral engagement	**12.5 million**

Table 12: Programme Objectives and Key Indicators of Perfomance

NTD Programme	Objective	Key Indicator	Baseline	Target	Milestones				
					2021/22	2022/23	2023/24	2024/25	2025/26
LYMPHATIC FILARIASIS To eliminate Lymphatic Filariasis as a public health problem by the 2030	To maintain achived geographical coverage of 100% and therapeutic coverage of 65% by the year 2026	Geographical Coverage	100%	100%	100%	100%	100%	100%	100%
		Therapeutic Coverage	65%	65%	65%	65%	65%	65%	65%
	To ensure that surveillance LF infection is conducted to 119 endemic councils.	# of councils conducted at least two post MDA surveillance	56	105	64	84	97	102	105
	To conduct a Coverage surveys	# of coverage surveys conducted	0	7	3	7	7	3	3
	To ensure that LF morbidity mapping surveys are conducted to 46 endemic councils.	# of mapping surveys conducted	6	16	0	1	3	3	3
	To conduct health promotion and behavioural change communication (BCC)	Number of BCC message delivery to community	Unknown	5 messages on LF prevention health education	1	1	1	1	1
		Number of BCC IEC material developed and distributed to community	0	700,000 leaflets and 4,900 posters	140,000 leaflets and 980 posters	140,000 leaflets	140,000 leaflets and 980 posters	140,000 leaflets	140,000 leaflets
	To strengthen domestic resource mobilization and utilization	Number of Councils uses own sources to finance NTD activities costs in CCHPs by 2026	0	12	0	3	3	3	3
	To support continued operational research	Number of concept papers developed	1	10	2	2	2	2	2
		Number of operational researches conducted	1	5	1	1	1	1	1
SHISTOSOMIASIS To eliminate Schistosomiasis as a public health problem by 2030	To treat all (100%) primary school age children regularly in all endemic communities	Geographical Coverage(wards)	3,763	3,763	3,763	730	3,542	730	3,575
		Therapeutic Coverage	85%	100%	100%	100%	100%	100%	100%
	To treat at least 75% of High Risk Adults (HRA) to all wards with high endemicity	Geographical Coverage	0	10%	30%	50%	60%	80%	100%
		Therapeutic Coverage	53%	75%	75%	75%	75%	75%	75%

NTD Programme	Objective	Key Indicator	Baseline	Target	Milestones				
					2021/22	2022/23	2023/24	2024/25	2025/26
	To conduct a Coverage Survey	# of districts	8	8	8	8	8	8	8
	To conduct mapping for High Risk Adult in wards with high endemicity	Proportion of wards with high endemicity mapped for High Risk Adults	12.3%	45%	65%	75%	85%	95%	100%
	To conduct health promotion and behavioural change communication (BCC)	Number of BCC message delivery to community	unknown	5 different messages on health education abous Schisto controlbehaviour change	1	1	1	1	1
		Number BCC IEC material developed and distributed to community	Unknown	752,000 leaflets, 14,000 posters	368,000 leaflets and 7,000 posters	368,000 leaflets	368,000 leaflets	368,000 leaflets, 7,000 posters	368,000 leaflets
		Proportion of target population with correct KAP about STH prevention, transmission and treatment	unkwown	100%	50%	60%	70%	90%	100%
	To conduct a scientific study on best options for snails control interventions in Tanzania	# of best options identified	0	1	1	1	1	1	1
	To promote availability of water, sanitation and hygiene (WASH).	Proportion of districts with sanitation facilities above 80%	184	184	184	184	184	184	184
	To strengthen domestic resource mobilization and utilization	Number of Councils uses own sources to finance NTD activities costs in CCHPs by 60%	0	92	20	40	60	80	92
	To Support continued operational research.	Number and types of research priority areas developed	1	10	2	2	2	2	2
	To Monitoring & Evaluation to ensure that decisions are evidence based	Activities follow up framework developed to track progress	0	20	4	4	4	4	4
		Number of Quarterly Data Review Meetings	4	20	4	4	4	4	4
		Number of Expert Advisory Committee meetings	0	10	2	2	2	2	2
		Number of TWG	1	5	1	1	1	1	1

NTD Programme	Objective	Key Indicator	Baseline	Target	Milestones				
					2021/22	2022/23	2023/24	2024/25	2025/26
	To conduct parasitological surveys	Number of Precision Mapping	50	134	30	39	40	30	34
		Number of Sentinel Site Assesment (SSA)		184	30	70	70	70	70
STH To eliminate STH as a public health problem by 2030	To treat all (100%) SAC children in endemic areas(wards)	Geographical Coverage	100%	100%	100%	100%	100%	100%	100%
		Therapeutic Coverage	85%	100%	100%	100%	100%	100%	100%
	To conduct a Coverage surveys	# of Councils	0	40	8	8	8	8	8
	To promote access and use of water and sanitation hygiene (WASH).	Proportion of districts with basic sanitation facilities above 80%	184	184	184	184	184	184	184
	To conduct health promotion and behavioural change communication (BCC)	Number and type of BCC message delivered to the community	unknown	5 different messges on schisto prevention health education	1	1	1	1	1
		Number and type BCC IEC material developed and distributed to community	unknown	9,200,000 leaflets, 14,000 posters	1,840,000 leaflets 7,000 posters	1840,000leaflets	1,840,000leaflets	1,840,000 leaflets	1840,000 leaflets
		Proportion of target population with correct KAP about STH prevention, transmission and treatment	unknown	60%	70%	80%	90%	100%	100%
	To strengthen domestic resource mobilization and utilization	Number of Councils uses own sources to finance NTD activities costs in CCHPs by 60%	0	92	20	40	60	80	92
	To monitor disease trends by conducting Parasitological surveys.	Number of Councils conducted prevalence evaluation surveys of SAC with STH infections of moderate and heavy intensity (M&HI) ≥ 2% < 10%	0	70	12	12	10	12	24
	To support continued operational research.	Number and types of research priority areas developed	unkown	10	2	2	2	2	2
	To conduct Monitoring & Evaluation to ensure that decisions are	Activities follow up framework developed to track progress	0	1	1	1	1	1	1

NTD Programme	Objective	Key Indicator	Baseline	Target	Milestones				
					2021/22	2022/23	2023/24	2024/25	2025/26
	evidence based	Number of Quarterly Data Review Meetings (Parasitological surveys)	0	20	4	4	4	4	4
		Number of Expert Meeting established	0	5	1	1	1	1	1
		Number of TWG	1	5	1	1	1	1	1
ONCHOCERCIASIS To eliminate Onchocerciasis (interruption of transmission) by 2030)	To sustain at least 80% therapeutic coverage to 28 Councils.	Therapeutic coverage	28	28	28	28	28	28	28
		Therapeutic coverage	83%	>(80%)	>(80%)	>(80%)	>(80%)	>(80%)	>(80%)
	To conduct a Coverage Survey	# of Councils	7	7	7	7	7	7	7
	To conduct Stop MDA surveys (Epidemiological and Entomological) in all qualifying foci.	Number of qualified foci conducted stop MDA survey.	4	3	0	5	0	0	0
	To conduct IVM MDA in oncho areas twice a year to 9 Council.	Therapeutic coverage	>(80%)	>(80%)	>(80%)	>(80%)	>(80%)	>(80%)	>(80%)
	Establish Vector control in 50% endemic councils.	Number of endemic councils established vector control activities	0	14	4	3	4	0	4
	To conduct health promotion and behavioural change communication (BCC	Number and type of BCC message delivery to community	unkown	5 messages on Oncho prevention health education	1	1	1	1	1
		Number and type BCC IEC material developed and distributed to community	unkown	1,400,000, leaflets on Oncho And 9,800 posters	280,000 leaflets 1,960 posters	280,000 leaflets	280,000 leaflets	280,000 leaflets 1,960 posters	280,000 leaflets
		Proportion of target population with correct KAP about STH prevention, transmission and treatment	unkown	100%	50%	60%	70%	80%	100%

NTD Programme	Objective	Key Indicator	Baseline	Target	Milestones				
					2021/22	2022/23	2023/24	2024/25	2025/26
	To strengthen domestic resource mobilization and utilization	Number of Councils uses own sources to finance NTD activities costs in CCHPs by 60%	0	92	20	40	60	80	92
	To support continue operational research.	Number and types of research priority areas developed	0	5	1	1	1	1	1
	To conduct Monitoring & Evaluation in 28 oncho endemic councils to ensure that decisions are evidence based (Epidemiological & Entomological surveys).	Activities follow up framework developed to track progress	0	1	1	0	0	0	0
		Number of quarterly implementations follow ups	2	20	4	4	4	4	4
		Proportion of Oncho indicators featured in DHIS2	1	2	0	1	0	0	0
		Number of monitoring survey conducted	14	28	9	5	8	2	4
		Number of Epi and Ento surveys conducted	0	12	7	0	5	0	0
	To conduct Oncho elimination mapping in 15 councils to determine endemic of Oncho	15 council mapped	15	15	15	15	15	15	15
TRACHOMA To eliminate blinding trachoma as a public health problem by 2030	To conduct surveys (TIS, TSS and TT only)	# and proportion of districts conducted TIS, TSS and TT only	71 TIS	16 TIS	3	3	3	3	4
			59 TSS	TSS	4	0	2	0	1
			25 TT only	25 TT only	0	11	0	14	0
	To Reduce TT backlog in all endemic councils by 90% by 2026	Number of districts with TT prevalence of < 0.2%	38	42	8	8	8	9	9
		TT surgical rate coverage	42,000	30,600	6,120	6,120	6,120	6,120	6,120
	To sustain at least 80% therapeutic coverage to all trachoma endemic districts with a TF prevalence ≥5%	# and proportion of endemic councils with TF prevalence >5% with therapeutic coverage of>80%	8	8	4	4	3	3	3
	To reduce number of trachoma endemic districts with a prevalence	# and proportion of districts with TF prevalence above 5%	63	5	3	0	1	0	1

NTD Programme	Objective	Key Indicator	Baseline	Target	Milestones				
					2021/22	2022/23	2023/24	2024/25	2025/26
	of TF > 5% from 8 to 3 by 2026								
	To conduct a Coverage surveys	# of districts	8	8	4	5	3	3	3
	To conduct health promotion and behavioural change communication (BCC)	Number BCC message delivery to community	unknown	5 different messges on trachoma prevention health education	1	1	1	1	1
		Number and type BCC IEC material developed and distributed to community	unknown	3,550,000 leaflets, 9,940 posters, 10 roller banners	710,000 leaflets, 4,970 posters	710,000 leaflets, 10 roller banners	71,000 leaflets	710,000 leaflets 4,970 posters	710,000 leaflets
		Proportion of target population with correct KAP about Trachoma prevention, transmission and treatment	unkown	100%	50%	60%	70%	80%	100%
	To strengthen domestic resource mobilization and utilization	Number of Councils uses own sources to finance NTD activities costs in CCHPs by 60%	0	92	20	40	60	80	92
	To promote availability of water, sanitation and hygiene (WASH).	Proportion of districts whose population with access to improved water and sanitation facilities above 80% Proportion of distrcts whose population has access to hand hygiene facilities above 50%	0	71	20	20	10	10	11
	To conduct operational research Conduct	Number and types of research priority areas developed	5	10	2	2	2	2	2
	To conduct Monitoring and Evaluation	Proportion of Trachoma Elimination Program indicators featured in DHIS2	2	2	0	0	2	0	0
		Quarterly, biannual and annual implementation reports	4	20	4	4	4	4	4
		TIS, TSS and TT only reports	2	10	2	2	2	2	2

PART THREE: OPERATIONAL FRAMEWORK

STRATEGIC PRIORITY ONE

Strengthening Government Ownership, Advocacy, Coordination and Partnerships

Tanzania priority for health service delivery is described in the Health policy (2017) and HSSP V 2021-2026. The Health Sector Strategic Plan is a comprehensive national strategy for the delivery of health care services in general, including NTDs. The strategic Plan aims at integrating health services activities at various levels and underscores the need for each health program, including the NTDs, to develop strategies of integration of their program activities into general health care systems at all levels. Diseases control programmes will benefit from general improvements in health facilities.

Organization technical set-up

The Directorate of Preventive Services (DPS) at the Ministry of Health, Community Development, Gender, Elderly and Children houses the NTD Program. The Program Manager for NTD oversees the running and management of the day-to-day activities of the program, provides technical assistance to the office of the DPS in the NTD planning and management, and acts as the link between MoHCDGEC and donors, and partners (NGOs/NGDOs). The position holder is assisted by the NTD secretariat in coordinating and managing the program. Members of the NTD secretariat include the NTD Program Coordinator, focal persons of the diseases (Onchocerciasis, Lymphatic filariasis, Trachoma Schistosomiasis/STH, and other NTD programe officers. The Secretariat meets weekly for operational matters. Some of the operational matters are reviewing of the progress of the program, developing and approving of the half-yearly plan of action and budget, review application of funds for the activities, as well as reviewing technical and financial reports. NTD secretariat also provides advice to the management on development of policies and procedures that will ensure the strategic directions set by the NTD program are achieved.

Other coordinating structures include: The Disease specific technical working groups for LF, Onchocerciasis, Trachoma and Schistosomiasis & Soil transmitted helminthiasis. The groups meet at least 2 times a year and are chaired by a technical expert of the specific diseases while members include representatives from MOH related departments and beyond MOH, Universities and Research organisations.

At regional and district levels the relevant authorities under the RHMTs and CHMTs as well as other partners implement the programme. At the health facility level, there are Frontline Facility Health workers (FLHWs) who provide oversight to the community drug distributors CDDs/HW. The CDDs/HW administers drugs to the community.

Media Engagement

In recognizing the power of media in relation to informing, educating and influencing national agenda and programs such as NTD, the program will continue to utilize all available avenues to ensure media coverage of all relevant NTD related work and events. The program will use forums such as "Media editors' platform", media council of Tanzania and similar entities to advocate for the media houses coverage of NTD activities and events from national to the grassroots levels. The program will also encourage and support individual reporters and journalists to write feature articles, documentaries and interviews in various mainstream media, both for electronic and print release/circulation. To do this effectively the program will continue collaborating with the Health, Education

and Promotion unit under MOHCDGEC to ensure full utilization of all channels and opportunities to reach the masses with NTD information countrywide.

Community Involvement and Participation

Involving the community at all levels is critical to a successful MDA and other program activities. Community-directed treatment with Ivermectin (CDTI) is a community-initiated approach whereby members of the community decide on the implementation and evaluation of a treatment or intervention. It has been very instrumental in Onchocerciasis and lymphatic Filariasis elimination activities.

This strategy relies on active community participation and focuses on empowering communities to take responsibility for Ivermectin delivery (deciding how, when and by whom the Ivermectin treatment should be administered). In the rural populations of sub-Saharan Africa where health systems are weak and under-resourced, the community-directed treatment strategy is proving to be one of Africa's most successful approach in reducing disease at low cost. NTD program adopted this approach since the integration in 2009, taking into consideration our local situation.

Regional and district NTD secretariats will continue being the focus of community involvement. Involvement will be done in many ways from making NTD a permanent agenda at all RCC/CHMT/ Full Councillors', Wards and Village development meetings as well as encouraging leaders to talk about NTDs when addressing Citizens (Wananchi) in different mass meetings and gatherings. Religious leaders and prayer houses are other relevant avenues where people can be informed of NTD activities and hence increased involvement.

Social Mobilization

Social mobilization is a key component to attain the desired goal in coordinating NTD interventions. By using NTD communication strategy as a guide to influence social support from the broader public, people in a given geographical or social setting are mobilized to understand and participate in NTD interventions. In this context social mobilization is conducted to empower the society and to raise awareness of NTDs. Social mobilization activities are conducted in all levels through different channels such as local media, print Medias (Flyers, banners, billboards, brochures, posters etc.) folk media and village meetings.

Advocacy Issues

Advocacy meetings are conducted at national, regional and district authorities to engage them and get their commitment to NTDs control and elimination efforts in the country. Advocacy interventions emphasize on the importance of being in the front liner in advocacy activities in their respective communities, in order to get increased/full participation in the interventions for the control and elimination of NTDs. Advocacy meetings are also conducted to parliament members, religious leaders, government leaders (e.g. Ministers, Councillors and Regional commissioners), head of ministries departments (e.g. Ministries of Health, Education and Water). Below is a summary of the strategic objectives and activities carried out by NTD program under strategic priority 1.

Strategic Priority 1; Strengthen government ownership, advocacy, coordination and partnership

Activity	Details (Sub-activities)	Timeframe	Resources needed
Strategic Objective 1: Strengthen coordination mechanism for the NTD control programme at national, regional and District level.			
Set up and strengthen the Coordination systems for the MOHCDGEC, NTD Units at National. Regional and District levels	Conduct materials and supplies needs assessment to NTD units at council levels	2021-2026	Finances
	Support NTD units' Maintenance and recurrent costs at council level	Quarterly	Stationery and material supplies communication, utilities and funds
	Procurement of Vehicles, Motorbikes and Bicycles for the councils	2021-2026	Funds, fuel, vehicles, Motorbikes
	Conduct meetings to guide establishment of coordination mechanisms at regional and Councils levels	2021-2026	Venue, personnel, transport, stationery, refreshments
Establish and conduct NTD secretariat meetings	Conduct NTD weekly Secretariat meetings at National level	weekly	Refreshments
Strategic Objective 2: Strengthen and foster partnerships for the control, elimination and eradication of targeted NTDs at national, district and community levels.			
Strengthen Country Partnership in NTD control	Conduct partners resource mapping to identify partner's interested areas for implementation in the master plan	Annually	Venue, personnel, transport, stationery, refreshments
	Use the identified resources gaps to advocate and secure more partners including corporate sector	Annually	Venue, personnel, transport, stationery, refreshments
	Plan for advocacy and reach out for more resources	Annually	Venue, personnel, transport, stationery, refreshments
	Conduct annual partners and stakeholders' meetings	Annually	Conference package, allowances, personnel, transport, stationery, refreshments
	Disseminate reports and relevant documents to all partners and stakeholders	Biannually	Tickets, venue, allowances, refreshments
Strategic Objective 3: Enhance high-level reviews of NTD programme performance and the use of lessons learnt to enhance advocacy, awareness and effective implementation.			
Establish and conduct NTD , review and planning meetings	Conduct NTD steering committee biannual meetings	Biannually	Venue, personnel, transport, stationery, refreshments, allowance
	Conduct program Review Meetings at all levels	Annually	Venue, personnel, transport, stationery, refreshments, allowance
Take part in high level policy/decision making	Senior MOHCDGEC management	As per needs	Travel expenses
	Participate in Joint Annual Health Sector		

Activity	Details (Sub-activities)	Timeframe	Resources needed
meetings at national and international forums	review/Bunge, RMOs/DMOs meetings to enhance NTD visibility and establishment of policy statements.		
	Participate in international fora, e.g. GAELF meetings, ITI, Global health meetings, NTD TEC, etc to exchange experiences and best practices to create more linkages with other regional institutions and partners		Travel expenses, conference registration fees
Strategic Objective 4: Strengthen IEC and BCC, visibility and profile of NTD control elimination and eradication interventions at all levels.			
Strengthen IEC and BCC fora for the NTD programme	Revise and implement appropriate integrated NTDs communication strategy	2022-2023	Venue, personnel, transport, stationery, refreshments, allowance, Consultancy
	Conduct KAP studies on integrated NTD at various levels	2022-2024	Personnel, transport, stationery, refreshments/conference package, allowance, FGD-tape recorders, Video Cameras
	Establish IEC & BCC resource centres at all levels	2022-2026	Computer, TV, camera, printers, photocopiers, internet.
	Advocate for provision of budget for procurement of non-donated drugs in the MTEF under DPS expenditure and other sources	2022-2026	In-house, allowances, Refreshments, travel costs.
	Advocate for provision budget for Praziquantel and other non-donated drugs for NTD in the CCHPs	2022-2026	In-house, allowances, Refreshments, travel costs
	Conduct sensitization and social mobilization meetings for MDA – RMO/DMO meeting, RCC, DCC, Senior MOHCDGEC management	2022-2026	Consultancy-for high level, Venue, personnel, transport, stationery, refreshments, allowance,
Conduct IEC & BCC Activities for the NTD Programme	Conduct multi-sectoral sensitization meetings among ministerial policy and decision makers	Biannually	Conference package, allowances
	Conduct mass media campaign to raise awareness and sensitization (radio programs, documentary, TV, print media and social marketing)	2022-2026	Airtime, IECs, stationery, Video tapes, consultancies, Printing
	CommemorationWorld NTD day-	Annually	IECs, Fuel, personnel, Entertainment, Chairs, tents consultancy, Refreshments,
	Conduct School NTD competition	World NTD Day	Prize money, certificates,
	Preparation of radio/TV programmes on NTDs for public health education	2022-2026	Refreshments, funds, personnel, airtime, venue,

Activity	Details (Sub-activities)	Timeframe	Resources needed
Community Sensitization and Mobilization on NTD control and elimination	Development, Production and dissemination of integrated NTD IEC materials	2022-2026	Conference package, Printing, funds, transport, allowances
	Organize and participate in various Exhibitions	2022-2026	Exhibition posts, Personnel, Transport, Fuel, printing
	Organize folk media for community sensitization on NTDs	2022-2026	Hire Consultant, travel costs, allowances

STRATEGIC PRIORITY TWO

Enhance Planning for result, resource mobilization and financial sustainability

The NTD programme is gradually expanding following the transition from disease specific interventions to integration and/or co-implementation. It is of paramount importance that plans made in advance consider the need for improving the capacity of country management teams to effectively coordinate for service improvement and expansion. These have been considered and well addressed herein to support work for sustainable NTD programs at all levels.

Planning of NTD activities

The government of Tanzania through the MOHCDGEC and PO-RALG is empowering the Local Government Authorities (LGAs) through decentralization by devolving powers of decision making to the LGAs. Support will be given to LGAs in prioritizing and planning their health and social welfare interventions based on priority needs. The LGAs will mobilize, manage and account for health and social welfare resources and implement health and social welfare activities in line with the National Health and Social Welfare Policies.

Comprehensive Plan of Operations is a principal prerequisite for a well-functioning NTD Programme. All NTD priorities in the Master Plan are incorporated into the plan. The plan also guarantees that the interventions are taken into consideration. Taking all this into account, it is expected that the plan will be realistic, logical and will link well with other health needs and the available resources.

It is essential that the respective authorities (MOHCDGEC, PO-RALG, and Councils) National programme, NGOs and other partners provide the planning team with reliable financial figures on time. However, it is also the responsibility of the LGAs to actively request for this information, in particular, from NTD Programmes and, NGOs and other partners. The process and timeline of developing NTD plans is as shown in the table below.

Table 13: Process and Timetable for Developing NTD Plans

S/No	Activity	Responsible	Completion Deadlines
1.	Council/CHMTs collect priorities/ needs from Hospitals, Health Centres, Dispensaries, Community levels and other stakeholders through their plans to accommodate them in the CCHP	Council/CHMT	Early November
2.	Councils notified or collect information of resources available for Health Block Grant, Health Basket Funds and other partners for the next financial year.	PO-RALG, MoHCDGEC, Councils, Partners	End of November
3.	Comprehensive Council Health Plan prepared where there is a Council Health Service Board (CHSB), it should be involved in the evaluation and approval of the CCHP	CHPT/CHSB	Mid January
4.	Recurrent and Development budgets prepared from the CCHP	DT/DPLO/CHMT	End of February
5.	CCHP and Budgets integrated into the Council Budget.	CMT	Mid March
6.	The CCHP (hard and soft copy) is submitted to the Regional Secretariat (RS). The RS checks the CCHP for its conformity with national guidelines. All recommendations from the RS to the Council are submitted in writing	COUNCIL DIRECTOR RS/RHMT	End of March
7.	CCHP and budget approved by the Council.	FULL COUNCIL	First week of April
8.	CCHP and Budget passed to Regional Secretariat (3 copies)	CHMT	End of April
9.	Assessment of CCHP report and forwarded by RS to PO-RALG and copied to MoHCDGEC both in hard and soft copy	RS/RHMT	End of April
10.	PO-RALG and MoHSW consolidate assessed CCHP reports from RS and recommend for funding approval	PO-RALG/ MoHCDGEC	Third week of May
11.	Distribution of papers and recommendations for funding approval based on CCHP and quarterly financial and performance progress report for current financial year to BFC members	PO-RALG/ MoHCDGEC	Fourth week of May
12.	BFC meeting	BFC	End May/ 1st week of June.

Programme Financing

Budgets will be made on yearly basis with a quarterly breakdown and will follow yearly-established plans. These budgets will show required funds for NTD programme implementations. The budgets will also show sources of funding and contributions from Government as well as donors and partners. The budgets will be prepared by the NTD secretariat in consultation with LGAs, partners and donors. Final estimates will be included in the MoHCDGEC -MTEF and CCHP for Local Government Authorities (LGAs) budgets by the end of March preceding the financial year starting on 1st July of every year.

Procurement Arrangement (Drugs, Equipment, Supplies etc.)
All program related procurement arrangements will be made by the NTD program within the office of the DPS under the supervision of the NTD Secretariat. Whenever possible cost-effective procurement bills will be paid through the NTD joint program account. Procurement of drugs as well as other medical supplies is currently done through Medical Stores Department (MSD) based on the existing government arrangement and Public Procurement Act (PPRA).

Flow of funds and disbursement
The account will be fed by commitment and contributions from donors and foreign partners. Funds allocated from MTEF and treasury for recurrent and program expenses will the channelled through this account as well. This will be the major account for the program and will be used for all direct and general cost for the NTD programme, local procurement, payments of contractors and consultants, and payments of local workshops, seminars and trainings, survey etc.

Disbursement mechanism for NTD Programme and council funds will follow the government procedures. At the Regional and District levels, the special account for health will be utilized for NTD programme purposes. These accounts will be fed by contributions from the joint national NTD programme account based on the plan of actions for each year and by the contributions from the Basket funds, Block Grants and other sources from the Regional Administrative Secretary (RAS) and District Executive Director (DED).

Accounting and Auditing
These being government funds, accounting and auditing will follow accounting procedures as laid down in the Financial Memorandum and Finance Regulation in place. The description of the procedures and their application to the NTD Programme Account will be as follows:

Accounting of the NTD program at the National level is the responsibility of the NTD Program Coordinator. This account will be audited by according to the prevailing laws, rules and regulations of the country.

The LGAs (regional and district) will use the normal accounting procedures as laid down in Finance Regulation. The description of the procedures and their application to the Health Account will be as follows: The Basket Funds are transferred to health account through which all income and expenditure for health activities are channelled. All income and expenditure on health services will be brought into these accounts of the local authorities (regional and district) through its general ledger.

Councils are required by law to maintain Books of Accounts as provided in the Local Authority Accounting Manual. These accounts should be closed at the end of the financial year and final statements prepared and submitted for audit as stipulated by the Local Government Finance Act No. 9 of 1982.

Special audit may be carried out by the independent auditors to investigate and report on findings. Areas that may be covered in such investigations may relate to fraud, embezzlement and review of specific accounts. Below is a summary of the strategic objectives and activities carried out by NTD program under strategic priority 2.

Strategic Priority 2; Enhance planning for results, resource mobilization and financial sustainability

Activity	Details (Sub activity)	Timeframe	Resources (needed)
Strategic Objective 1: Support national, regions and districts to develop integrated annual plans for the control, elimination of targeted NTDs			
Develop advocacy strategy plan to enhance 5 PCTs interventions adaptation by councils and health facilities	Develop advocacy plan implementation strategy (highlighting all key activities with approaches to implement, this will help understand what starts and what will be implemented later)	2021-2022	Allowance,venue,stationery,refreshments
	Appoint implementors leads and orient them with the implementation strategy		
	Develop a follow up plan for measuring the progress	2022-2023	Office space, Personnel
	Identify key 5PCTs interventions that councils should take as priorities and resources gaps of the annual plans	2022-2023	
	Use annual plan and resources Gaps to mobilize resources through other platforms like MTEF, Regional HP, CCHPs to advocate for the inclusion of NTD activities in their plans	Annually	Stationery and Material supplies communication, utilities and sundries, funds
	Identify potential platforms to present NTD interests , like RMO, DMOs, Joint Annual Health Technical Review, public conferences of the same line of field	2021 -2026	Funds, Fuel, Vehicles, Motorbikes
Establish and conduct technical working groups NTD secretariat meetings and other NTD control and elimination related meetings	Conduct NTD weekly Secretariat meetings at National level.	Weekly 2021-2026	Venue, Stationery Refreshments
	Conduct Diseases Specific TWG's	Annually	Venue, Stationery Refreshments
	Conduct NDGO Coalition	Annually	Venue, Stationery Refreshments
	Conduct NTD Monthly Secretariat meetings at Regional level	Monthly 2021-2026	Venue, Stationery Refreshments
	Conduct NTD Monthly Secretariat meetings at District level	Monthly 2021-2026	Venue, Stationery Refreshments
	Develop NTD Advocacy strategy	2021-2022	Allowance, venue,stationery, refreshments
	Conduct Advocacy sessions for involvement of more partners in NTD control at different levels	Biannually, 2021-2026	Venue, media, personnel, transport, stationery, refreshments
Strategic Objective 2: Enhance resource mobilization approaches and strategies at , National, Regional and district levels			
Develop a resources mobilization strategy that will identify all potential source of financial resources and set approaches to	Develop a resource mobilization strategy identifying potential sources and set approaches.	2021/2022	Conference package, allowances, personnel, transport, stationery, refreshments

onboard them. (Development partners, NGDOs, Government Departs, industries, factories, corporate sectors, and other Institutions)	Set annual targets of resource mobilization from all key sources	2021/2022	Photocopying/printing and binding, postage
	Identify implementation team and orient how to implement the strategy.	2021/2022	
	Identify the strong marketing firm to Outsource the resource mobilizations activities	2021/2022	
	Develop a follow up plan to track the progress	2021/22	Personnel
Conduct a stakeholders meeting	Conduct annual stakeholders meeting presents success stories, gaps for resources and next steps.	2021/22-23	Personnel
Strategic Objective 3: Strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms.			
Develop strategy for sustainable of NTD programme at all levels	Establish Financial GAP for Integrated NTD control Program and Solicit support at all levels (using multi sectoral approach).	At least Twice a year	
	Advocate for integration of NTDs control activities into MTEF, CCHP and Regional HPs on yearly basis.	Annually	Travel expenses, conference registration fees
Strategic Objective 4: Support to develop and update national NTD guidelines and tools			
Support provision of NTDCP guidelines and tools.	Develop and Customise the 5 PCTs interventions guidelines reflecting national context	2022-2023	Personnel, Funds and material
	Share the signed guidelines with stakeholders	2023-2024	Personnel, Funds and material
	Orient councils the use of the guidelines	2023-2024	Personnel, Funds and material
Advocate for inclusion of integrated NTD control Activities into Councils plans	Participate in councils, sectors budget sessions for inclusion of Integrated NTD Activities	2021-2026	Personnel, Funds and material

STRATEGIC PRIORITY THREE

Scaling Up Access to Interventions Treatment and System Capacity Building

The three strategies for NTD control; Mass Drug Administration (PCT), Case Management and transmission control are being used to eliminate (interruption of transmission) Onchocerciasis and to eliminate Lymphatic Filariasis, Trachoma, Soil Transmitted Helminth and Schistosomiasis to the level that they will no longer be a public health problem. PCT NTD targeted in Tanzania includes Lymphatic Filariasis, Trachoma, Onchocerciasis, STH and Schistosomiasis. Case management NTDs include Trachoma Trichiasis, and LF disabilities (hydrocoele and elephantiasis). Transmission control is through effective and comprehensive vector control for LF and Onchocerciasis,

3.2.1 Scaling up Preventive Chemotherapy Interventions

Disease Mapping

Baseline mapping for PCT NTD is complete for LF, Schistosomiasis, Onchocerciasis, STH and Trachoma. As indicated earlier, STH was mapped using a review of hospital records. The review indicated high prevalence across the country. However, findings from routine program monitoring, parasitological data indicate various degree of reduction in prevalence of STH following MDA. There is new effort to re-categorize STH and SCH endemicity using the available data.

The new strategy for Onchocerciasis elimination requires identification of all possible transmission areas across the country, widening the known transmission foci beyond the known meso and hyper-endemic communities. The program has identified several districts that will need "elimination mapping" for onchocerciasis. Generally, these are districts with characteristics that favour oncho transmission and all the ones that are adjacent to hyper/meso endemic districts. The table below illustrates the completion of baseline mapping in the country for all the PCT NTD.

Table 14: Mapping of PCT NTD by 2020

Name of Endemic NTD	No. of suspected districts to be endemic	No. of districts Mapped or known endemicity status	No. of districts remaining to be mapped	Diagnostics and other inputs
LF	184	184	0	NA
Onchocerciasis	183	183	1	OV16RDT OV16 ELISA
STH	184	184	0	NA
Schistosomiasis	184	184	0	NA
Trachoma	71	71	0	NA

Mass Drug Administration

Mass Drugs Administration for LF, trachoma and Onchocerciasis is carried out at community level house by house and in fixed posts when applicable (particularly in urban areas) while MDA for Schistosomiasis is done at schools, and for STH is done in schools

and community level. The table below shows the population at risk targeted by preventive chemotherapy interventions.

Table 15: Population at risk targeted by preventive chemotherapy interventions as of 2020

Name of NTD	No. of IUs above treatment threshold for intervention	No. of IUs above threshold for intervention	Total Population at risk: 2020	Pop at risk by age category		
				# Adults (15yrs and above)	# of School age children (5-14yrs)	No. in special targeted age-category (6 - 59 months)
LF	24	24	9,813,494	7,066,297	1,481,255	0
Onchocerciasis	28	28	6,288,043	4,239,554	1,237,332	0
STH	184	184	51,449,034	35,030,960	9,781,147	0
Schistosomiasis	184	184	20,070,954	10,289,807	9,781,147	0
Trachoma	6	6	1,306,247	736,985	265,584	277,558

Co-endemicty intervention packages

The PCT NTDs overlap in Tanzania. Currently, **t**here are four packages of disease overlap with three interventions combination of MDA depending on drugs used as shown in Figure 15 below.

Based on the PCT package highlighted below, table 16 below shows a summary of the key activities planned to be implemented to effectively achieve the delivery of the specific package of preventive chemotherapy interventions for endemic NTDs.

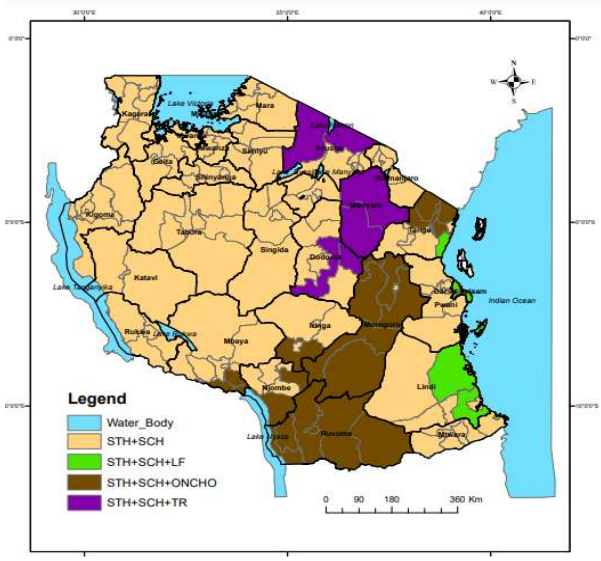


Figure 15: NTD Co-endemicity

About 144 councils in 23 regions require only school-based MDA for praziquantel and Albendazole. These are councils which have been either not endemic or have stopped MDA for other community based MDA PCT- NTDs thus remaining endemic for STH and Schistosomiasis.

About 19 councils in 5 regions required a combination of both Community and School based MDA for Ivermectin, Albendazole and Praziquantel. These councils are still endemic for LF, STH and Schistosomiasis. A combination of Albendazole and Ivermectin when distributed during community MDA helps to control STH along with elimination of LF. Distribution of Albendazole and Praziquantel during School based MDA among school aged children is crucial for control of STH and Schistosomiasis.

Combination of Community and School MDA targeting Onchocerciasis Elimination and Control of Schistosomiasis and STH is still required in 28 districts in 7 regions. In these districts a combination of Ivermectin for Community MDA and Albendazole along with Praziquantel is implemented for School based MDA.

A combination of Community MDA for Trachoma Elimination and Control of Schistosomiasis and STH is required in 8 district council of 4 regions. Most of the MDA for Zithromax is needed in Maasai community district**s** and few communities of Dodoma.

Table 16: Package Mass Drug of Administration types

Intervention package No.	Target Disease combination	MDA Type	Delivery channels	No. Of districts	Requirements	Other mass disease control interventions in the districts
I	STH, Schistosomiasis	T1	School based	144	Training of Health Personnel. Training of teachers & community volunteers. Social Mobilization. Supervision. Production and distribution of tools. Logistics for drug distribution and management. Data collection, report writing and submission	EPI campaign Immunization campaigns. ITN distribution and re-treatment
		T2	Community based	46		
II	STH, Schistosomiasis, LF	MDA1	Community based	19		
		T1	School based			
III	STH, Schistosomiasis, Onchocerciasis	MDA1	Community Based	28		
		T1	School based			
IV	STH, Schistosomiasis, Trachoma	MDA1 and MDA4	Community based	8		

MD1= Ivermectin + Albendazole, T1= Praziquantel + Albendazole, T2=Praziquantel, MD4= Zithromax

Table 17: Activities for PCT interventions

Activity	Details (Sub-activities)	Timeframe	Resources needed
Strategic Objective 1: Scale up integrated preventive chemotherapy to achieve 100% geographic coverage and treatment access to 5 PCTs NTD			
Conduct integrated MDA with, Albendazole, Ivermectin, Zithromax and Praziquantel annually to eligible NTD endemic districts	Conduct NTD Advocacy, Mobilization and Sensitization at all levels	Annually	Personnel, Funds and materials
	Conduct Cascaded Trainers of Trainers Training for the MDA at all levels	Annually	Personnel, Funds and materials
	Provide MDA	Annually and	Personnel, Funds and

		biannually	materials
	Supervision, data collection and Report writing	Biannually	Personnel, Funds and materials
	Planning &review of progress	Biannually	Personnel, Funds and materials
	Support and Participate in Drug distribution activities at the local level	Biannually	Personnel, Funds and material

Progression Plan for preventive chemotherapy

Optimal MDA coverage is important in ensuring continued suppression of intensity of infection in the community and particularly reaching as many individuals harbouring the infection as possible. Effective MDA has clearly proven to be beneficial in many endemic IUs in Tanzania. By 2019 districts, which had completed 5 or more rounds of MDA; with at least 65% coverage of IVM + ALB, package; had met criteria for stopping LF MDA. Many had met the criteria for stopping Zithromax MDA.

Challenges have been noted in 7 districts along the coastal belt of the Indian Ocean, where persistent LF infection has been noted despite a decade of MDA. Trachoma endemic communities in the Maasai corridor and in the nomadic communities also exhibit similar trends of recurrent and persistent active infections. This call for a more tailormade efforts to address "hot spot"/high transmission zones with innovative strategies including, but not limited to, intensified MDA, social mobilization, WASH/SWASH and vector control for LF, SAFE for Trachoma.

The program will continue monitoring evaluation impact of PCT interventions through routine surveys—in sentinel and spot check sites and via Transmission/Impact Assessment Surveys. These surveys allow for stopping MDA decisions to be made. Scaling down will be continued as shown on tables 18-21 below.

Table 18: Lymphatic Filariasis Annual Needs for Scaling Down (Drugs and Supplies)

NTD PROGRAM	ACTIVITY	UNITS	Annual Requirements/# of units/population					
			2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	Total
LF Elimination	LF MDA	# of districts	7	4	4	1	1	7
		# of pop at risk targeted	6,158,705	5,749,913	5,749,913	1,986,512	1,986,512	6,158,705
		Albendazole	6,774,576	6,324,904	6,324,904	2,185,163	2,185,163	27,911,005
		Ivermectin	15,396,763	14,374,783	14,374,783	4,966,280	4,966,280	63,434,104
	Sentinel site and spot check assessments	# of districts	1	7	0	4	0	8
	Transmission Assessment Surveys	# of districts	1	3	0	3	0	7
		FTS NB: 1700 per IU or EU	47,900	69,700	30,600	23,700	17,000	221,000
	Post MDA surveillance	# of districts	43	41	18	7	10	119

Table 19: Trachoma Annual Needs for Scaling Down (Drugs and Supplies)

NTD PROGRAM	ACTIVITY	UNITS	Annual Requirements/# of units/population					
			2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	Total
Trachoma Elimination	Trachoma MDA	# of districts MDA rounds	4	4	3	3	3	17
		# of pop at risk targeted	794,747	2,558,310	1387306	1,627528	1,387,306	7,755,197
		Zithromax Treatments	778,119	2,507,145	1359560	1,594,577	1,359,556	7,598,957
	Coverage surveys	# of Councils conducted coverage surveys	4	4	4	4	4	20
	Baseline surveys (repeat)	# of districts	0	3	0	0	0	3
	Trachoma Impact Survey	# of districts	3	3	3	3	4	16
	Trachoma surveillance survey	# of districts	4	0	2	0	1	7

Table 20: Schistosomiasis Annual Needs for Disease Control (Drugs and Supplies)

NTD PROGRAM	ACTIVITY	UNITS	Annual Requirements/# of units/population					
			2021/22	2022/23	2023/24	2024/25	2025/26	Total
SCH Elimination	Schisto MDA	# of wards	1,786	2,483	1,819	2,483	1,786	N/A
		# of pop at risk targeted	5,348,654	7,033,954	5,818,170	7,401,141	6,068,964	N/A
		#Praziquantel	13,371,635	17,584,885	14,545,425	18,502,853	15,172,410	79,177,208
	Coverage surveys	# of Councils conducted coverage surveys	8	8	8	8	8	40
	Impact Assesment /PM	# of districts	30	39	40	30	34	173
	Sentinel Site Assessment (SSA)	# of Council	30	70	70	70	70	310

Praziquantel distributions will be conducted at ward level from the year 2022, All wards with no, low and moderate endemicity will be eligible for impact assesment and those with high endemicity will be of second priority. All wards are eligible for SSA

Table 21: STH Annual Needs for Disease Control (Drugs and Supplies)

NTD PROGRAM	ACTIVITY	UNITS	Annual Requirements/# of units/population					
			2021/22	2022/23	2023/24	2024/25	2025/26	Total
STH Elimination	STH MDA	# of districts	184	184	184	184	184	N/A
		# of pop at risk targeted	12,589,987	12,930,630	13,281,792	13,643,847	14,017,185	N/A
		#Albendazole	13,848,986	14,223,693	14,609,972	15,008,231	15,418,904	73,109,786
	Coverage surveys	# of districts	8	8	8	8	8	40
	Impact Assesment	# of districts	30	39	40	30	34	173

Table 22: Onchocerciasis Annual Needs for Disease Control (Drugs and Supplies)

NTD PROGRAMME	ACTIVITY	UNITS	Annual Requirements/# of units/population					
			2021/2022	2022/2023	2023/2024	2024/2025	2025/2026	Total
Oncho Elimination	Oncho MDA	# of districts	28	24	24	19	11	N/A
		# of pop at risk targeted	6,713,842	6,108,191	6,243,373	4,304,914	2,855,244	N/A
		Ivermectin tabs	13,427,684	12,216,382	12,486,746	8,609,828	5,710,488	52,451,128
	Coverage surveys	# of Councils conducted coverage surveys	6	7	7	7	0	28
	Oncho Mapping	# of districts	15	6	0	0	0	21
		RDT/Needs NB: 3000 per EU	52,500	21,000	0	0	0	73,000
		ELISA needs	45,000	18,000	0	0	0	63,000
	Monitoring	# of districts	5	11	13	15	11	NA
		RDT needs	17,500	38,500	45,500	52,500	38,500	241,500
		ELISA Needs	15,000	33,000	39,000	45,000	33,000	207,000
	Epidemiological Surveys	# of districts	4	5	7	8	4	28
		RDTNeeds	14,000	17,500	24,500	28,000	14,000	98,000
		ELISA needs	12,000	15,000	21,000	24,000	12,000	84,000
	Entomological lsurveys	QIAGEN PCR TEST KIT needs	65	65	65	130	130	450

Post treatment surveillance is implemented to a period of 2 to 5 years after the last round of treatment. The program conducts an LF TAS survey twice in 5 years after IUs has achieved MDA stopping criteria. Trachoma surveillance survey is conducted after 2 and a half years of stopping Zithromax MDA. These surveillance activities allow the program to detect any early signs of recrudescence. In 2020, 102 districts were on surveillance for LF and 63 for trachoma.

3.2.2 Scaling up NTD Case Management and Chronic Care NTD Interventions

Disease Assessments

Case management is a package of activities that include identification of patients for specific NTD management. The plan takes into consideration the diversity of target diseases, overlapping and type of activities to be carried out in each specific disease intervention.

Interventions for Individual disease

Table 25 shows population at risk and planned interventions for each disease. Table 26 shows the intervention packages and table 27 shows activities for case management.

Table 23: Population at Risk Targeted by Case Management

Name of NTDs	Total districts targeted for interventions	Total number of endemic foci/ communities in the districts selected for interventions	Estimated total population at risk	Types of interventions to be delivered and requirements (needs)
Lymphatic Filariasis hydrocoele,	119	119	31 mil	Training of surgical teams from hospitals and health centres on hydrocelectomy (MO, theatre nurse and anasthesist) and Clinicians and nurses on , Lymphoedema management, Hospital facilities or appropriate basic facilities with good surgical facilities, Follow up/ supervision Mosquito control
Trachoma /trichiasis	89	89		Training of TT surgeons, and other eye care workers, Equip health facilities with basic TT surgery kits

Table 24: Intervention Packages for Group of Case Management Diseases and Chronic Care

Intervention package	NTDs targeted	Method of intervention delivery	Requirements	Other Non-NTD opportunities for Integration
Surgery	LF, trachoma trichiasis	Camping Hospital based	Surgical kits, Antibiotics, Surgeons, Nurses, Anaesthetic materials, physiotherapy	Routine OPD/IPD Care, Surgical Outreach Services
Rehabilitation	LF	Self-care training, Provision of protective footwear, Rehabilitation aids and appliances	Community based and Rehabilitation workers	Home Based Care activities

Table 25: Activities for Case Management Interventions

Activity	Details (Sub-activities)	Timeframe	Resources Needed
Strategic Objective 2: Scale up integrated case-management-based diseases interventions, including MMDP services for LF and Trachoma			
Strengthen capacity through Training on Case management NTDs	Training/Refresher training of Health staff on case management of NTDs i Train on Lymphoedema management, Face washing, self-care and Environment management in home-based health care as part of PHC in all NTD endemic districts	Jan – Dec	Personnel, Funds and material
	Training/Refresher training of LF patient's self-care groups on home-based care management of their conditions	Jan – Dec	Personnel, Funds and material
	Training/Refresher training of BTRP Surgeon and hydrocele surgeons	Jan – Dec	Personnel, Funds and material
Strengthen capacity for Diagnosis and Medical treatment of Case management of endemic NTDs	Periodically Prepare and disseminate standard operating procedures for treatment and diagnosis of NTDs	Jan – Dec	Funds and material
	Ensure adequate NTD drugs are supplied in health facilities for medical treatment of all case management NTDs	Apr - June	Funds and material
	Training/Refresher training of HF laboratory staff on the lab testing of case management NTDs	Apr - June	Personnel, Funds and material
Prevention/support of disability	Develop an Integrated morbidity intervention program, MMDP, for LF, and trachoma	Jan – Apr	Materials
	Develop and implement rehabilitation programs for patients with lymphoedema, , blindness due to Trachoma, severed skin morbidity due to ONCHO	Jan – Dec	Materials
	Keep & Update inventory of clients with chronic NTD for follow up and support	Jan – Dec	Materials
	Provide HBC management services to NTD patients	Jan – Dec	Materials
	Facilitate provision of hydrocelectomies services to selected regional and district hospitals (20 clients per months)	Jan – Dec	Personnel, Funds and materials
	Facilitate provision of Trichiasis operation services to selected regional and district hospitals (20 clients per months) (To include Materials and supplies) - to be done after Trachoma mapping	July - Sept	
	Facilitate provision of special footwear and rehabilitative aids and appliances to persons with LF related disabilities		
Facilitate and continuously support active and passive case finding of case management endemic NTDs	Capacity building of health workers/CDDs in case in surveillance of Neglected Tropical Diseases	July - Sept	
	Support Active Case finding for early detection of all NTDs at community level	Oct – Dec	Materials

3.2.3 Scaling up NTD Transmission Control Interventions

Vector- control interventions have been practiced in many tropical countries, including Tanzania but the impact has been significant in few diseases due to several reasons. These include low use of available vector control tools, reduced effectiveness and inappropriate use of pesticides, lack of an epidemiological basis for interventions, inadequate resources mainly shortage of trained personnel and inadequate infrastructure to address the problem of vectors and vector borne disease prevention and control in the country.

Although the magnitude of vector and vector borne diseases in the country is considerably high, little has been done to reduce disease transmission mainly on Lymphatic Filariasis, Schistosomiasis, and Onchocerciasis. The coverage of intervention activities for the diseases mentioned above is inadequate and somehow uncoordinated.

A few MDAs in the country have been involved in the control of vectors and VBDs without multisectoral collaboration. Although efforts have been made to strengthen interventions and research in vectors and vector borne diseases, there was lack of mechanism and institutional arrangement for coordinating these activities in the country. Due to previous experience on limited achievements in the prevention and control of vectors and vector borne diseases, it was sought to integrate them in NTDs strategic plan for resource allocation.

In February 2018, the government launched the 'One Health Coordination Desk', attached to Disaster Management Department within the Prime Minister's Office. The main aim is to coordinate various ministries in interventions to control diseases that require involvement of more than one ministry. This includes control of zoonoses (such as rabies, HAT, anthrax, RVF to mention the few), antimicrobial resistance, food safety and biorisk management. The country is expected to be well coordinated in implementing such interventions for diseases control and health security at large. The table below shows the packages to reduce the transmission.

The WASH (Water, Sanitation and Hygiene) sector is focused on improving health, such as reduced diarrheal diseases, improved livelihoods and overall well-being. NTDCP is collaborating with the National Sanitation Campaign (NSC) under the Environmental Health Section from the MoHCDGEC to imbed the implementation of water, sanitation and hygiene (WASH) services alongside NTD interventions across all districts as part of integrating and scaling up NTD preventive services.

Table 26: Scaling up Package to reduce Transmission

Package Type	Group of diseases	Requirements	Other Non-NTD opportunities
Vector Control	LF, Schistosomiasis, Onchocerciasis	Trainings for proper application of pesticides. Procurement and distribution of pesticides (for , snails, simulium,). Environmental management and hygiene. Skilled human resource for public health education. Supplies and allowances.	Vectors and VBD control unit at MoHCGDEC Environmental-Health Section. WASH programme Malaria Control program-larviciding, Environmental management, IRS, IVM, LLINs, NIMR TTRI Tanga.

Below is the table summarising the Integrated Vector Control acivities aiming at control and elimination of NTDs

Table 27: Activities for disease transmission control through Integrated Vector Management (IVM)

Activity	Details (Sub-activities)	Timeframe	Resources needed
Priority area 3: Strategic Objective 4: Strengthening integrated vector management and WASH activities for targeted NTDs			
Conduct IVM need assessment and advocate integration to key stakeholders for transmission control of NTDs	Identify key stakeholders for IVM implementation for specific selected NTD	2021/2022	Allowance, Stationary, fuel
	Assess country capacity on the implementation of IVM for NTDs prevention and control	Annually	Allowance, Stationary, fuel
	Development of IVM Policy guideline and implementation guide for transmission and control of NTDs	2023/2024	Allowance, Stationary, fuel
Capacity building on IVM and epidemic risk assessment to field operation officers for the selected NTDs	Training of stakeholders on IVM implementation for control of NTDs	2023-2024	Allowance, Stationary, fuel
Implement vector control Intervention for control of NTDs	Advocate for procurement of insecticides to control NTD related vectors	Continuously	Allowances, Pesticides, Targets, Equipment and other supplies
	Establish and implement Simulium control interventions in affected areas	2022-2023	Allowances, pesticides and relevant equipment's
To conduct scientific study on best options for control of snails	To search and identify scientific institution with technological, capabilities and experienced in the control of snails	2023	Allowances, Fuel, stationary, equipment and other supplies,
	To write a proposal and secure funds for implementation of snail control activities		
	Share the findings and recommended options for snails control to disrupt transmission of Schisto		Sub-contract
Behavioural change and communication activities to raise awareness on VBD prevention and control to communities	Establish and implement school-based programmes for NTDs prevention	2021 onwards	Allowance, fuel, stationery
	Prepare and disseminate IEC materials for VBD prevention and control (posters, leaflets, fact sheets, radio and TV spots)	2021 onwards	Allowance, fuel, stationeries

	Prepare documentaries for public awareness on prevention and control of each VBD	2021	Allowance, fuel, stationeries
	Conduct radio and TV sessions to educate the public on VBDs	Onwards	Transport
Monitoring and Evaluation of Vector control intervention for control of NTDs	Conduct backstopping supportive supervision to monitor the implementation of vector control interventions	Quarterly starting from 2021	Allowances, Fuel, stationary, equipment and other supplies,
	Conduct entomological and parasitological evaluation to monitor the effectiveness of vector control intervention for control of NTDs	Biannually	Allowances, Fuel, stationary Allowances, Fuel, stationary, equipment and other supplies
Integration of WASH interventions	Facilitate the integration, implementation and scale-up of WASH activities under the NSC alongside NTDs interventions	Annually	Personnel

Interventions for Other Neglected Tropical Diseases

There are other NTDs known to be endemic in our country apart from the five PC-NTDs. These include Human African Trypanosomiasis (HAT), Rabies, Tick borne Relapsing fevers, Echinococcosis (hydatid), Taeniasis (cysticercosis), Brucellosis, Plague, Leprosy, Leishmniasis, snakebite eenvenoming, scabies and other ectoparasitoses, Dengue and Chikungunya, mycetoma, chromoblastomycosis and other deep mycoses.
The interventions for all these NTDs, will depend on the availability of resources particularly through collaborations with other partners and sectors in and outside the country who are interested in working with the program to address some of the issues related to these NTDs.

Pharmacovigilance in NTD Control Activities

Adverse drug reactions (ADRs) are inevitable consequences of pharmacotherapy. No drug is safe under all circumstances of use or in all patients. ADRs may occur even if a drug is correctly selected and dosed. In Tanzania ADR, monitoring and reporting system is under the Tanzania Medicines and Medical Devices Authority (TMDA). ADR monitoring and reporting system is still weak in the country hence serious and mild ADRs tend to go unreported/underreported. NTD control program is planning to operate through collaboration with the existing system to strengthen and archive for detection, assessment, monitoring and reporting of ADRs.

Pharmacovigilance systems are still being strengthened and coordinated by the Tanzania Medicines and Medical Devices Authority (TMDA) together with established zonal Pharmacovigilance Centers located at Kilimanjaro Christian Medical Center (KCMC) - Kilimanjaro, Muhimbili National Hospital (MNH) - Dar-es-Salaam, Bugando Medical Center (BMC) – Mwanza, Mbeya Medical Center (MMC) – Mbeya, Ligula Regional Hospital in Mtwara, Dodoma Regional Hospital-Dodoma and Maweni Regional Hospital- Kigoma.

In strengthening pharmacovigilance system in Tanzania, TMDA has constantly devised measures to foster the reporting rate. Some of the measures are engaging ministry responsible for health, Regional and District health systems, manufacturers, MAHs as well as private pharmaceutical outlets in the collection of ADR reports, establishing more centers to coordinate collection of ADR reports, integrating pharmacovigilance into public health programmes, conducting training and sensitizing health care providers, manufacturers and patients to report adverse event to medicines and other products. The guideline for Pharmacovigilance has been developed. The guideline serves as the reference document for all matters of concern.

Roles of the NTD Control Program in pharmacovigilance:

1. Identifying focal persons to coordinate pharmacovigilance activities,
2. Planning and budgeting for pharmacovigilance activities,
3. Distribution of ADR forms in programme sites and collection of data using existing ADR reporting forms,
4. Establishing procedures for data analysis and review as well as risk management and follow-up of patients,
5. Collaborating with TMDA in implementing pharmacovigilance activities,

6. Training of health care providers in reporting adverse drug reactions including other aspects of pharmacovigilance,
7. Promoting rational and safe use of medicines by health care providers, educating and informing patients on the importance of reporting adverse drug reactions.
8. Assessment and communication of the risks and effectiveness of medicines used in Mass Drug Administration (MDA) campaigns
9. Setting up of an adequate email/referral system, to ease the process of ADR reporting.

Table 28 below summarizes the activities for strengthening and scaling up pharmaco-vigilance in NTD program

Table 28: Activities for strengthening pharmaco-vigilance in NTD program

Activity	Details (Sub-activities)	Timeframe	Resources needed
Strategic priority 3: Strategic Objective 5: Strengthening pharmaco-vigilance in NTD program and Ensure timely effective supply chain management of quality-assured NTD Medicines and other products up to the last mile			
Pharmaco-vigilance capacity building	Planning and budgeting for pharmaco-vigilance activities	Annually	Personnel, funds
	Training of health care providers, district and regional NTD teams and NTDCP secretariat on reporting adverse drug reactions	Annually	Personnel, funds
	Establish SOPs for data collection, review and patient follow-up	As per need	Personnel, funds
Implementation and sustainability of NTD pharmaco-vigilance	Collaborating with TMDA in implementing pharmaco-vigilance activities	Continuous	Personnel, funds
	Distribution of ADR forms in program sites and collection of data using existing ADR collection forms	As per need (Annually)	Personnel, funds
	Establish a feedback system to ease the process of ADR reporting	Continuous	Personnel, funds
	Promoting rational and safe use of medicines by health care providers, educating patients on the importance of reporting ADR	As per need (Annually)	Personnel, funds
	Assessment and communication of the risks and effective of medicines used in MDA campaigns	As per need (Annually)	Personnel, funds

Strengthening Capacity at National Level for NTD Programme Management and Implementation

The NTDCP secretariat is headed by the Program Manager and is made up of seven units. These units are; LF unit, Oncho unit, Trachoma and WASH unit, STH/SCH unit, M&E and research unit, Health Commodities and Logistics unit and Behaviour Change Communication unit.

The NTDCP secretariat needs to strengthen the capacity of its implementing staff on the implementation, surveillance and scaling down of NTD activities towards elimination of NTDs.

Capacity building activities of the NTDCP Secretariat have been on going with support from the government and donors. Needs for capacity building are usually identified through different review and planning meetings conducted under the program at different levels.

The areas that need capacity strengthening include; resource mobilization, implementation of surveillance activities, maintenance and sustainability of programme activities towards achieving NTD control and elimination targets.

Table 23 below summarizes the proposed activities earmarked to support capacity building in the NTD management at the national and sub national levels.

Table 29: Activities to support capacity building in NTD management at the national and subnational levels

Activity	Details (Sub-activities)	Timeframe	Resources needed
Strategic Priority 3: Strategic Objective 6: Strengthen capacity at national level for NTD programme Management and implementation and accelerate disease burden assessments and integrated mapping of NTDs			
Improve skills and knowledge of NTD Key staff in NTD management and control	Conduct orientation session on master plan, use, implementation and monitoring	Annually	Personnel, Funds and material
	Organize training of NTD Secretariat on NTD program management	Annually	Personnel, Funds and material
	Conduct a capability assessment of the NTDCP human resources	Annually	Personnel, Funds and material
	Share the capability assessment report for use and decision making	Annually	
	Develop, plans for mitigating the gaps identified	Annually	Funds and material
Support infrastructure, equipment's and other necessary items for the NTD programme management at all levels	Conduct a need assessment to strengthen coordination at all levels	July -June Annually	Funds
	Procurement and maintenance of vehicles, motorbikes and bicycles for councils levels to support interventions		Personnel, Funds and material
	Procurement and maintenance of computers and printers and supplies for NTD staff at National Regional and Districts offices	Jan – Dec Annually	Funds
	Establish a PPM plan for maintenance of the equipment	Annually	Personnel, Funds and material
	Establish and update inventory of NTD equipment and supplies	Annually	Personnel
Sustainability and Maintenance of the program	Incorporate and budget NTD Activities into CCHP	Annually	Personnel, Material
Leadership and Management Training	Conduct orientation of NTD activities on NTD program to the Management team at all level	Annually	Personnel, Funds and material

STRATEGIC PRIORITY FOUR
Enhance Monitoring, Evaluation, Surveillance and Operational Research

Monitoring, Evaluation and Surveillance

NTDCP activities are guided by; among others; the National Health Policy and policy guidelines. Key program performance indicators are outlined in the M&E framework. These include process, performance and impact indicators. NTDCP has data collection mechanisms in place, namely; the national HMIS and IDSR. A number of indicators for NTDs have already been incorporated. For instance, trachoma, LF, Onchocerciasis, STH, Schistosomiasis, TBRF, Trypanosomiasis, and leprosy are reported in the IDSR.

The NTDCP MIS database records information on district level activities, including; advocacy, training (NTD teams, FLHWs, teachers and CDDs), census, coverage, drugs status and financial status. Guided by an integrated M&E framework, the program monitors key program performance indicators at national, regional, district and community level.

However, efforts are ongoing to update the disease specific indicators to increase the sensitivity and specificity of the indicators, to increase the capacity at both the national and district levels on the efficient use of the NTDCP MIS and to facilitate the integration of NTDCP MIS with DHIS2 to have an integrated uniform NTD database.

Moreover, it is critical to establish / strengthen a strong communication and feedback mechanism that allows close contact across the different administrative levels and facilitates follow-up when needed. The information flows from community level to district, regional and national level. All feedback flows via the same pathway. Examples of indicators collected through this pathway include, community population census and training data, number of people treated, therapeutic coverage, SAE, MDA medicines received/utilized/remaining, NTD morbidity and financial reports. Figure 14 shows summary of the information flow.

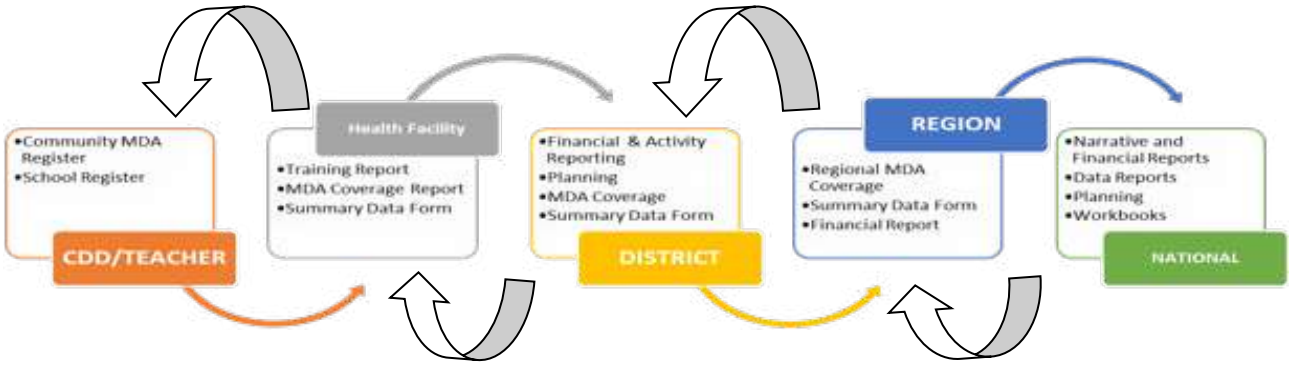


Figure 16 : NTD Information Pathway

Monitoring of program activities for NTD control involves a number of activities, for instance, mapping, baseline data collection (through sentinel and spot check sites), follow up surveys (e.g. epidemiological, entomological surveys and transmission assessment

surveys) and impact assessment. Mapping for NTD PCT has been completed for LF, STH, Schistosomiasis and Trachoma. Onchocerciasis mapping is incomplete.

Trachoma elimination is targeted for 2030 globally. Tanzania has aligned its plans to meet this target. Zithromax MDA is to be conducted for 3 up to 5 years before trachoma impact assessment in a given endemic implementation unit depending on the initial TF prevalence.

Lymphatic Filariasis elimination as public health problem is globally targeted for 2030. Interruption of disease transmission is done through annual MDA with Ivermectin + Albendazole following mapping and/or baseline data collection. Depending on the starting Mf and or/Ag prevalence, MDA will continue for 3 to 5 rounds (one round per year) before following up Mf and/or Antigen assessment is conducted. Where prevalence has been reduced below 1% Mf in given IUs, MDA is stopped and surveillance activities initiated. These include Transmission Assessment Surveys (TAS) every 2 to 3 years.

For STH elimination the program aims at treating 100% of the at-risk School Aged Children (SAC) population by 2026. STH has not been mapped in Tanzania but hospital records indicate the disease is endemic in all IUs. MDA is conducted twice yearly in LF endemic IUs through community based (IVM+ALB) and school based (PZQ+/ALB) medicine distribution targeting SAC. In the IUs that are not endemic for LF 1 round of Albendazole MDA will be done through primary schools targeting SAC.

Schistosomiasis elimination targets to treat 100% of SAC at risk by 2026 using Praziquantel. Where possible, high-risk adult groups will be treated with PZQ. Follow up surveys will be done to measure reduction in intensity of infection.

Onchocerciasis is planned for elimination by the year 2030. Disease transmission interruption efforts are geared towards mass Ivermectin distribution for at least 10 years. Epidemiological and entomological evalutions follow to determine circulating Mf load in human and vector before stopping MDA.

Mid-term program evaluation will be done independently after three years of implementation. The evaluation will look into progress and achievements met and also evaluate review and update the strategy as necessary to achieve the overall purpose. A number of M&E activities have been earmarked as shown on the table below:

Table 30: Strategic Priority 4: Enhance NTD Monitoring and Evaluation, surveillance and operations research

Activity	Details (Sub-activities)	Timeframe	Resources needed
Strategic Objective 1: Enhance Monitoring of NTD programme performance and outcome			
Develop integrated M&E framework and tools for NTDs control at different levels	Supporting M&E Unit to undertake monitoring/evaluation activities under the NTD programme as needed	Quarterly	Personnel & Diagnostics
	Support meeting for the M& E team to regularly review and summarize program performance information.	Quarterly	Stationery, printing,
	Develop, print and disseminated M&E framework for the integrated NTD program (capture all activities within ALL strategic priorities)	2021-2022	Conference package, Stationery, printing, allowance and fuel
	Review, update and disseminate specific integrated data collection and reporting tools for NTDCP for different levels	Annually	Conference package, Stationery, printing, allowance and fuel
	Develop and disseminate standard operating procedures (SOPs) for the PCT NTDs	2022-2023	Conference package, Stationery, printing, allowance and fuel
	Review, print and disseminated integrated post MDA assessment protocol (Impact assessment)	Annually	Conference package, Stationery, printing, allowance and fuel
	Review and adapt, post MDA coverage surveys protocol	Biannually	Conference package, Stationery, printing, allowance and fuel
	Develop SOPs for Case management for NTDs to guide prevention, diagnosis, treatment and control	2022-2023	Conference package, Stationary, printing, allowance and fuel
	Update NTD database to incorporate all NTDCP information	Quarterly	Conference package, Stationery, printing, allowance and fuel
M& E capacity Building	Conduct needs assessment for all regions and districts on M&E	Annually	Travel- fuel and per diem,

	Develop and produce data trainers Guide trainees' manuals Develop and disseminate data management trainers/trainees' guideline/manuals	2021-2022	Conference package, Stationery, printing, allowance and fuel
	Conduct M&E Training to Regional and District Coordinators	Annually	Conference package, Stationery, printing, allowance and fuel
	Orient key NTD staff- at all level on M&E tools- framework, SOPs, data collection tools and other outcomes of the need's assessment	Annually	Conference package, Stationery, printing, allowance and fuel
Coordination Management of supply chain processes and resource tracking	Establish and manage inventory of Drugs	Annually	Conference package, Stationery, printing, allowance and fuel
	Establish and manage inventory of supplies and equipment	Annually	Conference package, Stationery, printing, allowance and fuel
	Produce program performance report by every unit	Quarterly	In- house
	Develop format for program performance by different unit and individuals	Quarterly	
	Review reports and recommendation made in NTD meetings—task force, secretariat meetings, management and operation research meetings.	Quarterly	
Implementation monitoring	Through indicators formulated in the M& E framework monitor implementation of NTDCP activities delineated in all priority areas	Continuous	In-house
	Conduct Supportive supervision for NTD activities to Regional, districts and Communities	Annually	Travel-fuel, per diem and stationery,
	Monitor SAE related to MDA for PCT targeted NTDs	Per MDA	CHMTs, and TMDA
	Collect post MDA data collection and report writing	Continuous	Travel-fuel, per diem and stationery
	Conduct post MDA, coverage survey and spot checks (coverage validation)	after@MDA activity	Travel-fuel, per diem, allowances and stationery

	Conduct targeted monitoring for NTD morbidity control activities (e.g. LF, TT surgery camps, Lymphoedema management, Face washing, WASH, etc.)	Quarterly	Travel- fuel, per diem, stationary
	Conduct targeted monitoring of vector control activity control** (expand based on Integrated Vector Management -IVM activities)	Quarterly	Travel-fuel, per diem and stationery
	**Conduct technical backstopping monitoring visit to oversee NTD Activities (Advocacy (IEC/BCC etc.) at National, regional and districts level.	Quarterly	Travel-fuel, per diem and stationery
	Conduct (finalize) integrated mapping NTDs in all districts with incomplete mapping (and collect GPS coordinates)	July	Hire research team (consultant)
	Conduct precision/elimination mapping of SCH and Oncho and case management targeted NTDs in suspected endemic areas	2021-2026	Hire research team (consultant)
	Conduct follow-up prevalence assessment in all districts with ongoing MDAs (refer disease specific needs)	2021-2026	Hire research team (consultant)
Mid Term and End evaluation of the NTDCP Master Plan	Conduct midterm and summative evaluation of the NTD programs	2023-2024	Consultancy fee
	Conduct end term and summative evaluation of the NTD programs	2026	Consultancy fee
Strategic Objective 2. Strengthen the Surveillance and strengthen the response and control of epidemic prone NTDs			
Strengthen and support surveillance activities for the monitoring of NTDs (facilitation)	Develop/ and adapt post MDA surveillance system and tools for specific diseases, e.g. LF, Onchocerciasis, Trachoma	Annually	Conference package, allowances
	Train surveillance team	Periodically as per need	
	In collaboration with the existing country surveillance Teams, establish an integrated diseases surveillance system for all NTDs to be integrated in the national diseases surveillance system	2023-2024	Conference package, per diem and staff participation in MOHCDGEC IDSR meeting.
	Support surveillance for Trachoma, LF and Oncho following completion of MDAs	Continuos	

	Adapt surveillance tools and system	2021-2026	
Procure medical equipment and supplies for surveillance	Procurement of supplies periodically	Annually	Tender documents, finances
Strategic Objective 3: Support operational research, documentation and evidence to guide innovative approaches to NTDs programmes interventions			
	Develop an integrated NTDs control research agenda	Annually	in-house
	Conduct operations research studies on integrated NTDs	2021-2026	Call for research proposal, funding support
Strengthen Documentation systems and activities for the NTD Programme	Develop an integrated NTDs Documentation Plan and archives	2021-2026	in-house
	Conduct documentation activities for the NTD Programme as indicated in the plan	Annually	Contract out, finances
Periodically disseminate research and documentation articles to NTD Partners, MoHCDGEC, Policy makers and the scientific community to support NTD advocacy and information sharing	Attend in different national meetings/fora to share operation research and documentation findings	Annually	Travel- allowances
	Attend different international fora to share documentation and operations research findings	Annually	Travel, allowances
	Disseminate impact assessment results	Annually	Technical working group / Stakeholders' meetings
Strategic Objective 4: Establish integrated data management system (Monitoring Information System, MIS, for NTDs and link NTD MIS with DHIS2) and support impact analysis of NTD in Tanzania as part of WHO Africa region and global NTD data management system			
Capacity building on Integrated data management system	Training district NTD coordinators on the efficient use of NTDCP MIS	2021-2026	Personnel, conference packages and finances
	Update disease specific indicators and build capacity to collect data on to DHIS2	As per need (annually, every two years)	Personnel, finances and supplies

	Integration of NTDCP MIS with DHIS	2021-2026	Personnel, finances
Strengthen post intervention surveys/ impact analysis of NTDs control	Develop elimination strategy	2022-2023	Hire consultancy team
	Conduct impact survey of activities for LF and transmission surveys	Annually	Hire consultancy team
	Conduct impact survey of activities for Schistosomiasis and transmission surveys	Annually	Hire consultancy team
	Conduct impact survey of activities for Trachoma	Annually	Hire consultancy team
	Conduct impact survey of activities for STH	Annually	Hire consultancy team
	Support epidemiological evaluation for Onchocerciasis control and transmission /entomological surveys	Annually	Hire consultancy team
	Conduct impact assessment for case management NTDs	Annually	Hire consultancy team

Post intervention surveillance and integration with Primary Health Care

It is critical to continue disease surveillance after reaching the criteria for stopping MDA. Conducting effective surveillance enables to monitor the disease and determine if there is disease recrudescence. Once recrudescence is determined, additional rounds of MDA will be required as per the different disease guidelines.

Additionally, it is important to continue and scale up Morbidity Management and Disability Prevention (MMDP) services across all endemic districts after reaching the criteria for stopping MDA. Provision of MMDP services will assist to provide treatment and clear the backlog of those who are already affected with the diseases.

For diseases that are targeted for elimination, it is important to continue with disease surveillance to monitor the burden of disease and associated disabilities.

These services should be integrated to the Primary Health Care services to ensure their sustainability. In order to embed these services, into the routine primary health care, transitioning process is essentially needed. The transition process is whereby key activities become embedded and supported within the routine health care activities in the district. Table 28 below highlights post interventions and surveillance activities that will be implemented.

Table 31: Activities of surveillance and sustainability

Activity	Details (Sub-activities)	Timeframe	Resources needed
Strategic Objective: Strengthening post intervention surveillance and integration within primary health care			
Advocacy for post intervention surveillance	Conduct advocacy meetings to regional, districts authorities and local stakeholders on post intervention surveillance for specific NTDs	Annually	Funds, personnel
Capacity building for post intervention surveillance and MMDP activities	Training of surveillance teams	Periodically (as needed)	
	Training of health care workers on MMDP	Periodically (as needed)	
	Develop/adapt post MDA surveillance system and tools for specific diseases and an integrated disease surveillance system	Annually	
	Support surveillance for non PCT NTDs	Annually	
	Conduct supportive supervision of surveillance and MMDP services	As needed	
Equipments and consumables	Procurement of supplies for MMDP services	Annually	
Strategic objective: Establishing integrated data management system and support impact analysis for NTDs as part of the country NTDs data management system and country health plan			
Conduct supportive supervision, monitoring and evaluation of NTDs control Programme implementation.	Develop, produce and disseminate monitoring and evaluation tools	2021-2023	Conference package, fuel, transport, stationary, allowances
	Train health workers and community health workers on data collection management and dissemination	2021-2022	
	Develop, produce and disseminate integrated tools for reporting NTDs through existing DHIS	2021-2022	
	Integrate supportive supervision of activities implementation at the country level	2021-2024	

ASSUMPTIONS, RISKS AND MITIGATIONS

Risk is the process of examining how likely risk will arise in the implementation of NTD programme. It also involves examining how the programme outcome and objectives might change due to the impact of the risk. The impact could be in terms of schedule, quality, and cost. And Risk mitigation is the process of developing options and actions to enhance opportunities and reduce threats to the programme objectives. Risk mitigation progress monitoring includes tracking identifiable risks, identifying new risks, and evaluation risk process effectiveness throughout the programme period.

Table 32: Risk Criteria and Assessment

Risk Criteria and Assessment							
Potential Risk	**Before Risk Mitigation**			**Risk Mitigation**	**After risk Mitigation**		
	Likelihood of Occurrences	Impact	Score		Likelihood of Occurrences	Impact	Score
	Certain = 5 Likely = 4 Possible = 3 Unlikely = 2 Rare = 1	Severe = 5 Major = 4 Moderate = 3 Minor = 2 Insignificant = 1	Likelihood x Impact		Certain = 5 Likely = 4 Possible = 3 Unlikely = 2 Rare = 1	Severe = 5 Major = 4 Moderate = 3 Minor = 2 Insignificant = 1	Likelihood x Impact
Type of Risk							
Implementing activities out of master plan	5	5	25	Orientation of Master plan and use to generate all other/ annual plans	1	4	4
Councils, Health Facilities not prioritizing NTD activities, budgeting and allocating funds for.	5	4	20	Advocacy to councils/health governance leaders and planning teams	2	2	4
Insufficient of funds	5	4	20	Identify partners and secure resources commitments	2	2	4

Risk Rating (Likelihood x Impact)			
Severe	**Major**	**Moderate**	**Minor**
19 - 25	13 - 18	7 - 12	0 - 6

BUDGET JUSTIFICATION AND ESTIMATES

Table 33: NTDCP summary of budget estimates from 2021 – 2026

Strategic Priority 1; Strengthen government ownership, advocacy, coordination, and partnership

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Strategic Objective 1: Strengthen coordination mechanism for the NTD control programme at national, regional and District level.						
Conduct materials and supplies, needs assessment to NTD units at National Level	8,000,000.00	8,000,000.00	8,000,000.00	8,000,000.00	8,000,000.00	40,000,000.00
Support NTD units' Maintenance and recurrent costs at National Level	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	91,000,000.00
Procurement of Vehicles for the National Level.	0.00	50,000,000.00	0.00	50,000,000.00	0.00	500,000,000.00
Conduct meetings to guide establishment of coordination mechanisms at regional and Councils levels	36,717,718.00	36,717,718.00	36,717,718.00	36,717,718.00	36,717,718.00	183,588,590.00
Conduct NTD weekly Secretariat meetings at National level	960,000.00	960,000.00	960,000.00	960,000.00	960,000.00	4,800,000.00
Strategic Objective 2: Strengthen and foster partnerships for the control, elimination and eradication of targeted NTDs at national, district and community levels.						
Conduct partners resource mapping to identify partner's interested areas for implementation in the master plan	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	91,000,000.00
Use the identified resources gaps to advocate and secure more partners including corporate sector	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	91,000,000.00
Plan for advocacy and reach out for more resources	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	91,000,000.00
Conduct annual partners and stakeholders' meetings	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	91,000,000.00
Disseminate reports and relevant documents to all partners and stakeholders	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	91,000,000.00
Strategic Objective 3: Enhance high-level reviews of NTD programme performance and the use of lessons learnt to enhance advocacy, awareness and effective implementation.						
Conduct NTD steering committee biannual	45,815,178.00	45,815,178.00	45,815,178.00	45,815,178.00	45,815,178.00	229,075,890.00

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
meetings						
Conduct program Review Meetings at all levels	269,670,419.00	269,670,419.00	269,670,419.00	269,670,419.00	269,670,419.00	1,348,352,095.00
Senior MOHCDGEC management	28,400,700.00	28,400,700.00	28,400,700.00	28,400,700.00	28,400,700.00	142,003,500.00
Participate in Joint Annual Health Sector review/Bunge, RMOs/DMOs meetings to enhance NTD visibility and establishment of policy statements.	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	75,000,000.00
Participate in international for a, e.g. GAELF meetings, ITI, Global health meetings, NTD TEC, etc. to exchange experiences and best practices to create more linkages with other regional institutions and partners	60,000,000.00	60,000,000.00	60,000,000.00	60,000,000.00	60,000,000.00	300,000,000.00
Strategic Objective 4: Strengthen IEC and BCC, visibility and profile of NTD control elimination and eradication interventions at all levels.						
Revise and implement appropriate integrated NTDs communication strategy	0.00	18,200,000.00	0.00	0.00	0.00	18,200,000.00
Conduct KAP studies on integrated NTD at various levels	0.00	18,200,000.00	18,200,000.00	18,200,000.00	0.00	54,600,000.00
Establish IEC & BCC resource centres at all levels	9,500,000.00	9,500,000.00	9,500,000.00	9,500,000.00	9,500,000.00	47,500,000.00
Advocate for provision of budget for procurement of non-donated drugs in the MTEF under DPS expenditure and other sources	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	91,000,000.00
Advocate for provision budget for Praziquantel and other non-donated drugs for NTD in the CCHPs	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	18,200,000.00	91,000,000.00
Conduct sensitization and social mobilization meetings for MDA – RMO/DMO meeting, RCC, DCC, Senior MOHCDGEC management	28,200,000.00	28,200,000.00	28,200,000.00	28,200,000.00	28,200,000.00	141,000,000.00
Conduct multi - sectorial sensitization meetings among ministerial policy and decision makers	28,543,858.00	28,543,858.00	28,543,858.00	28,543,858.00	28,543,858.00	142,719,290.00
Conduct mass media campaign to raise awareness and sensitization (radio programs, documentary,	15,000,000.00	16,000,000.00	14,600,000.00	20,000,000.00	12,000,000.00	77,600,000.00

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
TV, print media and social marketing)						
Commemoration National NTD day-	65,172,000.00	65,172,000.00	65,172,000.00	65,172,000.00	65,172,000.00	325,860,000.00
Preparation of radio/TV programmes on NTDs for public health education	20,118,000.00	20,118,000.00	20,118,000.00	20,118,000.00	20,118,000.00	100,590,000.00
Development, Production and dissemination of integrated NTD IEC materials	34,658,333.33	34,658,333.33	34,658,333.33	34,658,333.33	34,658,333.33	173,291,666.67
Organize and participate in various Exhibitions	5,766,666.67	5,766,666.67	5,766,666.67	5,766,666.67	5,766,666.67	28,833,333.33
Organize folk media for community sensitization on NTDs	5,806,666.67	5,806,666.67	5,806,666.67	5,806,666.67	5,806,666.67	29,033,333.33
					SUBTOTAL	4,832,051,198.33
Strategic Priority 2; Enhance planning for results, resource mobilization and financial sustainability						
Develop a master plan implementation strategy (highlighting all key activities with approaches to implement, this will help understand what starts and what will be implemented later)	29,721,448.00	0.00	0.00	0.00	0.00	29,721,448.00
Orient NTD Staff with the implementation strategy	17,486,057.00	0.00	0.00	0.00	0.00	17,486,057.00
Identify and develop NTD activities to be implemented on yearly bases	17,486,057.00	0.00	0.00	0.00	0.00	17,486,057.00
Identify resources gaps of the annual plan	0.00	0.00	0.00	0.00	0.00	-
Use annual plan and resources Gaps to mobilize resources through other platforms like MTEF, Regional HP, CCHPs to advocate for the inclusion of NTD activities in their plans	20,000,000.00	20,000,000.00	20,000,000.00	20,000,000.00	20,000,000.00	100,000,000.00
Identify potential platforms to present NTD interests , like RMO, DMOs, Joint Annual Health Technical Review, public conferences of the same line of field	20,000,000.00	20,000,000.00	20,000,000.00	20,000,000.00	20,000,000.00	100,000,000.00
Conduct NTD weekly Secretariat meetings at National level.	480,000.00	480,000.00	480,000.00	480,000.00	480,000.00	2,400,000.00
Conduct Diseases Specific TWG's	23,000,000.00	23,000,000.00	23,000,000.00	23,000,000.00	23,000,000.00	115,000,000.00
Conduct NDGO Coalition	23,000,000.00	23,000,000.00	23,000,000.00	23,000,000.00	23,000,000.00	115,000,000.00
Develop NTD Advocacy strategy	23,000,000.00	0.00	0.00	0.00	0.00	23,000,000.00
Conduct Advocacy sessions for involvement of	40,000,000.00	40,000,000.00	40,000,000.00	40,000,000.00	40,000,000.00	200,000,000.00

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
more partners in NTD control at different levels						
Strategic Objective 2: Enhance resource mobilization approaches and strategies at , National, Regional and district levels						
Conduct annual partners and stakeholders' meetings	23,000,000.00	23,000,000.00	23,000,000.00	23,000,000.00	23,000,000.00	115,000,000.00
Disseminate the plans, reports and relevant documents to all partners and stakeholders.	30,000,000.00	30,000,000.00	30,000,000.00	30,000,000.00	30,000,000.00	150,000,000.00
Identify teams and write proposals to mobilizing funds for integrated NTD control programme activities	7,875,000.00	0.00	0.00	0.00	0.00	7,875,000.00
Identify the strong marketing firm to Outsource the resource mobilizations activities	7,875,000.00	0.00	7,875,000.00	0.00	0.00	15,750,000.00
Strategic Objective 3: Strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms.						
Develop strategy for sustainable of NTD programme	85,825,530.00	0.00	0.00	0.00	0.00	85,825,530.00
Advocate to the other Ministrial levels like MoF, MoW, MoNL-TANAPA, PO-Ralg.	30,000,000.00	30,000,000.00	30,000,000.00	30,000,000.00	30,000,000.00	150,000,000.00
Establish Financial GAP for Integrated NTD control Program and Solicit support at all levels (using multi sectoral approach).	0.00	0.00	0.00	0.00	0.00	-
Advocate for integration of NTDs control activities into MTEF, CCHP and Regional HPs on yearly basis.	29,721,448.00	29,721,448.00	29,721,448.00	29,721,448.00	29,721,448.00	148,607,240.00
Strategic Objective 4: Support to develop and update national NTD guidelines and tools						
Develop and Customise the 5 PCTs interventions guidelines reflecting national context	0.00	29,721,448.00	0.00	0.00	0.00	29,721,448.00
Share the signed guidelines with stakeholders	0.00	0.00	29,721,448.00	0.00	0.00	29,721,448.00
Participate in other councils, sectors budget sessions for inclusion of Integrated NTD Activities	29,721,448.00	29,721,448.00	29,721,448.00	29,721,448.00	29,721,448.00	148,607,240.00
					SUBTOTAL	1,601,201,468.00

Table 34: Scale up access to interventions, treatment and system capacity building

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Strategic objective 1. Scale up integrated preventive chemotherapy to achieve 100% geographic coverage and treatment access to 5 PCTs NTD						
LYMPHATIC FILARIASIS						
Conduct LF MDA annually	645,374,736.00	564,702,894.00	564,702,894.00	242,015,526.00	242,015,526.00	2,258,811,576.00
cost of Albendazole tabs needed for LF MDA annually	3,988,046,613.20	3,955,001,128.80	3,955,001,128.80	2,808,417,304.40	2,808,417,304.40	17,514,883,479.60
Cost of Ivermectin tabs needed for LF MDA annually	81,573,685,447.50	67,414,793,542.50	67,414,793,542.50	47,870,747,932.50	47,870,747,932.50	312,144,768,397.50
conduct LF sentinel Site Assessments annually	27,196,556.50	-	-	190,375,895.50	-	217,572,452.00
conduct TAS annually	27,196,556.50	-	-	108,786,226.00	-	135,982,782.50
cost of FTS needs annually	277,080,000.00	241,405,950.00	105,983,100.00	82,084,950.00	58,879,500.00	765,433,500.00
conduct LF post MDA surveillance annually	894,708,252.67	853,093,915.33	374,529,036.00	145,650,180.67	208,071,686.67	2,476,053,071.33
To prepare message on health education on prevention of LF	11,545,000.00	17,317,500.00	17,317,500.00	17,317,500.00	17,317,500.00	80,815,000.00
To prepare BCC IEC material on LF and distribute to community	0.00	0.00	0.00	0.00	0.00	-
To conduct operational research on LF	63,630,726.83	63,630,726.83	63,630,726.83	63,630,726.83	63,630,726.83	318,153,634.17
TRACHOMA						
Conduct Zithromax MDA annually	423,165,812.00	423,165,812.00	317,374,359.00	317,374,359.00	317,374,359.00	1,798,454,701.00
cost of Zithromax tabs/syrup needs annually	3,248,391,601.97	10,466,508,031.44	5,675,717,064.32	6,656,835,953.74	5,675,700,365.63	31,723,153,017.10
Conduct trachoma MDA coverage surveys annually	115,496,180.00	115,496,180.00	115,496,180.00	115,496,180.00	115,496,180.00	577,480,900.00
Conduct repeat trachoma baseline surveys annually	-	86,622,135.00	-	-	-	86,622,135.00
Conduct of trachoma Impact survey annually	86,459,350.50	86,459,350.50	86,459,350.50	86,459,350.50	115,279,134.00	461,116,536.00
conduct trachoma surveillance survey annually	115,496,180.00	-	57,748,090.00	-	28,874,045.00	202,118,315.00
Develop 5 BCC messages on health education about prevention of trachoma	4,943,064.94	4,943,064.94	4,943,064.94	4,943,064.94	4,943,064.94	24,715,324.69
Develop and distribute BCC IEC	289,280,944.72	284,111,195.32	282,361,350.33	289,280,944.72	282,361,350.33	1,427,395,785.40

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
material to the community: 3,550,000 leaflets, 9,940 posters, 10 roller banners						
Conduct operational research on trachoma	127,261,453.67	127,261,453.67	127,261,453.67	127,261,453.67	127,261,453.67	636,307,268.34
SCHISTOSOMIASIS						-
conduct sub district SCH MDA annually	5,605,185,654.32	1,087,373,246.79	5,275,994,575.50	1,087,373,246.79	5,325,149,804.46	18,381,076,527.86
cost of Praziquantel tabs needed annually	955,750,400.55	5,542,681,928.13	1,066,303,242.45	5,872,920,072.48	-	13,437,655,643.61
Conduct SCH coverage surveys annually	89,862,017.23	89,862,017.23	89,862,017.23	89,862,017.23	89,862,017.23	449,310,086.15
Conduct of SCH Precision Mapping annually	1,277,062,648.45	1,660,181,442.98	1,702,750,197.93	1,277,062,648.45	1,447,337,668.24	7,364,394,606.04
Conduct SCH Sentinel Site assessment annually	720,236,790.73	1,680,552,511.70	1,680,552,511.70	1,680,552,511.70	1,680,552,511.70	7,442,446,837.52
Prepare and distribute BCC IEC material to the community : 752000 leaflets, 14000 posters	149,134,516.02	146,350,671.72	146,350,671.72	146,350,671.72	149,134,516.02	737,321,047.19
To conduct a scientific study on best options for snails control interventions in Tanzania # of best options identified	63,630,726.83	-	-	63,630,726.83	-	127,261,453.67
To Support continued operational research on schistosomiasis	127,261,453.67	127,261,453.67	127,261,453.67	127,261,453.67	127,261,453.67	636,307,268.34
to conduct f Expert Advisory Committee meetings biannually	34,635,000.00	34,635,000.00	34,635,000.00	34,635,000.00	34,635,000.00	173,175,000.00
to conduct SCHISTO TWG biannually	23,090,000.00	23,090,000.00	23,090,000.00	23,090,000.00	23,090,000.00	115,450,000.00

SOIL TRANSMITTED HELMINTHS						
conduct STH MDA annually	7,674,173,928.00	7,674,173,928.00	7,674,173,928.00	7,674,173,928.00	7,674,173,928.00	38,370,869,640.00
cost of Albendazole tabs needed for STH MDA annually	639,546,173.48	656,850,142.74	674,688,506.96	693,080,107.58	712,044,986.72	3,376,209,917.48
conduct STH coverage surveys annually	89,866,280.00	89,866,280.00	89,866,280.00	89,866,280.00	89,866,280.00	449,331,400.00
Conduct prevalence evaluation surveys of SAC with STH infections of moderate and heavy intensity (M&HI)≥ 2% < 10%	415,620,000.00	415,620,000.00	346,350,000.00	415,620,000.00	831,240,000.00	2,424,450,000.00
develop BCC IEC material and distribute to community: 9,200,000 leaflets, 14,000 posters	734,537,202.89	731,753,358.59	731,753,358.59	734,537,202.89	731,753,358.59	3,664,334,481.57
develop 5 BCC messages on health education about STH prevention	4,943,064.94	4,943,064.94	4,943,064.94	4,943,064.94	4,943,064.94	24,715,324.69
ONCHOCERCIASIS						
conduct Ivermectin MDA for Oncho annually and biannually	4,451,613,460.00	4,451,613,460.00	3,338,710,095.00	3,338,710,095.00	2,543,779,120.00	18,124,426,230.00
cost of Ivermectin tabs need for Oncho MDA annually	46,506,783,534.00	47,563,746,756.00	34,302,129,942.00	35,048,708,148.00	26,029,040,667.00	189,450,409,047.00
Conduct MDA coverage for IVM MDA for Oncho annually	78,629,265.08	78,629,265.08	78,629,265.08	78,629,265.08	44,931,008.62	359,448,068.92
conduct Oncho exclusion mapping	638,531,324.22	-	-	-	-	638,531,324.22
cost of RDT/Needs annually for Oncho exclusion mapping	155,857,500.00	-	-	-	-	155,857,500.00
cost of ELISA needs for exclusion mapping annually	17,317,500.00	-	-	-	-	17,317,500.00
conduct monitoring of ONCHO annually	-	146,025,778.00	-	-	146,025,778.00	292,051,556.00
cost of RDT needs for Oncho monitoring annually	-	135,076,500.00	-	-	135,076,500.00	270,153,000.00
cost of ELISA Needs for Oncho monitoring	-	15,008,500.00	-	-	15,008,500.00	30,017,000.00
conduct Oncho epidemiological surveys annually	-	202,118,315.00	-	-	-	202,118,315.00
cost of RDT Needs for Oncho epidemiological surveys annually	-	72,733,500.00	-	51,952,500.00	-	124,686,000.00
cost of ELISA needs for epidemiological surveys annually	-	8,081,500.00	-	5,772,500.00	-	13,854,000.00

cost for QIAGEN PCR TEST KIT for entomological survey annually	-	8,081,500.00	-	5,772,500.00	-	13,854,000.00
Conduct stop MDA research	-	190,892,180.50	-	-	-	190,892,180.50
Develop 5 BCC messages on health education about Oncho prevention	4,943,064.94	4,943,064.94	4,943,064.94	4,943,064.94	4,943,064.94	24,715,324.69
Develop and distribute BCC IEC material to the community: 1,400,000, leaflets, 9,800 posters on Oncho	112,133,248.36	111,353,771.96	111,353,771.96	111,353,771.96	112,133,248.36	558,327,812.61
					SUBTOTAL	**680,760,958,968.71**

Table 35: Activities for Case Management Interventions

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Strategic Objective 2: Scale up integrated case management-based diseases intervention especially the following: Complicated LF and Trichiasis						
Training/Refresher training of Health staff on case management of NTDs i	194,156,883.00	0.00	0.00	0.00	0.00	194,156,883.00
Train on Lymphoedema management, Face washing, self-care and Environment management in home-based health care as part of PHC in all NTD endemic districts						-
Training/Refresher training of LF patient's self-care groups on home-based care management of their conditions	150,880,000.00	0.00	0.00	0.00	0.00	150,880,000.00
Training/Refresher training of BTRP Surgeon and hydrocele surgeons	83,430,000.00					83,430,000.00
Periodically Prepare and disseminate standard operating procedures for treatment and diagnosis of NTDs	75,870,000.00	0.00	0.00	0.00	0.00	75,870,000.00
Ensure adequate NTD drugs are supplied in health facilities for medical treatment of all case management NTDs	83,430,000.00					83,430,000.00
Training/Refresher training of HF	943,000,000.00	0.00	0.00	0.00	0.00	943,000,000.00

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
laboratory staff on the lab testing of case management NTDs						
Develop an Integrated morbidity intervention program, MMDP, for LF, leprosy and trachoma	14,196,011.00					14,196,011.00
Develop and implement rehabilitation programs for patients with lymphoedema, blindness due to Trachoma, severed skin morbidity due to ONCHO	29,721,448.00	0.00	0.00	0.00	0.00	29,721,448.00
Keep & Update inventory of clients with chronic NTD for follow up and support	0.00	0.00	0.00	0.00	0.00	-
Provide HBC management services to NTD patients	0.00	0.00	0.00	0.00	0.00	-
Facilitate provision of hydrocelectomies services to selected regional and district hospitals (20 clients per months)	192,960,000.00	192,960,000.00	192,960,000.00	192,960,000.00	192,960,000.00	964,800,000.00
Facilitate provision of Trichiasis operation services to selected regional and district hospitals (20 clients per months) (To include Materials and supplies) - to be done after Trachoma mapping	126,000,000.00	126,000,000.00	126,000,000.00	126,000,000.00	126,000,000.00	630,000,000.00
Facilitate provision of special footwear and rehabilitative aids and appliances to persons with LF related disabilities	40,000,000.00	40,000,000.00	40,000,000.00	40,000,000.00	40,000,000.00	200,000,000.00
Capacity building of health workers/CDDs in case in surveillance of Neglected Tropical Diseases	213,000,000.00	213,000,000.00	213,000,000.00	213,000,000.00	213,000,000.00	1,065,000,000.00
Support Active Case finding for early detection of all NTDs at community level	123,000,000.00	124,000,000.00	124,000,000.00	124,000,000.00	1,000,000.00	496,000,000.00
					SUBTOTAL	4,930,484,342.00

Table 36: Activities for disease transmission control through IVM

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Priority area 3: Strategic Objective 4: Strengthening integrated vector management and WASH activities for targeted NTDs						
Identify key stakeholders for IVM implementation for specific selected NTD	29,000,000.00	0.00	0.00	0.00	0.00	29,000,000.00
Assess country capacity on the implementation of IVM for NTDs prevention and control	29,000,000.00	29,000,000.00	29,000,000.00	29,000,000.00	29,000,000.00	145,000,000.00
Development of IVM Manual for NTDs	0.00	0.00	29,000,000.00	0.00	0.00	29,000,000.00
Training of stakeholders on IVM implementation for control of NTDs	0.00	0.00	24,000,000.00	0.00	0.00	24,000,000.00
Advocate for procurement of insecticides to control NTD related vectors	0.00	0.00	0.00	0.00	0.00	-
Establish and implement Simulium control interventions in affected areas	0.00	0.00	0.00	0.00	0.00	-
To search and identify scientific institution with technological, capabilities and experienced in the control of snails	0.00	0.00	20,000,000.00	0.00	0.00	20,000,000.00
To write a proposal and secure funds for implementation of snail control activities	0.00	0.00		0.00	0.00	-
Share the findings and recommended options for snails control to disrupt transmission of Schisto	0.00	0.00	0.00	0.00	0.00	-

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Establish and implement school-based programmes for NTDs prevention	36,717,718.00	0.00	0.00	0.00	0.00	36,717,718.00
Prepare and disseminate IEC materials for VBD prevention and control (posters, leaflets, fact sheets, radio and TV spots)	14,196,011.00	0.00	0.00	0.00	0.00	14,196,011.00
Prepare documentaries for public awareness on prevention and control of each VBD	14,196,011.00	0.00	0.00	0.00	0.00	14,196,011.00
Conduct radio and TV sessions to educate the public on VBDs	441,666.67	0.00	0.00	0.00	0.00	441,666.67
Conduct backstopping supportive supervision to monitor the implementation of vector control interventions	108,504,528.00	108,504,528.00	108,504,528.00	108,504,528.00	108,504,528.00	542,522,640.00
Conduct entomological and parasitological evaluation to monitor the effectiveness of vector control intervention for control of NTDs	0.00	0.00	0.00	0.00	0.00	-
Facilitate the integration, implementation and scale-up of WASH activities under the NSC alongside NTDs interventions	0.00	0.00	0.00	0.00	0.00	-
					SUBTOTAL	**855,074,046.67**

Table 37: Activities for strengthening pharmaco-vigilance in NTD program

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Strategic priority 3: Strategic Objective 5: Strengthening pharmaco-vigilance in NTD program and Ensure timely effective supply chain management of quality-assured NTD Medicines and other products up to the last mile						
Planning and budgeting for pharmaco-vigilance activities	20,925,000.00	20,925,000.00	20,925,000.00	20,925,000.00	20,925,000.00	104,625,000.00
Training of health care providers, district and regional NTD teams and NTDCP secretariat on reporting adverse drug reactions	193,500,000.00	193,500,000.00	193,500,000.00	193,500,000.00	193,500,000.00	967,500,000.00
Establish SOPs for data collection, review and patient follow-up	0.00	145,125,000.00	0.00	0.00	0.00	145,125,000.00
Collaborating with TMDA in implementing pharmaco-vigilance activities	0.00	0.00	0.00	0.00	0.00	-
Distribution of ADR forms in program sites and collection of data using existing ADR collection forms	0.00	0.00	0.00	0.00	0.00	-
Establish a feedback system to ease the process of ADR reporting	0.00	0.00	0.00	0.00	0.00	-
Promoting rational and safe use of medicines by health care providers, educating patients on the importance of reporting ADR	0.00	0.00	0.00	0.00	0.00	-
Assessment and communication of the risks and effective of medicines used in MDA campaigns	0.00	0.00	0.00	0.00	0.00	-
					SUBTOTAL	**1,217,250,000.00**

Table 38: Activities to support capacity building in NTD management at the national and subnational levels

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Strategic Priority 3: Strategic Objective 6: Strengthen capacity at national level for NTD programme Management and implementation and accelerate disease burden assessments and integrated mapping of NTDs						
Conduct orientation session on master plan, use, implementation and monitoring	17,486,057.00	17,486,057.00	17,486,057.00	17,486,057.00	17,486,057.00	87,430,285.00
Organize training of NTD Secretariat on NTD program management	17,486,057.00	17,486,057.00	17,486,057.00	17,486,057.00	17,486,057.00	87,430,285.00
Conduct a capability assessment of the NTDCP human resources	17,486,057.00	17,486,057.00	17,486,057.00	17,486,057.00	17,486,057.00	87,430,285.00
Share the capability assessment report for use and decision making	0.00	0.00	0.00	0.00	0.00	-
Develop, plans for mitigating the gaps identified	0.00	0.00	0.00	0.00	0.00	-
Conduct a need assessment to strengthen coordination at all levels	0.00	0.00	0.00	0.00	0.00	-
Procurement and maintenance of vehicle for National level to support interventions	0.00	200,000,000.00	0.00	0.00	0.00	200,000,000.00
Procurement and maintenance of computers and printers and supplies for NTD staff at National and Regional offices	42,000,000.00	42,000,000.00	42,000,000.00	42,000,000.00	42,000,000.00	210,000,000.00
Establish a PPM plan for maintenance of the equipment	8,000,000.00	8,000,000.00	8,000,000.00	8,000,000.00	8,000,000.00	40,000,000.00
Establish and update inventory of NTD equipment and supplies	0.00	0.00	0.00	0.00	0.00	-

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Incorporate and budget NTD Activities into CCHP	0.00	0.00	0.00	0.00	0.00	-
Conduct orientation of NTD activities on NTD program to the Management team at all level						-
					SUBTOTAL	**712,290,855.00**

Table 39: Strategic Priority 4: Enhance NTD Monitoring and Evaluation, surveillance and operations research

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Strategic Objective 1: Enhance Monitoring of NTD programme performance and outcome						
Supporting M&E Unit to undertake monitoring/evaluation activities under the NTD programme as needed	44,931,008.62	44,931,008.62	44,931,008.62	44,931,008.62	44,931,008.62	224,655,043.08
Support meeting for the M& E team to regularly review and summarize program performance information.	2,000,000.00	2,000,000.00	2,000,000.00	2,000,000.00	2,000,000.00	10,000,000.00
Develop, print and disseminated M&E framework for the integrated NTD program (capture all activities within ALL strategic priorities)	22,147,928.00	0.00	0.00	0.00	0.00	22,147,928.00

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Review, update and disseminate specific integrated data collection and reporting tools for NTDCP for different levels	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	74,600,000.00
Develop and disseminate standard operating procedures (SOPs) for the PCT NTDs	0.00	22,147,928.00	0.00	0.00	0.00	22,147,928.00
Review, print and disseminated integrated post MDA assessment protocol (Impact assessment)	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	74,600,000.00
Review and adapt, post MDA coverage surveys protocol	29,840,000.00	29,840,000.00	29,840,000.00	29,840,000.00	29,840,000.00	149,200,000.00
Develop SOPs for Case management for NTDs to guide prevention, diagnosis, treatment and control	0.00	32,147,928.00	0.00	0.00	0.00	32,147,928.00
Update NTD database to incorporate all NTDCP information	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	74,600,000.00
Conduct needs assessment for all regions and districts on M&E	127,906,565.21	127,906,565.21	127,906,565.21	127,906,565.21	127,906,565.21	639,532,826.06
Develop and produce data trainers Guide trainees' manuals	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	74,600,000.00
Develop and disseminate data management trainers/trainees' guideline/manuals	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	74,600,000.00

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Conduct M&E Training to Regional and District Coordinators	127,906,565.21	127,906,565.21	127,906,565.21	127,906,565.21	127,906,565.21	639,532,826.06
Orient key NTD staff- at all level on M&E tools-framework, SOPs, data collection tools and other outcomes of the need's assessment	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	74,600,000.00
Establish and manage inventory of Drugs	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	74,600,000.00
Establish and manage inventory of supplies and equipment	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	14,920,000.00	74,600,000.00
Produce program performance report by every unit	0.00	0.00	0.00	0.00	0.00	-
Develop format for program performance by different unit and individuals	0.00	0.00	0.00	0.00	0.00	-
Review reports and recommendation made in NTD meetings—task force, secretariat meetings, management and operation research meetings.	0.00	0.00	0.00	0.00	0.00	-

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Through indicators formulated in the M& E framework monitor implementation of NTDCP activities delineated in all priority areas	0.00	0.00	0.00	0.00	0.00	-
Conduct Supportive supervision for NTD activities to Regional, districts and Communities	127,906,565.21	0.00	0.00	0.00	0.00	127,906,565.21
Monitor SAE related to MDA for PCT targeted NTDs	224,655,043.08	0.00	0.00	0.00	0.00	224,655,043.08
Collect post MDA data collection and report writing	416,143,373.33	0.00	0.00	0.00	0.00	416,143,373.33
Conduct post MDA, coverage survey and spot checks (coverage validation)	416,143,373.33	0.00	0.00	0.00	0.00	416,143,373.33
Conduct targeted monitoring for NTD morbidity control activities (e.g. LF, TT surgery camps, Lymphoedema management, Face washing, WASH, etc.)	449,310,086.15	0.00	0.00	0.00	0.00	449,310,086.15

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Conduct targeted monitoring of vector control activity control** (expand based on Integrated Vector Management -IVM activities)	0.00	0.00	0.00	0.00	0.00	-
**Conduct technical backstopping monitoring visit to oversee NTD Activities (Advocacy (IEC/BCC etc.) at National, regional and districts level.	82,800,740.00	0.00	0.00	0.00	0.00	82,800,740.00
Conduct (finalize) integrated mapping NTDs in all districts with incomplete mapping (and collect GPS coordinates)	80,000,000.00	0.00	0.00	0.00	0.00	80,000,000.00
Conduct precision/elimination mapping of SCH and Oncho and case management targeted NTDs in suspected endemic areas	80,000,000.00	80,000,000.00	80,000,000.00	80,000,000.00	80,000,000.00	400,000,000.00
Conduct follow-up prevalence assessment in all districts with ongoing MDAs (refer disease specific needs)	80,000,000.00	80,000,000.00	80,000,000.00	80,000,000.00	80,000,000.00	400,000,000.00
Conduct midterm and summative evaluation of the NTD programs	0.00	0.00	17,486,057.00	0.00	0.00	17,486,057.00

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Conduct end term and summative evaluation of the NTD programs	0.00	0.00	0.00	0.00	17,486,057.00	17,486,057.00
Strategic Objective 2. Strengthen the Surveillance and strengthen the response and control of epidemic prone NTDs						
Develop/ and adapt post MDA surveillance system and tools for specific diseases, e.g. LF, Onchocerciasis, Trachoma	164,000,000.00		164,000,000.00	0.00	0.00	328,000,000.00
Train surveillance team	0.00	0.00	49,500,000.00	0.00	0.00	49,500,000.00
In collaboration with the existing country surveillance Teams, establish an integrated diseases surveillance system for all NTDs to be integrated in the national diseases surveillance system	0.00	0.00	22,205,653.00	0.00	0.00	22,205,653.00
Support surveillance for Trachoma, LF and Oncho following completion of MDAs	0.00	0.00	0.00	0.00	0.00	-
Adapt surveillance tools and system	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	111,028,265.00
Strategic Objective 3: Support operational research, documentation and evidence to guide innovative approaches to NTDs programmes interventions						
Develop an integrated NTDs control research agenda	0.00	0.00	0.00	0.00	0.00	-

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Conduct operations research studies on integrated NTDs	80,000,000.00	80,000,000.00	80,000,000.00	80,000,000.00	80,000,000.00	400,000,000.00
Develop an integrated NTDs Documentation Plan and archives	0.00	0.00	0.00	0.00	0.00	-
Conduct documentation activities for the NTD Programme as indicated in the plan						-
Attend in different national meetings/for a to share operation research and documentation findings	11,400,000.00	11,400,000.00	11,400,000.00	11,400,000.00	11,400,000.00	57,000,000.00
Attend different international for a to share documentation and operations research findings	17,323,500.00	17,323,500.00	17,323,500.00	17,323,500.00	17,323,500.00	86,617,500.00
Disseminate impact assessment results	68,722,767.00	68,722,767.00	68,722,767.00	68,722,767.00	68,722,767.00	343,613,835.00
Strategic Objective 4: Establish integrated data management system (Monitoring Information System, MIS, for NTDs and link NTD MIS with DHIS2) and support impact analysis of NTD in Tanzania as part of WHO Africa region and global NTD data management system						
Training district NTD coordinators on the efficient use of NTDCP MIS	483,750,000.00	241,875,000.00	241,875,000.00	241,875,000.00	241,875,000.00	1,451,250,000.00
Update disease specific indicators and build capacity to collect data on	377,200,000.00	377,200,000.00	377,200,000.00	377,200,000.00	377,200,000.00	1,886,000,000.00

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
to DHIS2						
Integration of NTDCP MIS with DHIS	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	111,028,265.00
Develop elimination strategy	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	111,028,265.00
Conduct impact survey of activities for LF and transmission surveys	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	111,028,265.00
Conduct impact survey of activities for Schistosomiasis and transmission surveys	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	111,028,265.00
Conduct impact survey of activities for Trachoma	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	111,028,265.00
Conduct impact survey of activities for STH	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	111,028,265.00
Support epidemiological evaluation for Onchocerciasis control and transmission /entomological surveys	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	111,028,265.00
Conduct impact assessment for case management NTDs	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	22,205,653.00	111,028,265.00
					SUBTOTAL	10,591,537,147.31

Table 40: Activities of surveillance and sustainability

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Strategic Objective: Strengthening post intervention surveillance and integration within primary health care						
Conduct advocacy meetings to regional, districts authorities and local stakeholders on post intervention surveillance for specific NTDs	62,100,555.00	62,100,555.00	62,100,555.00	62,100,555.00	62,100,555.00	310,502,775.00
Training of surveillance teams	0.00	49,500,000.00	0.00	49,500,000.00	0.00	99,000,000.00
Training of health care workers on MMDP	49,500,000.00	49,500,000.00	49,500,000.00	0.00	0.00	148,500,000.00
Develop/adapt post MDA surveillance system and tools for specific diseases and an integrated disease surveillance system	943,000,000.00	49,500,000.00	49,500,000.00	49,500,000.00	49,500,000.00	1,141,000,000.00
Support surveillance for non PCT NTDs	0.00	49,500,000.00	0.00	0.00	0.00	49,500,000.00
Conduct supportive supervision of surveillance and MMDP services	44487503	49,500,000.00	44487503	0.00	0.00	138,475,006.00
Strategic objective: Establishing integrated data management system and support impact analysis for NTDs as part of the country NTDs data management system and country health plan						
Develop, produce and disseminate monitoring and evaluation tools	85,825,530.00	85,825,530.00	0.00	0.00	0.00	171,651,060.00
Train health workers and community health workers on data collection management and dissemination	980,720,000	0.00	0.00	0.00	0.00	980,720,000.00
Develop, produce and disseminate integrated tools for reporting NTDs through existing DHIS	85,825,530.00	0.00	0.00	0.00	0.00	85,825,530.00

Sub-activities	2021/22	2022/23	2023/24	2024/25	2025/26	
Integrate supportive supervision of activities implementation at the country level	54,252,264.00	54,252,264.00	54,252,264.00	0.00	0.00	162,756,792.00
SUBTOTAL						**3,386,931,163.00**
					GRAND TOTAL	708,887,779,189.01

ANNEXES

Annex 1: Distance Chart

	DAR	ARUSHA	BABATI	BARIADI	BUKOBA	DODOMA	GEITA	IRINGA	KIBAHA	KIGOMA	LINDI	MBEYA	MOROGORO	MOSHI	MPANDA	MTWARA	MUSOMA	MWANZA	NJOMBE	SHINYANGA	SINGIDA	SONGWE	S'WANGA	TABORA	TANGA
DAR		646	814	1127	1433	451	1228	492	35	1258	452	822	192	566	1383	556	1370	1152	710	989	696	947	1150	829	354
ARUSHA	646		168	762	1068	425	863	689	611	1090	1098	1020	621	80	1581	1202	499	787	907	624	331	1144	1348	661	435
BABATI	814	168		594	900	257	695	521	779	922	1266	851	516	248	1413	1370	513	619	739	456	163	976	1179	493	603
BARIADI	1127	762	594		654	676	376	940	1092	761	1579	899	935	842	695	1683	164	230	1158	138	431	1396	928	332	1197
BUKOBA	1433	1068	900	654		982	298	1246	1398	551	1885	1205	1241	1148	720	1989	634	416	1464	516	737	1671	954	638	1503
DODOMA	451	425	257	676	982		777	264	416	807	903	594	259	505	1155	1007	919	701	482	538	245	720	922	378	588
GEITA	1228	863	695	376	298	777		1041	1193	514	1680	1000	1036	943	684	1784	337	119	1259	239	532	1496	917	433	1298
IRINGA	492	689	521	940	1246	264	1041		457	1071	944	330	300	769	891	1048	1183	965	218	802	509	455	658	642	629
KIBAHA	35	611	779	1092	1398	416	1193	457		1223	487	787	157	531	1348	591	1335	1117	675	954	661	912	1115	794	319
KIGOMA	1258	1090	922	761	551	807	514	1071	1223		1710	860	1066	1170	299	1814	851	633	1089	622	759	1326	532	429	1525
LINDI	452	1098	1266	1579	1885	903	1680	944	487	1710		1068	644	1018	1629	104	1822	1604	839	1441	1148	602	1396	1281	806
MBEYA	822	1020	851	899	1205	594	1000	330	787	860	1068		630	1100	561	1122	1142	924	229	761	603	466	328	567	959
MOROGORO	192	621	516	935	1241	259	1036	300	157	1066	644	630		541	1191	748	1178	960	518	797	504	755	958	637	329
MOSHI	566	80	248	842	1148	505	943	769	531	1170	1018	1100	541		1104	1122	579	867	987	704	411	1224	1428	741	355
MPANDA	1383	1581	1413	695	720	1155	684	891	1348	299	1629	561	1191	1104		1683	938	720	790	557	693	1027	233	363	1520

MTWARA	556	1202	1370	1683	1989	1007	1784	1048	591	1814	104	1122	748	1122	1683		1926	1708	893	1545	1252	656	1450	1385	910
MUSOMA	1370	499	513	164	634	919	337	1183	1335	851	1822	1142	1178	579	938	1926		218	1401	381	674	1638	1171	575	933
MWANZA	1152	787	619	230	416	701	119	965	1117	633	1604	924	960	867	720	1708	218		1183	163	456	1420	953	357	1222
NJOMBE	710	907	739	1158	1464	482	1259	218	675	1089	839	229	518	987	790	893	1401	1183		1020	727	237	557	796	847
SHINYANGA	989	624	456	138	516	538	239	802	954	622	1441	761	797	704	557	1545	381	163	1020		293	1257	790	194	1059
SINGIDA	696	331	163	431	737	245	532	509	661	759	1148	603	504	411	693	1252	674	456	727	293		964	931	330	766
SONGEA	947	1144	976	1396	1671	720	1496	455	912	1326	602	466	755	1224	1027	656	1638	1420	237	1257	964		794	1033	1084
S'WANGA	1150	1348	1179	928	954	922	917	658	1115	532	1396	328	958	1428	233	1450	1171	953	557	790	931	794		596	1287
TABORA	829	661	493	332	638	378	433	642	794	429	1281	567	637	741	363	1385	575	357	796	194	330	1033	596		1096
TANGA	354	435	603	1197	1503	588	1298	629	319	1525	806	959	329	355	1520	910	933	1222	847	1059	766	1084	1287	1096	

NOTE:

ROUTE	VIA		ROUTE	VIA		ROUTE	VIA
Dar – Kigoma	Itigi - Tabora		Bukoba - Mbeya	Nzega - Tabora		Kigoma – Njombe	Mpanda - Sumbawanga – Mbeya
Dar – Musoma	Singida - Shinyanga - Mwanza		Bukoba - Njombe	Singida - Dodoma - Iringa		Kigoma – Tabora	Malagarasi
Arusha – Iringa	Babati – Dodoma		Dodoma - Mbeya	Mtera - Iringa		Lindi – Mbeya	Masasi - Songea – Njombe
Arusha - Kigoma	Singida - Nzega – Tabora		Dodoma - Kigoma	Itigi - Tabora		Mbeya – Mtwara	Njombe - Songea – Masasi
Arusha – Mbeya	Babati - Dodoma – Iringa		Geita - Mpanda	Nyakanazi - Kasulu		Mbeya – Singida	Rungwa – Itigi
Arusha - Musoma	Serengeti		Geita - Njombe	Singida - Dodoma - Iringa		Musoma - S'wanga	Tabora - Ipole – Mpanda
Arusha - Mwanza	Babati - Singida - Shinyanga		Iringa - Kigoma	Dodoma - Itigi - Tabora		Musoma – Tanga	Serengeti – Arusha
Babati – Iringa	Dodoma		Iringa - Tabora	Dodoma - Itigi		Mwanza – Tanga	Shinyanga - Singida – Arusha
Babati – Morogoro	Dodoma		Kigoma - Mbeya	Mpanda - Sumbawanga		Singida - S'wanga	Rungwa – Mbeya
Babati – Musoma	Makuyuni – Serengeti		Kigoma – Musoma	Nyakanazi - Geita - Mwanza		Singida – Tabora	Nzega

Annex 2: Population data, Schools and Health Facilities by District

S/No	Region	District Council	Projected Population From 2012[1]			No. of Primary Schools [2]	No of Health Facilities[3]		
			Total Population	Under five years	Total SAC		Dispensary	Health Center	Hospitals
1	Arusha	Arusha City Council	525,787	61,982	103,914	152	61	18	7
2	Arusha	Arusha District Council	398,956	57,414	100,314	149	48	7	2
3	Arusha	Karatu District Council	290,175	41,334	73,192	118	50	10	1
4	Arusha	Longido District Council	148,263	27,690	43,265	60	24	5	1
5	Arusha	Meru District Council	337,221	39,468	82,466	169	50	10	2
6	Arusha	Monduli District Council	193,853	34,154	54,155	82	44	5	2
7	Arusha	Ngorongoro District Council	209,819	42,778	62,023	81	30	6	4
8	Dar-es-salaam	Ilala Municipal Council	1,517,132	224,856	331,607	255	154	19	17
9	Dar-es-salaam	Kigamboni Municipal Council	202,219	31,204	47,582	62	32	3	2
10	Dar-es-salaam	Kinondoni Municipal Council	1,143,836	159,478	224,651	157	105	10	26
11	Dar-es-salaam	Temeke Municipal Council	1,495,076	224,002	338,869	143	112	17	6
12	Dar-es-salaam	Ubungo Municipal Council	1,043,551	151,379	215,556	175	95	11	8
13	Dodoma	Bahi District Council	279,443	53,634	74,844	72	37	6	1
14	Dodoma	Chamwino District Council	418,704	77,290	113,931	122	66	5	3
15	Dodoma	Chemba District Council	293,619	54,217	83,809	104	38	4	1
16	Dodoma	Dodoma Municipal Council	536,687	73,245	117,118	144	73	11	7
17	Dodoma	Kondoa District Council	259,963	45,913	78,965	94	31	6	0
18	Dodoma	Kondoa Town Council	74,718	10,620	19,122	34	10		1
19	Dodoma	Kongwa District Council	395,035	72,031	109,580	117	59	4	1
20	Dodoma	Mpwapwa District Council	389,241	67,541	108,113	122	59	5	1

S/No	Region	District Council	Projected Population From 2012[1]			No. of Primary Schools [2]	No of Health Facilities[3]		
			Total Population	Under five years	Total SAC		Dispensary	Health Center	Hospitals
21	Geita	Bukombe District Council	313,269	66,243	92,005	89	14	5	2
22	Geita	Chato District Council	511,662	107,931	154,159	143	32	8	1
23	Geita	Geita District Council	861,622	183,702	254,749	217	52	7	1
24	Geita	Geita Town Council	271,655	53,312	70,954	78	19	3	3
25	Geita	Mbogwe District Council	270,047	58,121	82,023	93	16	3	
26	Geita	Nyang'hwale District Council	206,545	44,766	62,452	63	17	2	1
27	Iringa	Iringa District Council	308,009	46,177	77,674	154	71	10	2
28	Iringa	Iringa Municipal Council	190,477	23,176	34,951	59	23	3	3
29	Iringa	Kilolo District Council	262,438	38,888	66,832	120	59	2	2
30	Iringa	Mafinga Town Council	89,816	12,076	18,055	41	16	7	1
31	Iringa	Mufindi District Council	298,741	44,817	76,585	153	67	10	2
32	Kagera	Biharamulo District Council	426,188	94,185	124,559	94	27	6	1
33	Kagera	Bukoba District Council	380,091	61,722	109,908	153	34	7	2
34	Kagera	Bukoba Municipal Council	172,489	25,335	38,176	45	20	5	1
35	Kagera	Karagwe District Council	439,526	80,763	119,705	121	43	3	3
36	Kagera	Kyerwa District Council	423,760	82,057	123,287	105	30	3	2
37	Kagera	Missenyi District Council	266,713	43,496	73,124	111	33	3	2
38	Kagera	Muleba District Council	710,607	124,982	200,798	242	44	5	3
39	Kagera	Ngara District Council	418,973	87,053	117,134	128	54	5	3
40	Katavi	Mlele District Council	49,514	10,277	14,292	19	8	2	1
41	Katavi	Mpanda District Council	255,817	58,277	77,582	58	23	3	1

S/No	Region	District Council	Projected Population From 2012[1]			No. of Primary Schools [2]	No of Health Facilities[3]		
			Total Population	Under five years	Total SAC		Dispensary	Health Center	Hospitals
42	Katavi	Mpanda Municipal Council	157,153	29,809	42,244	45	17	4	1
43	Katavi	Mpimbwe District Council	147,685	34,956	45,280	37	11	3	1
44	Katavi	Nsimbo District Council	195,718	42,220	58,837	50	17	4	0
45	Kigoma	Buhigwe District Council	331,550	63,933	96,926	91	29	4	2
46	Kigoma	Kakonko District Council	221,548	42,180	65,228	60	23	4	0
47	Kigoma	Kasulu District Council	556,871	113,285	169,000	80	33	8	2
48	Kigoma	Kasulu Town Council	275,002	47,575	78,809	67	18	3	2
49	Kigoma	Kibondo District Council	346,091	65,975	101,452	85	39	6	1
50	Kigoma	Kigoma District Council	274,635	47,689	80,453	109	34	4	0
51	Kigoma	Kigoma-Ujiji Municipal Council	289,879	41,206	76,300	53	18	5	2
52	Kigoma	Uvinza District Council	505,343	96,259	144,669	119	40	5	2
53	Kilimanjaro	Hai District Council	251,838	34,350	50,136	132	54	6	2
54	Kilimanjaro	Moshi District Council	552,235	70,868	113,814	259	91	8	6
55	Kilimanjaro	Moshi Municipal Council	230,784	30,548	36,171	53	32	10	5
56	Kilimanjaro	Mwanga District Council	155,370	22,488	35,089	116	50	7	1
57	Kilimanjaro	Rombo District Council	302,118	42,779	72,326	161	39	6	3
58	Kilimanjaro	Same District Council	320,377	49,974	75,124	201	59	8	2
59	Kilimanjaro	Siha District Council	138,530	23,497	30,957	68	17	5	2
60	Lindi	Kilwa District Council	221,013	37,012	57,592	111	54	5	2
61	Lindi	Lindi District Council	229,443	31,583	52,419	79	48	6	2
62	Lindi	Lindi Municipal Council	94,462	11,478	19,868	74	17	3	1

S/No	Region	District Council	Projected Population From 2012[1]			No. of Primary Schools [2]	No of Health Facilities[3]		
			Total Population	Under five years	Total SAC		Dispensary	Health Center	Hospitals
63	Lindi	Liwale District Council	108,788	15,146	27,698	56	36	2	1
64	Lindi	Nachingwea District Council	215,425	27,631	47,612	110	40	3	3
65	Lindi	Ruangwa District Council	156,669	19,195	33,734	86	35	6	1
66	Manyara	Babati District Council	413,161	69,039	115,168	150	44	8	2
67	Manyara	Babati Town Council	124,079	17,304	28,953	42	13	3	2
68	Manyara	Hanang District Council	364,935	67,977	104,499	130	27	8	1
69	Manyara	Kiteto District Council	314,647	61,108	88,411	93	29	2	1
70	Manyara	Mbulu District Council	254,242	46,492	72,365	96	26	2	1
71	Manyara	Mbulu Town Council	169,980	27,066	47,252	57	12	2	1
72	Manyara	Simanjiro District Council	232,061	44,145	65,418	98	40	4	2
73	Mara	Bunda District Council	304,040	62,420	90,516	104	27	5	2
74	Mara	Bunda Town Council	156,528	29,436	44,425	72	17	2	2
75	Mara	Butiama District Council	290,833	61,024	86,002	94	36	2	1
76	Mara	Musoma District Council	286,379	57,987	81,073	114	26	2	0
77	Mara	Musoma Municipal Council	185,526	30,493	48,210	55	17	6	3
78	Mara	Rorya District Council	362,002	75,054	105,593	137	38	8	4
79	Mara	Serengeti District Council	342,097	76,575	102,613	132	50	8	2
80	Mara	Tarime District Council	357,462	77,884	108,815	139	32	13	1
81	Mara	Tarime Town Council	106,978	19,680	29,625	39	11	4	1
82	Mbeya	Busokelo District Council	122,840	19,573	32,379	62	20	4	2
83	Mbeya	Chunya District Council	204,533	41,954	50,620	68	27	4	1

S/No	Region	District Council	Projected Population From 2012[1]			No. of Primary Schools [2]	No of Health Facilities[3]		
			Total Population	Under five years	Total SAC		Dispensary	Health Center	Hospitals
84	Mbeya	Kyela District Council	283,529	46,597	72,845	106	45	1	3
85	Mbeya	Mbarali District Council	389,200	76,482	98,631	122	53	6	3
86	Mbeya	Mbeya City Council	500,667	76,536	109,123	97	43	6	7
87	Mbeya	Mbeya District Council	391,767	71,015	101,264	167	73	4	3
88	Mbeya	Rungwe District Council	312,007	48,965	80,307	149	45	6	2
89	Morogoro	Gairo District Council	237,328	45,183	69,070	66	31	1	1
90	Morogoro	Ifakara Town Council	131,829	16,332	29,945	94	22	6	4
91	Morogoro	Kilombero District Council	373,087	53,116	93,725	103	43	4	0
92	Morogoro	Kilosa District Council	538,757	83,824	133,365	167	67	10	3
93	Morogoro	Malinyi District Council	139,913	22,778	36,871	36	15	2	2
94	Morogoro	Morogoro District Council	346,376	54,332	88,328	161	70	7	1
95	Morogoro	Morogoro Municipal Council	394,494	48,373	79,899	108	46	15	3
96	Morogoro	Mvomero District Council	382,659	61,491	97,838	149	64	9	3
97	Morogoro	Ulanga District Council	185,615	28,729	48,200	63	23	2	1
98	Mtwara	Masasi District Council	304,967	40,440	71,268	131	43	5	2
99	Mtwara	Masasi Town Council	105,899	13,458	23,378	42	15	3	1
100	Mtwara	Mtwara District Council	139,987	19,518	34,479	69	29	3	1
101	Mtwara	Mtwara Municipal Council	128,598	13,351	25,279	37	19	4	1
102	Mtwara	Nanyamba Town Council	121,560	16,567	29,563	67	24	4	0
103	Mtwara	Nanyumbu District Council	175,464	25,215	44,192	94	17	3	1
104	Mtwara	Newala District Council	135,087	17,154	29,323	77	23	3	0

S/No	Region	District Council	Projected Population From 2012[1]			No. of Primary Schools [2]	No of Health Facilities[3]		
			Total Population	Under five years	Total SAC		Dispensary	Health Center	Hospitals
105	Mtwara	Newala Town Council	103,483	13,150	22,746	46	15	3	1
106	Mtwara	Tandahimba District Council	263,829	34,150	59,559	126	35	4	1
107	Mwanza	Buchosa District Council	454,350	99,024	131,153	95	30	5	1
108	Mwanza	Ilemela Municipal Council	472,807	80,068	115,525	129	39	10	4
109	Mwanza	Kwimba District Council	559,472	125,605	168,016	154	49	6	2
110	Mwanza	Magu District Council	411,868	87,437	122,115	118	43	5	1
111	Mwanza	Misungwi District Council	483,358	108,371	141,984	149	51	4	2
112	Mwanza	Nyamagana Municipal Council	501,650	86,475	120,338	137	36	12	13
113	Mwanza	Sengerema District Council	463,224	101,315	136,944	109	42	5	1
114	Mwanza	Ukerewe District Council	479,844	101,631	135,118	128	34	3	2
115	Njombe	Ludewa District Council	159,069	21,776	39,046	115	61	7	3
116	Njombe	Makambako Town Council	112,646	15,351	25,545	44	13	4	2
117	Njombe	Makete District Council	115,233	13,580	26,024	104	50	5	3
118	Njombe	Njombe District Council	101,089	14,491	24,702	56	25	4	1
119	Njombe	Njombe Town Council	157,669	18,705	34,505	94	58	9	3
120	Njombe	Wang'ing'ombe District Council	191,851	25,600	46,252	116	45	4	4
121	Pwani	Bagamoyo District Council	119,601	16,026	24,793	55	24	4	1
122	Pwani	Chalinze District Council	260,323	41,427	64,062	119	54	8	1
123	Pwani	Kibaha District Council	86,335	11,641	19,004	46	29	4	1
124	Pwani	Kibaha Town Council	161,254	20,095	33,097	69	30	8	2
125	Pwani	Kibiti Town Council	122,059	20,702	35,005	78	54	4	2

S/No	Region	District Council	Projected Population From 2012[1]			No. of Primary Schools [2]	No of Health Facilities[3]		
			Total Population	Under five years	Total SAC		Dispensary	Health Center	Hospitals
126	Pwani	Kisarawe District Council	122,064	16,943	27,404	91	35	5	1
127	Pwani	Mafia District Council	54,625	7,710	12,811	34	20	1	1
128	Pwani	Mkuranga District Council	265,590	40,169	69,538	138	48	6	1
129	Pwani	Rufiji District Council	134,001	21,811	36,642	49	28	4	1
130	Rukwa	Kalambo District Council	260,857	43,857	78,093	98	62	5	1
131	Rukwa	Nkasi District Council	355,853	59,024	104,629	107	47	7	2
132	Rukwa	Sumbawanga District Council	381,454	64,228	113,506	104	63	8	1
133	Rukwa	Sumbawanga Municipal Council	271,885	35,381	75,554	69	34	5	2
134	Ruvuma	Madaba District Council	57,682	7,516	14,199	29	16	3	0
135	Ruvuma	Mbinga District Council	285,505	40,671	71,419	167	50	5	2
136	Ruvuma	Mbinga Town Council	142,520	20,504	34,024	79	21	3	1
137	Ruvuma	Namtumbo District Council	240,138	35,906	61,622	112	46	8	1
138	Ruvuma	Nyasa District Council	175,549	26,433	44,327	111	28	5	3
139	Ruvuma	Songea District Council	152,205	20,933	36,406	75	33	1	2
140	Ruvuma	Songea Municipal Council	247,796	31,512	55,346	93	38	5	1
141	Ruvuma	Tunduru District Council	354,048	47,833	90,855	152	60	5	3
142	Shinyanga	Kahama Town Council	316,624	48,684	82,228	115	35	6	2
143	Shinyanga	Kishapu District Council	355,154	61,588	102,734	122	51	7	2
144	Shinyanga	Msalala District Council	323,588	60,874	96,858	97	30	5	0
145	Shinyanga	Shinyanga District Council	431,248	78,721	128,763	139	38	5	1

S/No	Region	District Council	Projected Population From 2012[1]			No. of Primary Schools [2]	No of Health Facilities[3]		
			Total Population	Under five years	Total SAC		Dispensary	Health Center	Hospitals
146	Shinyanga	Shinyanga Municipal Council	214,383	27,836	53,039	64	29	2	2
147	Shinyanga	Ushetu District Council	352,592	65,960	107,340	109	27	3	1
148	Simiyu	Bariadi District Council	388,409	97,385	116,984	86	28	2	1
149	Simiyu	Bariadi Town Council	226,210	51,348	66,195	44	16	2	2
150	Simiyu	Busega District Council	296,012	64,613	87,332	91	24	4	2
151	Simiyu	Itilima District Council	453,807	109,880	140,520	91	33	3	1
152	Simiyu	Maswa District Council	500,914	110,279	144,081	129	48	4	1
153	Simiyu	Meatu District Council	438,876	104,524	128,286	116	52	3	1
154	Singida	Ikungi District Council	339,539	58,709	95,909	112	40	3	2
155	Singida	Iramba District Council	291,483	45,974	80,498	108	38	4	1
156	Singida	Itigi District Council	140,600	24,170	38,139	50	17	2	1
157	Singida	Manyoni District Council	227,711	38,075	61,561	73	36	2	2
158	Singida	Mkalama District Council	233,515	37,083	68,034	84	33	4	2
159	Singida	Singida District Council	280,057	46,435	82,301	98	30	2	2
160	Singida	Singida Municipal Council	192,277	26,144	45,874	62	16	3	1
161	Songwe	Ileje District Council	160,348	21,924	42,786	84	33	2	2
162	Songwe	Mbozi District Council	574,861	87,714	157,996	189	82	9	2
163	Songwe	Momba District Council	209,170	43,346	59,434	86	35	3	0
164	Songwe	Songwe District Council	170,565	31,859	45,704	56	27	1	2
165	Songwe	Tunduma Town Council	163,906	28,083	39,553	53	10	4	0
166	Tabora	Igunga District Council	539,459	106,453	155,562	145	60	5	1

S/No	Region	District Council	Projected Population From 2012[1]			No. of Primary Schools [2]	No of Health Facilities[3]		
			Total Population	Under five years	Total SAC		Dispensary	Health Center	Hospitals
167	Tabora	Kaliua District Council	527,879	109,934	157,775	109	45	3	2
168	Tabora	Nzega District Council	557,769	109,138	166,198	151	40	5	2
169	Tabora	Nzega Town Council	114,616	18,407	29,291	36	7	4	0
170	Tabora	Sikonge District Council	242,320	48,064	70,896	99	31	4	2
171	Tabora	Tabora Municipal Council	309,530	44,937	77,148	83	36	4	4
172	Tabora	Urambo District Council	259,721	50,138	75,769	81	26	3	1
173	Tabora	Uyui District Council	529,969	107,886	161,046	145	52	1	1
174	Tanga	Bumbuli District Council	189,348	24,934	51,853	99	21	3	1
175	Tanga	Handeni District Council	323,431	53,312	84,545	119	49	2	1
176	Tanga	Handeni Town Council	94,334	13,510	23,640	37	10	1	1
177	Tanga	Kilindi District Council	278,565	49,116	71,245	114	36	4	1
178	Tanga	Korogwe District Council	289,830	38,639	71,750	140	48	5	2
179	Tanga	Korogwe Town Council	86,645	9,165	17,364	34	13	4	1
180	Tanga	Lushoto District Council	391,406	54,300	109,901	169	57	5	1
181	Tanga	Mkinga District Council	137,268	19,065	34,938	83	31	3	0
182	Tanga	Muheza District Council	249,782	29,362	54,832	119	42	4	2
183	Tanga	Pangani District Council	65,746	8,001	14,431	36	20	2	1
184	Tanga	Tanga City Council	342,880	34,667	67,990	107	38	9	6

Data source:
1: Ministry of Health Community Development, Gender, Elderly and Children - 16 April 2019.
2:https://www.tamisemi.go.tz/ Accessed on 30th July 2021.
3: http://hfrportal.moh.go.tz/ Accessed on 30th July 2021.

Annex 3: Prevalence of LF

S/No.	Region	District (IU)	Prevalence: as of July, 2019	Method	Diagnostic	Year	Remarks
1	Arusha	Arusha City Council	0.00%	remapping	ICT	2015	Non endemic
2	Arusha	Arusha District Council	0.00%	remapping	ICT	2015	Non endemic
3	Arusha	Karatu District Council	0.00%	remapping	ICT	2015	Non endemic
4	Arusha	Longido District Council	0.00%	remapping	ICT	2015	Non endemic
5	Arusha	Meru District Council	0.00%	remapping	ICT	2015	Non endemic
6	Arusha	Monduli District Council	0.00%	remapping	ICT	2015	Non endemic
7	Arusha	Ngorongoro District Council	0.00%	remapping	ICT	2015	Non endemic
8	Dar Es Salaam	Dar es Salaam City Council	2.60%	SSA	FTS	2020	On MDA
10	Dar Es Salaam	Kigamboni Municipal Council	0.00%	TAS 1	FTS	2021	Stopped MDA
11	Dar Es Salaam	Kinondoni Municipal Council	3.80%	SSA	FTS	2020	on MDA
12	Dar Es Salaam	Temeke Municipal Council	2.60%	SSA	FTS	2020	on MDA
13	Dar Es Salaam	Ubungo Municipal Council	0.00%	TAS 1	FTS	2021	Stopped MDA
14	Dodoma	Bahi District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
15	Dodoma	Chamwino District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
16	Dodoma	Chemba District Council	0.00%	TAS2	FTS	2021	Post MDA surveillance
17	Dodoma	Dodoma Municipal Council	0.50%	TAS3	FTS	2021	Post MDA surveillance
18	Dodoma	Kondoa District Council	0.00%	TAS2	FTS	2021	Post MDA surveillance
19	Dodoma	Kondoa Town Council	0.00%	TAS2	FTS	2021	Post MDA surveillance
20	Dodoma	Kongwa District Council	0.10%	TAS3	FTS	2021	Post MDA surveillance
21	Dodoma	Mpwapwa District Council	0.10%	TAS2	FTS	2018	Post MDA surveillance
22	Geita	Bukombe District Council	0.00%	remapping	ICT	2015	Non endemic
23	Geita	Chato District Council	0.00%	remapping	ICT	2015	Non endemic
24	Geita	Geita District Council	0.00%	remapping	ICT	2015	Non endemic
25	Geita	Geita Town Council	0.00%	remapping	ICT	2015	Non endemic
26	Geita	Mbogwe District Council	0.00%	remapping	ICT	2015	Non endemic
27	Geita	Nyang'hwale District Council	0.00%	remapping	ICT	2015	Non endemic
28	Iringa	Iringa Municipal Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
29	Iringa	Iringa District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
30	Iringa	Kilolo District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
31	Iringa	Mafinga Town Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
32	Iringa	Mufindi District Council	0.06%	TAS3	FTS	2021	Post MDA surveillance
33	Kagera	Biharamulo District Council	0.00%	remapping	ICT	2015	Non endemic
34	Kagera	Bukoba District Council	0.00%	remapping	ICT	2015	Non endemic
35	Kagera	Bukoba Municipal Council	0.00%	remapping	ICT	2015	Non endemic
36	Kagera	Karagwe District Council	0.00%	remapping	ICT	2015	Non endemic
37	Kagera	Kyerwa District Council	0.00%	remapping	ICT	2015	Non endemic
38	Kagera	Missenyi District Council	0.02%	remapping	ICT	2015	Non endemic

39	Kagera	Muleba District Council	0.00%	remapping	ICT	2015	Non endemic
40	Kagera	Ngara District Council	0.00%	remapping	ICT	2015	Non endemic
41	Katavi	Mlele District Council	0.00%	TAS2	FTS	2018	Post MDA surveillance
42	Katavi	Mpanda District Council	0.00%	TAS2	FTS	2018	Post MDA surveillance
43	Katavi	Mpanda Municipal Council	0.00%	TAS2	FTS	2018	Post MDA surveillance
44	Katavi	Mpimbwe District Council	0.00%	TAS2	FTS	2018	Post MDA surveillance
45	Katavi	Nsimbo District Council	0.00%	TAS2	FTS	2018	Post MDA surveillance
46	Kigoma	Buhigwe District Council	0.00%	remapping	ICT	2015	Non endemic
47	Kigoma	Kakonko District Council	0.00%	remapping	ICT	2015	Non endemic
48	Kigoma	Kasulu District Council	0.00%	remapping	ICT	2015	Non endemic
49	Kigoma	Kasulu Town Council	0.00%	remapping	ICT	2015	Non endemic
50	Kigoma	Kibondo District Council	0.00%	remapping	ICT	2015	Non endemic
51	Kigoma	Kigoma District Council	0.00%	remapping	ICT	2015	Non endemic
52	Kigoma	Kigoma-Ujiji Municipal Council	0.00%	remapping	ICT	2015	Non endemic
53	Kigoma	Uvinza District Council	0.00%	remapping	ICT	2015	Non endemic
54	Kilimanjaro	Hai District Council	0.00%	remapping	ICT	2015	Non endemic
55	Kilimanjaro	Moshi District Council	0.40%	remapping	ICT	2015	Non endemic
56	Kilimanjaro	Moshi Municipal Council	0.00%	remapping	ICT	2015	Non endemic
57	Kilimanjaro	Mwanga District Council	0.00%	remapping	ICT	2015	Non endemic
58	Kilimanjaro	Rombo District Council	0.00%	remapping	ICT	2015	Non endemic
59	Kilimanjaro	Same District Council	0.00%	remapping	ICT	2015	Non endemic
60	Kilimanjaro	Siha District Council	0.00%	remapping	ICT	2015	Non endemic
61	Lindi	Kilwa District Council	2.30%	SSA	FTS	2020	On MDA
62	Lindi	Lindi District Council	6.20%	SSA	FTS	2020	On MDA
63	Lindi	Lindi Municipal Council	0.37%	TAS1	FTS	2019	Stop MDA
64	Lindi	Liwale District Council	0.00%	TAS2	FTS	2018	Post MDA surveillance
65	Lindi	Nachingwea District Council	0.00%	TAS1	FTS	2019	Stop MDA
66	Lindi	Ruangwa District Council	0.00%	TAS1	FTS	2019	Stop MDA
67	Manyara	Babati District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
68	Manyara	Babati Town Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
69	Manyara	Hanang District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
70	Manyara	Kiteto District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
71	Manyara	Mbulu District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
72	Manyara	Mbulu Town Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
73	Manyara	Simanjiro District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
74	Mara	Bunda District Council	0.00%	remapping	ICT	2015	Non-Endemic
75	Mara	Bunda Town Council	0.00%	remapping	ICT	2015	Non-Endemic
76	Mara	Butiama District Council	0.00%	remapping	ICT	2015	Non-Endemic
77	Mara	Musoma District Council	0.00%	remapping	ICT	2015	Non-Endemic
78	Mara	Musoma Municipal Council	0.00%	remapping	ICT	2015	Non-Endemic
79	Mara	Rorya District Council	0.00%	remapping	ICT	2015	Non-Endemic

80	Mara	Serengeti District Council	0.00%	remapping	ICT	2015	Non-Endemic
81	Mara	Tarime District Council	0.00%	remapping	ICT	2015	Non-Endemic
82	Mara	Tarime Town Council	0.00%	remapping	ICT	2015	Non-Endemic
83	Mbeya	Busokelo District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
84	Mbeya	Chunya District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
85	Mbeya	Kyela District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
86	Mbeya	Mbarali District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
87	Mbeya	Mbeya City Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
88	Mbeya	Mbeya District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
89	Mbeya	Rungwe District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
90	Morogoro	Gairo District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
91	Morogoro	Ifakara Town Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
92	Morogoro	Kilombero District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
93	Morogoro	Kilosa District Council	0.24%	TAS1	FTS	2019	Stop MDA
94	Morogoro	Malinyi District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
95	Morogoro	Morogoro District Council	0.00%	TAS1	FTS	2019	Stop MDA
96	Morogoro	Morogoro Municipal Council	0.05%	TAS1	FTS	2019	Stop MDA
97	Morogoro	Mvomero District Council	0.24%	TAS1	FTS	2019	Stop MDA
98	Morogoro	Ulanga District Council	0.19%	TAS2	FTS	2019	Post MDA surveillance
99	Mtwara	Masasi District Council	0.00%	TAS1	FTS	2021	MDA Stopped
100	Mtwara	Masasi Town Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
101	Mtwara	Mtwara District Council	0.14%	TAS3	FTS	2021	Post MDA surveillance
102	Mtwara	Mtwara Municipal Council	2.90%	SSA	FTS	2020	On MDA
103	Mtwara	Nanyamba District Council	0.14%	TAS3	FTS	2021	Post MDA surveillance
104	Mtwara	Nanyumbu District Council	0.13%	TAS3	FTS	2021	Post MDA surveillance
105	Mtwara	Newala District Council	0.00%	TAS3	FTS	2019	Post MDA surveillance
106	Mtwara	Newala Town Council	0.06%	TAS3	FTS	2019	Post MDA surveillance
107	Mtwara	Tandahimba District Council	0.25%	TAS3	FTS	2016	Post MDA surveillance
108	Mwanza	Buchosa District Council	0.00%	remapping	ICT	2015	Non endemic
109	Mwanza	Ilemela Municipal Council	0.00%	remapping	ICT	2015	Non endemic
110	Mwanza	Kwimba District Council	0.00%	remapping	ICT	2015	Non endemic
111	Mwanza	Magu District Council	0.00%	remapping	ICT	2015	Non endemic
112	Mwanza	Misungwi District Council	0.00%	remapping	ICT	2015	Non endemic
113	Mwanza	Mwanza City Council	0.00%	remapping	ICT	2015	Non endemic
114	Mwanza	Sengerema District Council	0.00%	remapping	ICT	2015	Non endemic
115	Mwanza	Ukerewe District Council	0.00%	remapping	ICT	2015	Non endemic
116	Njombe	Ludewa District Council	0.00%	TAS2	ICT	2018	Post MDA surveillance
117	Njombe	Makambako Town Council	0.00%	TAS3	FTS	2020	Post MDA surveillance
118	Njombe	Makete District Council	0.00%	TAS3	FTS	2020	Post MDA surveillance
119	Njombe	Njombe District Council	0.00%	TAS2	FTS	2018	Post MDA surveillance
120	Njombe	Njombe Town Council	0.00%	TAS2	FTS	2018	Post MDA surveillance
121	Njombe	Wanging'ombe District Council	0.00%	TAS3	FTS	2020	Post MDA surveillance
122	Pwani	Bagamoyo District Council	0.65%	TAS2	FTS	2018	Post MDA surveillance

123	Pwani	Chalinze District Council	0.65%	TAS2	FTS	2018	Post MDA surveillance
124	Pwani	Kibaha District Council	0.23%	TAS1	FTS	2021	Stop MDA
125	Pwani	Kibaha Town Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
126	Pwani	Kibiti District Council	0.00%	TAS3	FTS	2020	Post MDA surveillance
127	Pwani	Kisarawe District Council	0.19%	TAS3	FTS	2021	Post MDA surveillance
128	Pwani	Mafia District Council	4.10%	SSA	FTS	2020	On MDA
129	Pwani	Mkuranga District Council	0.00%	TAS3	FTS	2019	Post MDA surveillance
130	Pwani	Rufiji District Council	0.00%	TAS3	FTS	2020	Post MDA surveillance
131	Rukwa	Kalambo District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
132	Rukwa	Nkasi District Council	0.06%	TAS3	FTS	2021	Post MDA surveillance
133	Rukwa	Sumbawanga District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
134	Rukwa	Sumbawanga Municipal Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
135	Ruvuma	Madaba District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
136	Ruvuma	Mbinga District Council	0.00%	TAS2	FTS	2018	Post MDA surveillance
137	Ruvuma	Mbinga Town Council	0.00%	TAS2	FTS	2018	Post MDA surveillance
138	Ruvuma	Namtumbo District Council	0.13%	TAS3	FTS	2021	Post MDA surveillance
139	Ruvuma	Nyasa District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
140	Ruvuma	Songea District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
141	Ruvuma	Songea Municipal Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
142	Ruvuma	Tunduru District Council	0.06%	TAS3	FTS	2021	Post MDA surveillance
143	Shinyanga	Kahama Town Council	0.00%	remapping	ICT	2015	Non endemic
144	Shinyanga	Kishapu District Council	0.00%	remapping	ICT	2015	Non endemic
145	Shinyanga	Msalala District Council	0.00%	remapping	ICT	2015	Non endemic
146	Shinyanga	Shinyanga District Council	0.00%	remapping	ICT	2015	Non endemic
147	Shinyanga	Shinyanga Municipal Council	0.00%	remapping	ICT	2015	Non endemic
148	Shinyanga	Ushetu District Council	0.00%	remapping	ICT	2015	Non endemic
149	Simiyu	Bariadi District Council	0.00%	remapping	ICT	2015	Non endemic
150	Simiyu	Bariadi Town Council	0.00%	remapping	ICT	2015	Non endemic
151	Simiyu	Busega District Council	0.00%	remapping	ICT	2015	Non endemic
152	Simiyu	Itilima District Council	0.00%	remapping	ICT	2015	Non endemic
153	Simiyu	Maswa District Council	0.00%	remapping	ICT	2015	Non endemic
154	Simiyu	Meatu District Council	0.00%	remapping	ICT	2015	Non endemic
155	Singida	Ikungi District Council	0.06%	TAS3	FTS	2021	Post MDA surveillance
156	Singida	Iramba District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
157	Singida	Itigi District Council	0.06%	TAS3	FTS	2021	Post MDA surveillance
158	Singida	Manyoni District Council	0.06%	TAS3	FTS	2021	Post MDA surveillance
159	Singida	Mkalama District Council	0.00%	TAS3	FTS	2021	Post MDA surveillance
160	Singida	Singida District Council	0.06%	TAS3	FTS	2021	Post MDA surveillance
161	Singida	Singida Municipal Council	0.06%	TAS3	FTS	2021	Post MDA surveillance
162	Songwe	Ileje District Council	0.13%	TAS3	FTS	2021	Post MDA surveillance
163	Songwe	Mbozi District Council	0.00%	TAS3	FTS	2020	Post MDA surveillance
164	Songwe	Momba District Council	0.00%	TAS3	FTS	2020	Post MDA surveillance
165	Songwe	Songwe District Council	0.06%	TAS3	FTS	2021	Post MDA surveillance

166	Songwe	Tunduma Town Council	0.00%	TAS2	FTS	2020	Post MDA surveillance
167	Tabora	Igunga District Council	0.06%	TAS2	FTS	2019	Post MDA surveillance
168	Tabora	Kaliua District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
169	Tabora	Nzega District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
170	Tabora	Nzega Town Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
171	Tabora	Sikonge District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
172	Tabora	Tabora Municipal Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
173	Tabora	Urambo District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
174	Tabora	Uyui District Council	0.00%	TAS2	FTS	2019	Post MDA surveillance
175	Tanga	Bumbuli District Council	0.00%	TAS3	FTS	2019	Post MDA surveillance
176	Tanga	Handeni District Council	0.00%	TAS3	FTS	2020	Post MDA surveillance
177	Tanga	Handeni Town Council	0.00%	TAS3	FTS	2020	Post MDA surveillance
178	Tanga	Kilindi District Council	0.00%	TAS3	FTS	2020	Post MDA surveillance
179	Tanga	Korogwe District Council	0.06%	TAS1	FTS	2021	Stop MDA
180	Tanga	Korogwe Town Council	5.00%	TAS1	FTS	2021	Stop MDA
181	Tanga	Lushoto District Council	0.00%	TAS3	FTS	2019	Post MDA surveillance
182	Tanga	Mkinga District Council	0.12%	TAS1	FTS	2019	Stop MDA
183	Tanga	Muheza District Council	0.30%	TAS3	FTS	2019	Post MDA surveillance
184	Tanga	Pangani District Council	2.63%	SSA	FTS	2019	On MDA
185	Tanga	Tanga City Council	0.06%	SSA	FTS	2019	Stop MDA

Annex 4: Prevalence of Schistosomiasis

Region	District	Site	Prevalence (%)	Method Used	Year of Survey & Reference
Arusha	Arusha District Council		5.84	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Arusha	Arusha City Council		4.89	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Arusha	Karatu District Council		5.43	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Arusha	Longido District Council			WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Arusha	Meru District Council			WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Arusha	Monduli District Council		6.13	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Arusha	Ngorongoro District Council		8.96	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dar-es-Salaam	Dar es Salaam City Council		16.68	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dar-es-Salaam	Ilala Municipal Council		16.68	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dar-es-Salaam	Kigamboni Municipal Council		14.77	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dar-es-Salaam	Kinondoni Municipal Council		13.25	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dar-es-Salaam	Temeke Municipal Council		14.77	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dar-es-Salaam	Ubungo Municipal Council		13.25	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dodoma	Bahi District Council		26	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dodoma	Chamwino District Council		26.85	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dodoma	Chemba District Council		12.5	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dodoma	Dodoma Municipal Council		17.38	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dodoma	Kondoa District Council		12.5	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dodoma	Kondoa Town Council		12.5	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dodoma	Kongwa District Council		8.69	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Dodoma	Mpwapwa District Council		16.44	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Geita	Bukombe District Council		26.09	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Geita	Chato District Council			WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Geita	Geita District Council		25.09	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Geita	Geita Town Council		25.09	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Geita	Mbogwe District Council		26.09	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)

Geita	Nyang'hwale District Council		25.09	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Iringa	Iringa District Council		14.97	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Iringa	Iringa Municipal Council		5.49	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Iringa	Kilolo District Council		15	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Iringa	Mafinga Town Council		10.16	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Iringa	Mufindi District Council		10.16	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kagera	Biharamulo District Council		2.5	Kato Katz & Filtration	2019
Kagera	Bukoba District Council		10.8	Kato Katz & Filtration	2019
Kagera	Bukoba Municipal Council		4.07	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kagera	Karagwe District Council		22.5	Kato Katz & Filtration	2019
Kagera	Kyerwa District Council		8.48	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kagera	Missenyi District Council		6.13	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kagera	Muleba District Council		5	Kato Katz & Filtration	2019
Kagera	Ngara District Council		0	Kato Katz & Filtration	2019
Katavi	Mlele District Council		21.03	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Katavi	Mpanda District Council		21.03	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Katavi	Mpanda Town Council		21.03	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Katavi	Mpimbwe District Council		21.03	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Katavi	Nsimbo District Council		21.03	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kigoma	Buhigwe District Council		9.74	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kigoma	Kakonko District Council		8.78	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kigoma	Kasulu District Council		5	Kato Katz & Filtration	2019
Kigoma	Kasulu Town Council		9.74	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kigoma	Kibondo District Council		0	Kato Katz & Filtration	2019
Kigoma	Kigoma District Council		0.8	Kato Katz & Filtration	2004 (SCI/MoHSW 2010)
Kigoma	Kigoma-Ujiji Municipal Council		5.8	Kato Katz & Filtration	2019
Kigoma	Uvinza District Council		12.53	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kilimanjaro	Hai District Council		6.88	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kilimanjaro	Moshi District Council		5.89	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)

Kilimanjaro	Moshi Municipal Council		9.73	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kilimanjaro	Mwanga District Council		8.67	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kilimanjaro	Rombo District Council		3.99	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kilimanjaro	Same District Council		8.8	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Kilimanjaro	Siha District Council		6.88	WHO BIU Questionnaire	2005 (SCI/MoHSW 2010)
Lindi	Kilwa District Council		16.72	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Lindi	Lindi District Council		24.55	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Lindi	Lindi Municipal Council	Ruaha	0	Kato Katz	2017
Lindi	Lindi Municipal Council	Mingonyo	0	Kato Katz	2017
Lindi	Lindi Municipal Council	Ruaha	61	Urine Filtration	2017
Lindi	Lindi Municipal Council	Mingonyo	1.7	Urine Filtration	2017
Lindi	Liwale District Council		29.68	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Lindi	Nachingwea District Council	Gama	0	Kato Katz	2017
Lindi	Nachingwea District Council	Mkumba	0	Kato Katz	2017
Lindi	Nachingwea District Council	Gama	18.3	Urine Filtration	2017
Lindi	Nachingwea District Council	Mkumba	6.7	Urine Filtration	2017
Lindi	Ruangwa District Council	Chikwale	0	Kato Katz	2017
Lindi	Ruangwa District Council	Chinokole	0	Kato Katz	2017
Lindi	Ruangwa District Council	Chikwale	8.3	Urine Filtration	2017
Lindi	Ruangwa District Council	Chinokole	1.7	Urine Filtration	2017
Manyara	Babati District Council	Gichameda	15	Kato Katz	2017
Manyara	Babati District Council	Kisangaji	18	Kato Katz	2017
Manyara	Babati District Council	Gichameda	23.3	Urine Filtration	2017
Manyara	Babati District Council	Kisangaji	31.1	Urine Filtration	2017
Manyara	Babati Town Council	Imbilili	0	Kato Katz	2017
Manyara	Babati Town Council	Malangi	0	Kato Katz	2017
Manyara	Babati Town Council	Imbilili	3.3	Urine Filtration	2017
Manyara	Babati Town Council	Malangi	13.3	Urine Filtration	2017
Manyara	Hanang District Council	Dang'aida	0	Kato Katz	2017

Manyara	Hanang District Council	Hirbadaw	0	Kato Katz	2017
Manyara	Hanang District Council	Dang'aida	0	Urine Filtration	2017
Manyara	Hanang District Council	Hirbadaw	0	Urine Filtration	2017
Manyara	Kiteto District Council	Chapakazi	0	Kato Katz	2017
Manyara	Kiteto District Council	Oloimugi	0	Kato Katz	2017
Manyara	Kiteto District Council	Chapakazi	0	Urine Filtration	2017
Manyara	Kiteto District Council	Oloimugi	0	Urine Filtration	2017
Manyara	Mbulu District Council	Masieda	0	Kato Katz	2017
Manyara	Mbulu District Council	Yaeda Chini	0	Kato Katz	2017
Manyara	Mbulu District Council	Masieda	0	Urine Filtration	2017
Manyara	Mbulu District Council	Yaeda Chini	0	Urine Filtration	2017
Manyara	Mbulu Town Council		5.45	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Manyara	Simanjiro District Council	Ngorika	0	Kato Katz	2017
Manyara	Simanjiro District Council	Nyumba ya Mungu	0	Kato Katz	2017
Manyara	Simanjiro District Council	Ngorika	0	Urine Filtration	2017
Manyara	Simanjiro District Council	Nyumba ya Mungu	0	Urine Filtration	2017
Mara	Bunda District Council		8.2	Kato Katz + Urine Filtration2019	
Mara	Bunda Town Council		0.1	Kato Katz + Urine Filtration2019	2019
Mara	Butiama District Council		0.6	Kato Katz + Urine Filtration2019	2019
Mara	Musoma District Council		11.6	Kato Katz + Urine Filtration2019	2019
Mara	Musoma Municipal Council		6.4	Kato Katz + Urine Filtration2019	2019
Mara	Rorya District Council		11.8	Kato Katz + Urine Filtration2019	2019
Mara	Serengeti District Council		0.3	Kato Katz + Urine Filtration2019	2019
Mara	Tarime District Council		1.2	Kato Katz + Urine Filtration2019	2019
Mara	Tarime Town Council		5.7	Kato Katz + Urine Filtration2019	2019
Mbeya	Busokelo District Council		15.41	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mbeya	Chunya District Council		21.74	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mbeya	Kyela District Council		35.56	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mbeya	Mbarali District Council		26.89	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)

Mbeya	Mbeya City Council		9.26	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mbeya	Mbeya District Council		9.62	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mbeya	Rungwe District Council		15.41	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Morogoro	Gairo District Council		19.74	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Morogoro	Kilombero District Council		13.43	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Morogoro	IfakaraTown Council		13.43	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Morogoro	Kilosa District Council		19.74	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Morogoro	Malinyi District Council		13.4	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Morogoro	Morogoro District Council		16.22	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Morogoro	Morogoro Municipal Council		22.1	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Morogoro	Mvomero District Council		24.36	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Morogoro	Ulanga District Council		13.4	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mtwara	Masasi District Council		38.75	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mtwara	Masasi Town Council		38.75	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mtwara	Mtwara District Council		30.19	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mtwara	Mtwara Municipal Council		16.84	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mtwara	Nanyamba District Council		30.19	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mtwara	Nanyumbu District Council		38.8	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mtwara	Newala District Council		11.53	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mtwara	Newala Town Council		11.53	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mtwara	Tandahimba District Council		19.97	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mwanza	Buchosa District Council		23.87	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mwanza	Ilemela Municipal Council		16.03	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mwanza	Kwimba District Council		6.3	Kato Katz & Filtration	2019
Mwanza	Magu District Council		36.49	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mwanza	Misungwi District Council		28.84	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mwanza	Nyamagana Municipal Council		12.66	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Mwanza	Sengerema District Council		0.8	Kato Katz & Filtration	2019
Mwanza	Ukerewe District Council		21.07	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)

Njombe	Ludewa District Council		18.86	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Njombe	Makambako Town Council		9.3	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Njombe	Makete District Council		5.23	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Njombe	Njombe District Council		9.3	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Njombe	Njombe Town Council		9.3	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Pwani	Wanging'ombe District Council		9.3	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Pwani	Bagamoyo District Council		12.47	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Pwani	Chalinze District Council		12.47	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Pwani	Kibaha District Council		20.46	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Pwani	Kibaha Town Council		20.5	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Pwani	Kibiti District Council		9.32	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Pwani	Kisarawe District Council		19.12	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Pwani	Mafia District Council		7.57	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Pwani	Mkuranga District Council		9.66	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Pwani	Rufiji District Council		9.32	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Rukwa	Kalambo District Council		19.74	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Rukwa	Nkasi District Council		18.8	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Rukwa	Sumbawanga District Council		19.74	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Rukwa	Sumbawanga Municipal Council		10.31	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Ruvuma	Madaba District Council		19.34	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Ruvuma	Mbinga District Council		14.85	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Ruvuma	Mbinga Town Council		14.85	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Ruvuma	Namtumbo District Council		19.7	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Ruvuma	Nyasa District Council		14.85	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Ruvuma	Songea District Council		19.34	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Ruvuma	Songea Municipal Council		11.97	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Ruvuma	Tunduru District Council		53.48	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Shinyanga	Kahama Town Council		26.42	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Shinyanga	Kishapu District Council		0	Kato Katz + Urine Filtration2019	2019

Shinyanga	Msalala District Council		26.42	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Shinyanga	Shinyanga District Council		0	Kato Katz + Urine Filtration2019	2019
Shinyanga	Shinyanga Municipal Council		0	Kato Katz + Urine Filtration2019	2019
Shinyanga	Ushetu District Council		0.8	Kato Katz + Urine Filtration2019	2019
Simiyu	Bariadi District Council		36.51	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Simiyu	Bariadi Town Council		36.51	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Simiyu	Busega District Council		36.49	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Simiyu	Itilima District Council		36.51	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Simiyu	Maswa District Council		30.31	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Simiyu	Meatu District Council		24.64	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Singida	Ikungi District Council		15.68	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Singida	Iramba District Council		12.54	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Singida	Itigi District Council		20.97	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Singida	Manyoni District Council		20.97	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Singida	Mkalama District Council		12.54	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Singida	Singida District Council		15.68	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Singida	Singida Municipal Council		13.3	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Songwe	Ileje District Council		12.38	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Songwe	Mbozi District Council		36.03	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Songwe	Momba District Council		36.03	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Songwe	Songwe District Council		21.74	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Songwe	Tunduma Town Council		36.03	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Tabora	Igunga District Council	Itundulu	0	Kato Katz	2017
Tabora	Igunga District Council	Makomero	0	Kato Katz	2017
Tabora	Igunga District Council	Itundulu	5	Urine Filtration	2017
Tabora	Igunga District Council	Makomero	54.8	Urine Filtration	2017
Tabora	Kaliua District Council		7.72	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Tabora	Nzega District Council	Kabale	0	Kato Katz	2017
Tabora	Nzega District Council	Mwamalulu	0	Kato Katz	2017

Tabora	Nzega District Council	Kabale	3.3	Urine Filtration	2017
Tabora	Nzega District Council	Mwamalulu	11.1	Urine Filtration	2017
Tabora	Nzega Town Council	Ikuklu	0	Kato Katz	2017
Tabora	Nzega Town Council	Nzegandogo	0	Kato Katz	2017
Tabora	Nzega Town Council	Ikuklu	13.3	Urine Filtration	2017
Tabora	Nzega Town Council	Nzegandogo	3.3	Urine Filtration	2017
Tabora	Sikonge District Council	Ibumba	0	Kato Katz	2017
Tabora	Sikonge District Council	Ilulu	0	Kato Katz	2017
Tabora	Sikonge District Council	Ibumba	0	Urine Filtration	2017
Tabora	Sikonge District Council	Ilulu	0	Urine Filtration	2017
Tabora	Tabora Manicipal Council	Blockfarm	0	Kato Katz	2017
Tabora	Tabora Manicipal Council	Umanda P/ S	1.6	Kato Katz	2017
Tabora	Tabora Manicipal Council	Blockfarm	0	Urine Filtration	2017
Tabora	Tabora Manicipal Council	Umanda P/ S	0	Urine Filtration	2017
Tabora	Urambo District Council	Songambele	0	Kato Katz	2017
Tabora	Urambo District Council	Yelayela	0	Kato Katz	2017
Tabora	Urambo District Council	Songambele	0	Urine Filtration	2017
Tabora	Urambo District Council	Yelayela	0	Urine Filtration	2017
Tabora	Uyui District Council	Shitage	0	Kato Katz	2017
Tabora	Uyui District Council	Mbeya	0	Kato Katz	2017
Tabora	Uyui District Council	Shitage	0	Urine Filtration	2017
Tabora	Uyui District Council	Mbeya	0	Urine Filtration	2017
Tanga	Bumbuli District Council		7.23	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Tanga	Handeni District Council		13.17	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Tanga	Handeni Town Council		13.17	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Tanga	Kilindi District Council		13.2	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Tanga	Korogwe District Council	Bombomajimoto P/S	51.6	Urine Filtration	2019
Tanga	Korogwe District Council	Tewe P/S	0	Urine Filtration	2019
Tanga	Korogwe District Council	Bombomajimoto P/S	0	Kato Katz	2019

Tanga	Korogwe District Council	Tewe P/S	1.6	Kato Katz	2019
Tanga	Korogwe Town Council	Mahenge P/S	0	Urine Filtration	2019
Tanga	Korogwe Town Council	Matondoro P/S	1.6	Urine Filtration	2019
Tanga	Korogwe Town Council	Mahenge P/S	0	Kato Katz	2019
Tanga	Korogwe Town Council	Matondoro P/S	0	Kato Katz	2019
Tanga	Lushoto District Council		7.23	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Tanga	Mkinga District Council	Gonja Segoma	0	Kato Katz	2017
Tanga	Mkinga District Council	Maforoni A	0	Kato Katz	2017
Tanga	Mkinga District Council	Gonja Segoma	19.1	Urine Filtration	2016
Tanga	Mkinga District Council	Maforoni A	0	Urine Filtration	2017
Tanga	Muheza District Council		23.71	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Tanga	Pangani District Council		19.29	WHO BIU Questionnaire	2004 (SCI/MoHSW 2010)
Tanga	Tanga City Council	Kibafuta	0	Kato Katz	2017
Tanga	Tanga City Council	Shaban Robert	0	Kato Katz	2017
Tanga	Tanga City Council	Kibafuta	0	Urine Filtration	2017
Tanga	Tanga City Council	Shaban Robert	3.4	Urine Filtration	2017

Annex 5: Prevalence of Trachoma

Region	District	Baseline Prevalence Category	Diagnostic Method	Year	TF Prevalence at Impact Assessment
Arusha	Arusha City Council	Not Suspected	N/A	N/A	N/A
Arusha	Arusha District Council	< 5	TF Prevalence	2012	1.50%
Arusha	Karatu District Council	< 5	TF Prevalence	2012	2.90%
Arusha	Longido District Council	>= 50	TF Prevalence	2019	5.31%
Arusha	Meru District Council	< 5	TF Prevalence	2012	1.50%
Arusha	Monduli District Council	>= 50	TF Prevalence	2018	2.44%
Arusha	Ngorongoro District Council	>= 50	TF Prevalence	2018	15.52%
Dar Es Salaam	Dar es Salaam City Council	Not Suspected	N/A	N/A	N/A
Dar Es Salaam	Ilala Municipal Council	Not Suspected	N/A	N/A	N/A
Dar Es Salaam	Kigamboni Municipal Council	Not Suspected	N/A	N/A	N/A
Dar Es Salaam	Kinondoni Municipal Council	Not Suspected	N/A	N/A	N/A
Dar Es Salaam	Temeke Municipal Council	Not Suspected	N/A	N/A	N/A
Dar Es Salaam	Ubungo Municipal Council	Not Suspected	N/A	N/A	N/A
Dodoma	Bahi District Council	30 - 49.9	TF Prevalence	2018	4.90%
Dodoma	Chamwino District Council (N)	30 - 49.9	TF Prevalence	2019	4.97%
Dodoma	Chamwino District Council (S)	30 - 49.9	TF Prevalence	2019	6.66%
Dodoma	Chemba District Council	10-29.9	TF Prevalence	2019	3.40%
Dodoma	Dodoma Municipal Council	Not Suspected	N/A	N/A	N/A
Dodoma	Kondoa District Council	10-29.9	TF Prevalence	2017	1.79%
Dodoma	Kondoa Town Council	10-29.9	TF Prevalence	2018	0.60%
Dodoma	Kongwa District Council (N)	10-29.9	TF Prevalence	2017	7.47%
Dodoma	Kongwa District Council (S)	10-29.9	TF Prevalence	2019	2.31%
Dodoma	Mpwapwa District Council (N)	10-29.9	TF Prevalence	2019	0.73%
Dodoma	Mpwapwa District Council (S)	10-29.9	TF Prevalence	2019	1.73%
Geita	Bukombe District Council	Not Suspected	N/A	N/A	N/A
Geita	Chato District Council	Not Suspected	N/A	N/A	N/A
Geita	Geita District Council	Not Suspected	N/A	N/A	N/A
Geita	Geita Town Council	Not Suspected	N/A	N/A	N/A
Geita	Mbogwe District Council	Not Suspected	N/A	N/A	N/A
Geita	Nyang'hwale District Council	Not Suspected	N/A	N/A	N/A
Iringa	Iringa District Council	< 5	TF Prevalence	2004	3.70%
Iringa	Iringa Municipal Council	Not Suspected	N/A	N/A	N/A
Iringa	Kilolo District Council	< 5	TF Prevalence	2004	3.70%
Iringa	Mafinga Town Council	Not Suspected	N/A	N/A	N/A
Iringa	Mufindi District Council	< 5	TF Prevalence	2014	0.30%
Kagera	Biharamulo District Council	Not Suspected	N/A	N/A	N/A
Kagera	Bukoba District Council	Not Suspected	N/A	N/A	N/A
Kagera	Bukoba Municipal Council	Not Suspected	N/A	N/A	N/A
Kagera	Karagwe District Council	10-29.9	TF Prevalence	2016	0.62%
Kagera	Kyerwa District Council	10-29.9	TF Prevalence	2016	1.33%
Kagera	Missenyi District Council	Not Suspected	N/A	N/A	N/A

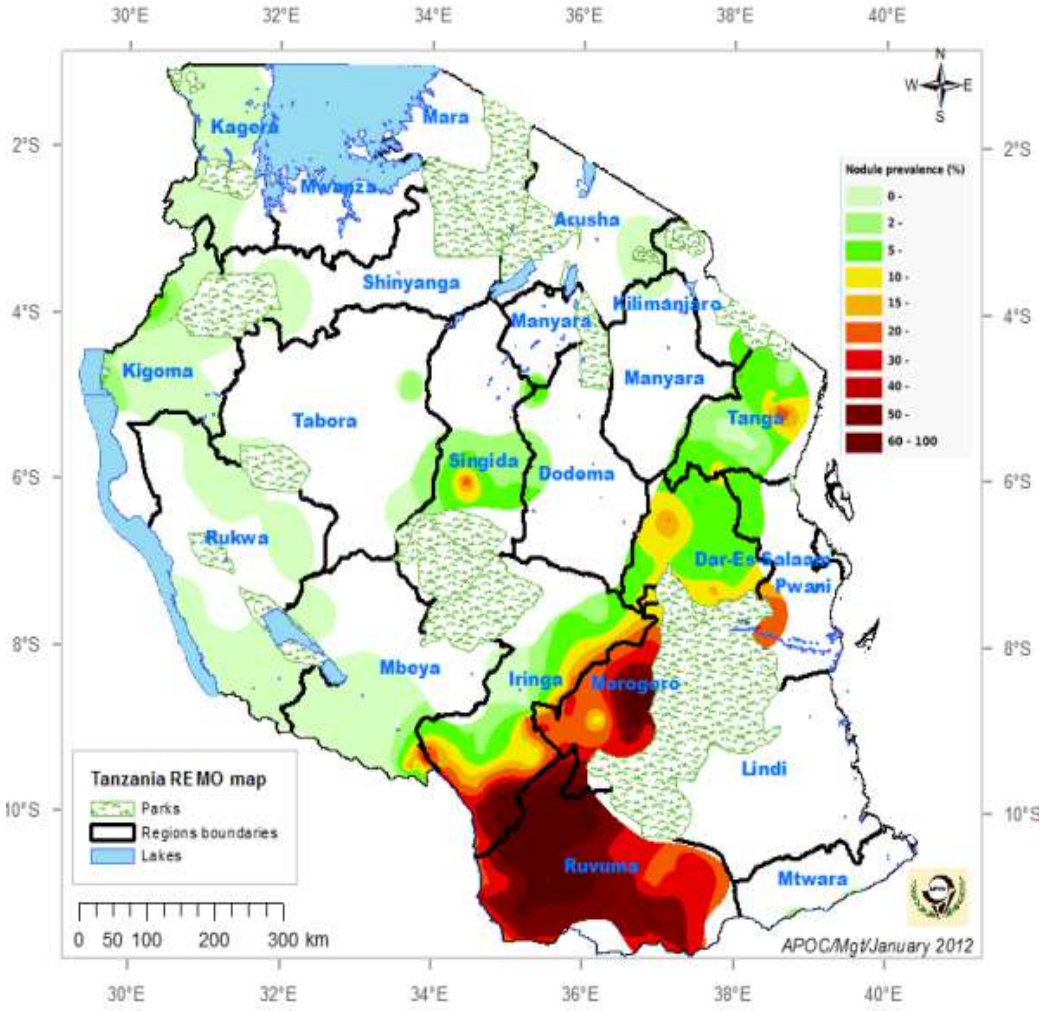
Kagera	Muleba District Council	< 5	TF Prevalence	2014	3.00%
Kagera	Ngara District Council	5-9.9	TF Prevalence	2018	1.50%
Katavi	Mlele District Council	Not Suspected	N/A	N/A	N/A
Katavi	Mpanda District Council	Not Suspected	N/A	N/A	N/A
Katavi	Mpanda Municipal Council	Not Suspected	N/A	N/A	N/A
Katavi	Mpimbwe District Council	Not Suspected	N/A	N/A	N/A
Katavi	Nsimbo District Council	< 5	TF Prevalence	2014	3.90%
Kigoma	Buhigwe District Council	Not Suspected	N/A	N/A	N/A
Kigoma	Kakonko District Council	Not Suspected	N/A	N/A	N/A
Kigoma	Kasulu District Council	Not Suspected	N/A	N/A	N/A
Kigoma	Kasulu Town Council	Not Suspected	N/A	N/A	N/A
Kigoma	Kibondo District Council	Not Suspected	N/A	N/A	N/A
Kigoma	Kigoma - Ujiji Mc	Not Suspected	N/A	N/A	N/A
Kigoma	Kigoma District Council	Not Suspected	N/A	N/A	N/A
Kigoma	Uvinza District Council	Not Suspected	N/A	N/A	N/A
Kilimanjaro	Hai District Council	< 5	TF Prevalence	2004	4.90%
Kilimanjaro	Moshi District Council	< 5	TF Prevalence	2014	0.10%
Kilimanjaro	Moshi Municipal Council	Not Suspected	N/A	N/A	N/A
Kilimanjaro	Mwanga District Council	< 5	TF Prevalence	2014	1.00%
Kilimanjaro	Rombo District Council	5-9.9	TF Prevalence	2018	0.00%
Kilimanjaro	Same District Council	< 5	TF Prevalence	2014	1.00%
Kilimanjaro	Siha District Council	< 5	TF Prevalence	2013	2.80%
Lindi	Kilwa District Council	30 - 49.9	TF Prevalence	2017	1.07%
Lindi	Lindi District Council	30 - 49.9	TF Prevalence	2017	1.84%
Lindi	Lindi Municipal Council	Not Suspected	N/A	N/A	N/A
Lindi	Liwale District Council	30 - 49.9	TF Prevalence	2018	1.80%
Lindi	Nachingwea District Council	30 - 49.9	TF Prevalence	2018	0.80%
Lindi	Ruangwa District Council	10-29.9	TF Prevalence	2017	0.17%
Manyara	Babati District Council	< 5	TF Prevalence	2012	0.30%
Manyara	Babati Town Council	Not Suspected	N/A	N/A	N/A
Manyara	Hanang District Council	10-29.9	TF Prevalence	2017	0.98%
Manyara	Kiteto District Council (N)	30 - 49.9	TF Prevalence	2019	14.60%
Manyara	Kiteto District Council (S)	30 - 49.9	TF Prevalence	2019	9.20%
Manyara	Mbulu District Council	< 5	TF Prevalence	2012	3.10%
Manyara	Mbulu Town Council	Not Suspected	N/A	N/A	N/A
Manyara	Simanjiro District Council	30 - 49.9	TF Prevalence	2019	7.42%
Mara	Bunda District Council	< 5	TF Prevalence	2014	4.10%
Mara	Bunda Town Council	Not Suspected	N/A	N/A	N/A
Mara	Butiama District Council	Not Suspected	N/A	N/A	N/A
Mara	Musoma District Council	Not Suspected	N/A	N/A	N/A
Mara	Musoma Municipal Council	Not Suspected	N/A	N/A	N/A
Mara	Rorya District Council	Not Suspected	N/A	N/A	N/A
Mara	Serengeti District Council	< 5	TF Prevalence	2012	0.10%
Mara	Tarime District Council	Not Suspected	N/A	N/A	N/A
Mara	Tarime Town Council	Not Suspected	N/A	N/A	N/A
Mbeya	Busokelo District Council	Not Suspected	N/A	N/A	N/A
Mbeya	Chunya District Council	10-29.9	TF Prevalence	2018	2.20%

Mbeya	Kyela District Council	Not Suspected	N/A	N/A	N/A
Mbeya	Mbarali District Council	< 5	TF Prevalence	2016	3.90%
Mbeya	Mbeya City Council	Not Suspected	N/A	N/A	N/A
Mbeya	Mbeya District Council	Not Suspected	N/A	N/A	N/A
Mbeya	Rungwe District Council	Not Suspected	N/A	N/A	N/A
Morogoro	Gairo District Council	10-29.9	TF Prevalence	2016	4.20%
Morogoro	Ifakara Town Council	Not Suspected	N/A	N/A	N/A
Morogoro	Kilombero District Council	Not Suspected	N/A	N/A	N/A
Morogoro	Kilosa District Council	10-29.9	TF Prevalence	2016	1.05%
Morogoro	Malinyi District Council	Not Suspected	N/A	N/A	N/A
Morogoro	Morogoro District Council	5-9.9	TF Prevalence	2018	0.40%
Morogoro	Morogoro Municipal Council	Not Suspected	N/A	N/A	N/A
Morogoro	Mvomero District Council	5-9.9	TF Prevalence	2018	0.50%
Morogoro	Ulanga District Council	Not Suspected	N/A	N/A	N/A
Mtwara	Masasi District Council	30 - 49.9	TF Prevalence	2018	1.00%
Mtwara	Masasi Town Council	30 - 49.9	TF Prevalence	2018	0.50%
Mtwara	Mtwara District Council	30 - 49.9	TF Prevalence	2018	0.20%
Mtwara	Mtwara-Mikindani Municipal Council	< 5	TF Prevalence	2014	0.40%
Mtwara	Nanyamba District Council	30 - 49.9	TF Prevalence	2014	0.20%
Mtwara	Nanyumbu District Council	30 - 49.9	TF Prevalence	2018	0.90%
Mtwara	Newala District Council	30 - 49.9	TF Prevalence	2018	1.50%
Mtwara	Newala Town Council	30 - 49.9	TF Prevalence	2018	1.20%
Mtwara	Tandahimba District Council	10-29.9	TF Prevalence	2018	2.80%
Mwanza	Buchosa District Council	< 5	TF Prevalence	2014	4.30%
Mwanza	Ilemela Municipal Council	Not Suspected	N/A	N/A	N/A
Mwanza	Kwimba District Council	10-29.9	TF Prevalence	2017	0.65%
Mwanza	Magu District Council	10-29.9	TF Prevalence	2016	2.12%
Mwanza	Misungwi District Council (N)	5-9.9	TF Prevalence	2019	1.11 %
Mwanza	Misungwi District Council (S)	5-9.9	TF Prevalence	2019	1.67%
Mwanza	Mwanza-Nyamagana City Council	Not Suspected	N/A	N/A	N/A
Mwanza	Sengerema District Council	< 5	TF Prevalence	2014	4.30%
Mwanza	Ukerewe District Council	Not Suspected	N/A	N/A	N/A
Njombe	Ludewa District Council	Not Suspected	N/A	N/A	N/A
Njombe	Makambako Town Council	Not Suspected	N/A	N/A	N/A
Njombe	Makete District Council	< 5	TF Prevalence	2014	1.20%
Njombe	Njombe District Council	< 5	TF Prevalence	2014	0.30%
Njombe	Njombe Town Council	Not Suspected	N/A	N/A	N/A
Njombe	Wanging'ombe District Council	< 5	TF Prevalence	2014	1.00%
Pwani	Bagamoyo District Council	10-29.9	TF Prevalence	2017	0.15%
Pwani	Chalinze District Council	10-29.9	TF Prevalence	2017	1.87%
Pwani	Kibaha District Council	< 5	TF Prevalence	2013	3.90%
Pwani	Kibaha Town Council	Not Suspected	N/A	N/A	N/A
Pwani	Kisarawe District Council	30 - 49.9	TF Prevalence	2018	0.09%
Pwani	Kibiti District Council	10-29.9	TF Prevalence	2018	2.30%
Pwani	Mafia District Council	Not Suspected	N/A	N/A	N/A

Pwani	Mkuranga District Council	10-29.9	TF Prevalence	2018	0.80%
Pwani	Rufiji District Council	10-29.9	TF Prevalence	2018	0.90%
Rukwa	Kalambo District Council	10-29.9	TF Prevalence	2018	5.40%
Rukwa	Nkasi District Council	10-29.9	TF Prevalence	2018	4.90%
Rukwa	Sumbawanga District Council	10-29.9	TF Prevalence	2018	4.30%
Rukwa	Sumbawanga Municipal Council	Not Suspected	N/A	N/A	N/A
Ruvuma	Madaba District Council	10-29.9	TF Prevalence	2016	0.15%
Ruvuma	Mbinga District Council	< 5	TF Prevalence	2014	0.00%
Ruvuma	Mbinga Town Council	< 5	TF Prevalence	2014	0.00%
Ruvuma	Namtumbo District Council	10-29.9	TF Prevalence	2016	2.58%
Ruvuma	Nyasa District Council	< 5	TF Prevalence	2014	0.30%
Ruvuma	Songea District Council	10-29.9	TF Prevalence	2016	0.15%
Ruvuma	Songea Municipal Council	Not Suspected	N/A	N/A	N/A
Ruvuma	Tunduru District Council (E)	>= 50	TF Prevalence	2019	0.73%
Ruvuma	Tunduru District Council (W)	>= 50	TF Prevalence	2019	1.05%
Shinyanga	Kahama Town Council	Not Suspected	N/A	N/A	N/A
Shinyanga	Kishapu District Council	10-29.9	TF Prevalence	2017	0.39%
Shinyanga	Msalala District Council	< 5	TF Prevalence	2017	0.90%
Shinyanga	Shinyanga District Council	10-29.9	TF Prevalence	2017	0.45%
Shinyanga	Shinyanga Municipal Council	Not Suspected	N/A	N/A	N/A
Shinyanga	Ushetu District Council	< 5	TF Prevalence	2017	0.49%
Simiyu	Bariadi District Council	< 5	TF Prevalence	2012	1.80%
Simiyu	Bariadi Town Council	Not Suspected	N/A	N/A	N/A
Simiyu	Busega District Council	< 5	TF Prevalence	2014	3.10%
Simiyu	Itilima District Council	< 5	TF Prevalence	2012	1.80%
Simiyu	Maswa District Council	Not Suspected	N/A	N/A	N/A
Simiyu	Meatu District Council (N)	10-29.9	TF Prevalence	2019	3.85%
Simiyu	Meatu District Council (S)	10-29.9	TF Prevalence	2019	2.58%
Singida	Ikungi District Council	30 - 49.9	TF Prevalence	2017	1.96%
Singida	Iramba District Council	30 - 49.9	TF Prevalence	2017	0.88%
Singida	Itigi District Council	10-29.9	TF Prevalence	2017	3.10%
Singida	Manyoni District Council	10-29.9	TF Prevalence	2017	4.11%
Singida	Mkalama District Council	30 - 49.9	TF Prevalence	2017	0.91%
Singida	Singida District Council	10-29.9	TF Prevalence	2017	0.28%
Singida	Singida Municipal Council	5-9.9	TF Prevalence	2018	0.10%
Songwe	Ileje District Council	Not Suspected	N/A	N/A	N/A
Songwe	Mbozi District Council	Not Suspected	N/A	N/A	N/A
Songwe	Momba District Council	Not Suspected	N/A	N/A	N/A
Songwe	Songwe District Council	10-29.9	TF Prevalence	2019	2.18%
Songwe	Tunduma Town Council	Not Suspected	N/A	N/A	N/A
Tabora	Igunga District Council (N)	30 - 49.9	TF Prevalence	2018	1.39%
Tabora	Igunga District Council (S)	30 - 49.9	TF Prevalence	2018	1.22%
Tabora	Kaliua District Council	< 5	TF Prevalence	2012	0.20%
Tabora	Nzega District Council (N)	10-29.9	TF Prevalence	2017	0.50%
Tabora	Nzega District Council (S)	10-29.9	TF Prevalence	2017	1.23%
Tabora	Nzega Town Council	10-29.9	TF Prevalence	2014	3.00%

Tabora	Sikonge District Council	10-29.9	TF Prevalence	2017	1.27%
Tabora	Tabora Municipal Council	Not Suspected	N/A	N/A	N/A
Tabora	Urambo District Council	< 5	TF Prevalence	2012	0.40%
Tabora	Uyui District Council	< 5	TF Prevalence	2012	0.10%
Tanga	Bumbuli District Council	< 5	TF Prevalence	2006	2.00%
Tanga	Handeni District Council	10-29.9	TF Prevalence	2015	1.10%
Tanga	Handeni Town Council	10-29.9	TF Prevalence	2015	1.10%
Tanga	Kilindi District Council	10-29.9	TF Prevalence	2019	3.59%
Tanga	Korogwe District Council	< 5	TF Prevalence	2012	1.20%
Tanga	Korogwe Town Council	Not Suspected	N/A	N/A	N/A
Tanga	Lushoto District Council	< 5	TF Prevalence	2006	1.10%
Tanga	Mkinga District Council	Not Suspected	N/A	N/A	N/A
Tanga	Muheza District Council	< 5	TF Prevalence	2014	0.10%
Tanga	Pangani District Council	< 5	TF Prevalence	2014	1.10%
Tanga	Tanga City Council	Not Suspected	N/A	N/A	N/A

Annex 7: Prevalence of Onchocerciasis (Map -Remo)



Annex 8: NTD Co-endemicity by District

Registration	District	Diseases											
		Preventive Chemotherapy Diseases					Case Management Diseases						
		LF	STH	SCH	Trachoma	Ocho	Plague	TBRF	HAT	Rabies animal bite	Cysticercosis	Echinococcus	Leprosy
Arusha	Arusha City Council		v	v									
Arusha	Arusha District Council		v	v									
Arusha	Karatu District Council		v	v									
Arusha	Longido District Council		v	v	v								
Arusha	Meru District Council		v	v									
Arusha	Monduli District Council		v	v									
Arusha	Ngorongoro District Council		v	v	v								
Dar Es Salaam	Dar es Salaam City Council	v	v	v									
Dar Es Salaam	Ilala Municipal Council	v	v	v									
Dar Es Salaam	Kigamboni Municipal Council	v	v	v									
Dar Es Salaam	Kinondoni Municipal Council	v	v	v									
Dar Es Salaam	Temeke Municipal Council	v	v	v									
Dar Es Salaam	Ubungo Municipal Council	v	v	v									
Dodoma	Bahi District Council		v	v									
Dodoma	Chamwino District Council		v	v									
Dodoma	Chemba District Council		v	v	v								
Dodoma	Dodoma Municipal Council		v	v									
Dodoma	Kondoa District Council		v	v									
Dodoma	Kondoa Town Council		v	v									
Dodoma	Kongwa District Council		v	v									
Dodoma	Mpwapwa District Council		v	v	v								
Geita	Bukombe District Council		v	v									
Geita	Chato District Council		v	v									

Geita	Geita District Council		v	v									
Geita	Geita Town Council		v	v									
Geita	Mbogwe District Council		v	v									
Geita	Nyang'hwale District Council		v	v									
Iringa	Iringa Municipal Council		v	v									
Iringa	Iringa District Council		v	v									
Iringa	Kilolo District Council		v	v									
Iringa	Mafinga Town Council		v	v									
Iringa	Mufindi District Council		v	v		v							
Kagera	Biharamulo District Council		v	v									
Kagera	Bukoba District Council		v	v									
Kagera	Bukoba Municipal Council		v	v									
Kagera	Karagwe District Council		v	v									
Kagera	Kyerwa District Council		v	v									
Kagera	Missenyi District Council		v	v									
Kagera	Muleba District Council		v	v									
Kagera	Ngara District Council		v	v									
Katavi	Mlele District Council		v	v									
Katavi	Mpanda District Council		v	v									
Katavi	Mpanda Municipal Council		v	v									
Katavi	Mpimbwe District Council		v	v									
Katavi	Nsimbo District Council		v	v									
Kigoma	Buhigwe District Council		v	v									
Kigoma	Kakonko District Council		v	v									
Kigoma	Kasulu District Council		v	v									
Kigoma	Kasulu Town Council		v	v									
Kigoma	Kibondo District Council		v	v									
Kigoma	Kigoma District Council		v	v									
Kigoma	Kigoma-Ujiji Municipal Council		v	v									

Kigoma	Uvinza District Council		v	v									
Kilimanjaro	Hai District Council		v	v									
Kilimanjaro	Moshi District Council		v	v									
Kilimanjaro	Moshi Municipal Council		v	v									
Kilimanjaro	Mwanga District Council		v	v									
Kilimanjaro	Rombo District Council		v	v									
Kilimanjaro	Same District Council		v	v									
Kilimanjaro	Siha District Council		v	v									
Lindi	Kilwa District Council	v	v	v									
Lindi	Lindi District Council	v	v	v									
Lindi	Lindi Municipal Council	v	v	v									
Lindi	Liwale District Council		v	v									
Lindi	Nachingwea District Council	v	v	v									
Lindi	Ruangwa District Council	v	v	v									
Manyara	Babati District Council		v	v									
Manyara	Babati Town Council		v	v									
Manyara	Hanang District Council		v	v									
Manyara	Kiteto District Council		v	v	v								
Manyara	Mbulu District Council		v	v									
Manyara	Mbulu Town Council		v	v									
Manyara	Simanjiro District Council		v	v	v								
Mara	Bunda District Council		v	v									
Mara	Bunda Town Council		v	v									
Mara	Butiama District Council		v	v									
Mara	Musoma District Council		v	v									
Mara	Musoma Municipal Council		v	v									
Mara	Rorya District Council		v	v									
Mara	Serengeti District Council		v	v									
Mara	Tarime District Council		v	v									

Mara	Tarime Town Council		v	v									
Mbeya	Busokelo District Council		v	v		v							
Mbeya	Chunya District Council		v	v									
Mbeya	Kyela District Council		v	v		v							
Mbeya	Mbarali District Council		v	v									
Mbeya	Mbeya City Council		v	v									
Mbeya	Mbeya District Council		v	v									
Mbeya	Rungwe District Council		v	v		v							
Morogoro	Gairo District Council		v	v		v							
Morogoro	Ifakara Town Council		v	v		v							
Morogoro	Kilombero District Council		v	v		v							
Morogoro	Kilosa District Council	v	v	v		v							
Morogoro	Malinyi District Council		v	v		v							
Morogoro	Morogoro District Council	v	v	v		v							
Morogoro	Morogoro Municipal Council	v	v	v									
Morogoro	Mvomero District Council	v	v	v		v							
Morogoro	Ulanga District Council		v	v		v							
Mtwara	Masasi District Council	v	v	v									
Mtwara	Masasi Town Council		v	v									
Mtwara	Mtwara District Council		v	v									
Mtwara	Mtwara Municipal Council	v	v	v									
Mtwara	Nanyamba District Council		v	v									
Mtwara	Nanyumbu District Council		v	v									
Mtwara	Newala District Council		v	v									
Mtwara	Newala Town Council		v	v									
Mtwara	Tandahimba District Council		v	v									
Mwanza	Buchosa District Council		v	v									
Mwanza	Ilemela Municipal Council		v	v									
Mwanza	Kwimba District Council		v	v									

Mwanza	Magu District Council		v	v									
Mwanza	Misungwi District Council		v	v									
Mwanza	Mwanza City Council		v	v									
Mwanza	Sengerema District Council		v	v									
Mwanza	Ukerewe District Council		v	v									
Njombe	Ludewa District Council		v	v		v							
Njombe	Makambako Town Council		v	v									
Njombe	Makete District Council		v	v									
Njombe	Njombe District Council		v	v		v							
Njombe	Njombe Town Council		v	v									
Njombe	Wanging'ombe District Council		v	v									
Pwani	Bagamoyo District Council		v	v									
Pwani	Chalinze District Council		v	v									
Pwani	Kibaha District Council	v	v	v									
Pwani	Kibaha Town Council		v	v									
Pwani	Kibiti District Council		v	v									
Pwani	Kisarawe District Council		v	v									
Pwani	Mafia District Council	v	v	v									
Pwani	Mkuranga District Council		v	v									
Pwani	Rufiji District Council		v	v									
Rukwa	Kalambo District Council		v	v	v								
Rukwa	Nkasi District Council		v	v									
Rukwa	Sumbawanga District Council		v	v									
Rukwa	Sumbawanga Municipal Council		v	v									
Ruvuma	Madaba District Council		v	v		v							
Ruvuma	Mbinga District Council		v	v		v							
Ruvuma	Mbinga Town Council		v	v		v							
Ruvuma	Namtumbo District Council		v	v		v							
Ruvuma	Nyasa District Council		v	v		v							

Ruvuma	Songea District Council		v	v		v							
Ruvuma	Songea Municipal Council		v	v		v							
Ruvuma	Tunduru District Council		v	v		v							
Shinyanga	Kahama Town Council		v	v									
Shinyanga	Kishapu District Council		v	v									
Shinyanga	Msalala District Council		v	v									
Shinyanga	Shinyanga District Council		v	v									
Shinyanga	Shinyanga Municipal Council		v	v									
Shinyanga	Ushetu District Council		v	v									
Simiyu	Bariadi District Council		v	v									
Simiyu	Bariadi Town Council		v	v									
Simiyu	Busega District Council		v	v									
Simiyu	Itilima District Council		v	v									
Simiyu	Maswa District Council		v	v									
Simiyu	Meatu District Council		v	v									
Singida	Ikungi District Council		v	v									
Singida	Iramba District Council		v	v									
Singida	Itigi District Council		v	v									
Singida	Manyoni District Council		v	v									
Singida	Mkalama District Council		v	v									
Singida	Singida District Council		v	v									
Singida	Singida Municipal Council		v	v									
Songwe	Ileje District Council		v	v		v							
Songwe	Mbozi District Council		v	v									
Songwe	Momba District Council		v	v									
Songwe	Songwe District Council		v	v	v								
Songwe	Tunduma Town Council		v	v									
Tabora	Igunga District Council		v	v									
Tabora	Kaliua District Council		v	v									

Tabora	Nzega District Council		v	v									
Tabora	Nzega Town Council		v	v									
Tabora	Sikonge District Council		v	v									
Tabora	Tabora Municipal Council		v	v									
Tabora	Urambo District Council		v	v									
Tabora	Uyui District Council		v	v									
Tanga	Bumbuli District Council		v	v		v							
Tanga	Handeni District Council		v	v									
Tanga	Handeni Town Council		v	v									
Tanga	Kilindi District Council		v	v									
Tanga	Korogwe District Council	v	v	v		v							
Tanga	Korogwe Town Council	v	v	v									
Tanga	Lushoto District Council		v	v		v							
Tanga	Mkinga District Council	v	v	v		v							
Tanga	Muheza District Council		v	v		v							
Tanga	Pangani District Council	v	v	v									
Tanga	Tanga City Council	v	v	v									

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