



GENDER ASSESSMENT OF THE NATIONAL RESPONSE TO TB IN TANZANIA

UNAIDS/STOP TB Gender Assessment Tool for
HIV and TB responses



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LIST OF ABBREVIATIONS

ACSM	Advocacy Communication Social Mobilisation
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Anti-Retroviral
BMF	Benjamin Mkapa Foundation
CBTBC	Community-based TB care
CCM	Country Coordinating Mechanism
CNR	Case notification rate
CPS	Combination Prevention Strategy
CPT	Cotrimoxazole Preventive Therapy
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization
DHS	Demographic and Health Surveys
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment Short course
DR-TB	Drug Resistant Tuberculosis
DSP	Directorate Special Programmes
EANNASO	Eastern Africa National Networks of AIDS Service Organisations
EPTB	Extra Pulmonary TB
FSW	Female Sex Workers
GBV	Gender-Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOT	Government of Tanzania
GOVT	Government
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IDU	Injecting Drug Users
IEC	Information Education Communication
IP	Implementing Partner
IPT	Isoniazid Preventive Therapy
IPV	Intimate Partners Violence
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KAP	Knowledge Attitude Practice
KII	Key Informant Interviews
M&E	Monitoring and Evaluation
MDR TB	Multidrug-resistant TB
MSM	Men who have sex with men
NACOPHA	National Council of People living with HIV
NACP	National AIDS Control Programme
NMSF	National Multi-Sectoral Strategic Framework

NSP	New Smear positive
NTLP	National Tuberculosis and Leprosy Programme
OPM	Office Of the Prime Minister
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	U. S. President's Emergency Plan for AIDS Relief
PGCD	Police Gender and Children's Desk
PLHIV	People Living with HIV
PMDT	Programmatic management of drug resistant tuberculosis
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PMU	Programme Management Unit
PWID	People Who Inject Drugs
RH	Reproductive Health
SADC	Southern African Development Community
SGBV	Sexual and Gender Based Violence
SRHR	Sexual and Reproductive Health and Rights
STIS	Sexually Transmitted Infections
SWS	Sex Workers
TB	Tuberculosis
TDHS	Tanzania Demographic and Health Survey
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
VAC	Violence Against Children
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
XDR-TB	Extensively Drug Resistant TB

EXECUTIVE SUMMARY

Introduction:

Tanzania has one of the 30 high TB burden countries in the world notified about over 60,000 TB patients in a year. Of the notified TB patients, about 50% are co-infected with HIV. TB thrives in conditions of structural inequity, where the complexities of poverty, social inequity, disempowerment, rights-violations, conflict and patriarchy render communities susceptible to TB and marginalize access to diagnosis, treatment and care. Gender issues in health have been treated mostly as being synonymous with women's health. However, it is noted that, for infectious diseases, policy and practice need to be guided by epidemiological data and consideration of transmission dynamics between men and women. TB burden, across the globe, is disproportionately higher in men compared to women. To address these gender differences in TB and HIV responses, there are national, regional and international policies and guidelines that give directives in gender mainstreaming in TB and HIV programs.

Methods:

We used UNAIDS/Stop TB Gender Assessment Tool to conduct TB gender assessment in Tanzania. It makes use of a number of terms common to the HIV, TB and gender responses. The Tanzania TB and HIV gender assessment was purposively focused on TB more than HIV because of the lack of TB gender assessment in Tanzania. TB gender assessment tool findings transforms from gender-blind to gender-sensitive, and ultimately to gender-transformative TB responses. The assessment involved the following processes:

- **Desk Review:** Tanzania has invested in prevention and control of these two epidemics, TB and HIV. The country has adopted international and regional guidelines and policies for control of these two diseases of public health importance. To better understand the country response on TB and HIV, we evaluated the following; policies, strategic plans, reports, published manuscript on peer reviewed journals and reports. The reports came either from the government agencies and programs, development and implementing partners, civil or community organizations.
- **Key informant interviews:** The key informant interviews (KII) were done to add on anecdotal evidence, opinions and reviews of the selected organizations and individuals on the overall TB and HIV responses. The selected organizations were under the guidance of NTLP and included government agencies and programs, development and implementing partners, civil or community organizations.
- **TB and HIV data analysis:** The routine collected aggregated data were collected from NTLP. The data included yearly notification data and TB treatment outcomes. The efforts were done to ensure age and sex disaggregated data was collected from NTLP. In addition, we collected data from other organizations to complement data provided by NTLP to further understand the TB and HIV responses in Tanzania.

Findings and recommendation: The following are the gaps and recommendation follows the TB gender assessment done in Tanzania.

Epidemiological context

The TB data of patients notified in Tanzania has the following gaps with respect to the gender issues.

- **Registers:** the unit and district registers record patients age and sex, but lacks the data on the occupation and if TB patients belong to a certain vulnerable group. The provision such a variable will help to estimate the contribution of these vulnerable population into the TB burden.

Population estimates and TB burden vulnerable groups: the vulnerable populations in TB such as miners, IDU, health care workers do not have age and sex disaggregated data. The current recording and reporting tools do not capture the vulnerable populations.

- **Uncollected vulnerable groups data:** several implementing partners including the NTLP do collect data for some of the vulnerable groups but not streamlined to the data collection systems of NTLP. For instance, several districts with Methadone clinics, have placed unit registers to record IDU who get TB. However, such data does not get recorded in the district registers.
- **Knowledge, attitude and Practice:** there is no national data summarizing the knowledge of TB symptoms, prevention and transmission disaggregated by age, sex and geographical location.

TB policies and plans

Gender policy and plans: there are no TB gender policies and plans.

- **Gender-based violence:** TB programs has neither the gender-based violence policy nor any assessment of the links between TB and gender-based violence.
- **Advocacy, Communication and Social Mobilization:** NTLP has the ACSM strategy but it lacks gender-related issues in TB programming and responses.
- **Sexual and reproductive health rights:** no policy that recognize and address the linkages between HIV and TB.

TB responses

- **Gender analysis in TB control:** there is lack of understanding the impact of gender-related impediments like stigma, discrimination, gender-based violence, gender imbalances on the TB control in Tanzania.
- **Compensation for the providers:** the health care workers as one of the vulnerable groups have no clearly defined compensation mechanism once they develop TB disease.
- **Attitudes of public service providers:** TB program has not provision and response which may include information, education and communication (IEC) materials, of the public service providers such as health care workers and policy officers on TB.
- **Partnerships to address gender-based violence:** there are no partnerships that are specific to address gender-based violence against women, children and adolescents. The current efforts to address gender-based violence are from the HIV program.
- **Key populations:** the NTLP strategic plan have included few key populations such as children, IDU, miners and prisoners. There is a need to include other key populations like health care workers, urban poor, mobile populations will be key to reduce the inequities and control TB.
- **Community:** community responses have no gender-related interventions at the community level.

The key recommendations are in line with the gaps found from the epidemiological context, policies and responses. A detailed matrix of the gaps and recommendation:

Epidemiological context addressing gender equity in TB programmes

- **Strategic information in TB:** ensure all data on TB using the NTLP recording and reporting tools to have age and sex disaggregated data to understand gender dynamics in TB responses and institute appropriate responses. The SI tools to capture the vulnerable groups
- **Operational research:** to conduct operational research to i) address gender-related issues such as gender-based violence and TB, ii) estimate the population size of the vulnerable groups and TB burden with a gender-perspective, iii) determine gender-responsive interventions and evaluate their impact on reducing the TB burden in the country.

Socio-cultural response in TB programme

- **Stigma and discrimination:** to conduct Stigma Index study to assess to understand the stigma and discrimination dimension in TB control. The findings of stigma and discrimination should inform reduction interventions.
- **Gender-based violence:** promote understanding and responding to gender-based violence among TB patients and their families. Police Gender and Children's Desk (PGCD) should also include and follow-up on GBV happening among TB patients and properly recorded.

Policies, coordination and responses

- **Policies:** the NTLP should develop gender-transformative policies and plans to address the gender-related issues in the TB epidemiology and TB responses.
- **Coordination of gender responses:** NTLP to be involved in the coordinating forums and Technical Working Groups (TWG) on gender to drive the gender-related agenda on TB to the national policies and guidelines.
- **Civil societies:** identify CSO and assign their roles in the promoting gender equity in TB responses at the community level. Capitalize on the experience of HIV-centered CSO to build capacity to CSO working on TB.
- **ACSM:** the ACSM strategy of NTLP should be amended to include gender-related issues and improve awareness to implementing key gender-related issues.

Summary of the gaps in TB response in Tanzania

- M&E tools do not capture in vulnerable population.
- No population estimates of vulnerable groups including HIV and TB burden estimates.
- No gender mainstreaming policies and plans in TB responses.
- No stigma and discrimination reports on TB.
- NTLP does not participate in the gender-related coordination or technical working groups.

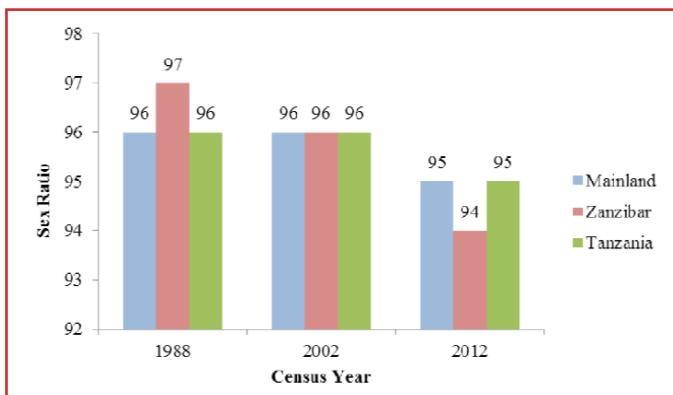
DEFINITION OF TERMS

CAREGIVER:	Caregivers are people who provide unpaid care by looking after a person living with or affected by HIV and/or TB
CASE NOTIFICATION RATE:	refers to new and recurrent episodes of TB notified to WHO for a given year, expressed per 100 000 population
CLOSE CONTACT OF TB AFFECTED:	A person who is not in the household but who shared an enclosed space, such as a social gathering place, workplace, or facility, with the index case for extended daytime periods during the 3 months before the start of the current treatment episode.
DISCRIMINATION	<p>involves treating someone in a different and unjust, unfair or prejudicial manner, often on the basis of their belonging, or being perceived to belong, to a particular group. It is often viewed as the end result of the process of stigmatization. In other words, when stigma is acted upon (sometimes called “enacted stigma”), the result is discrimination.</p> <p>“Discrimination consists of actions or omissions that are derived from stigma and directed towards those individuals who are stigmatized.” For example, HIV-related discrimination occurs when someone is treated differently (and to their disadvantage) because they are known to be living with HIV, suspected of being HIV-positive, or closely associated with people living with HIV (such as their partner or a member of their household).</p>
GENDER:	Gender refers to the social attributes and opportunities associated with being male female or a transgender person and the relationships between women and men and girls and boys and transgender people, as well as the relations between women and those between men and between transgender people. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context/time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities.
GENDER-BASED VIOLENCE:	It describes violence that establishes, maintains or attempts to reassert unequal power relations based on gender. The term was first defined to describe the gendered nature of men's violence against women. Hence, it is often used interchangeably with ‘violence against women’. The definition has evolved to include violence perpetrated against some boys, men and transgender persons because they don't conform to or challenge prevailing gender norms and expectations (e.g. may have feminine appearance) or heterosexual norms.
GENDER EQUALITY:	Gender equality, or equality between men and women, entails the concept that all human beings, both men and women, are free to develop their personal abilities and make choices without any limitations set by stereotypes, rigid gender roles, and prejudices. Gender equality is a recognized human right. It means that the different behaviours, aspirations, and needs of women and men are considered, valued, and favoured equally. It signifies that there is no discrimination on the grounds of a person's gender in the allocation of resources or benefits, or in access to services. Gender equality may be measured in terms of whether there is equality of opportunity or equality of results.
GENDER-RELATED BARRIERS:	Legal, social, cultural or economic barriers to access services, participation and/or opportunities, imposed on the basis of socially constructed gender roles
TB INFECTION OR LTBI:	Infection with Mycobacterium tuberculosis may occur following exposure to a TB case and means that the person carries the bacteria inside the body. Many people have TB infection and remain well, while others develop disease. When infection has occurred but the infected individual is showing no signs or symptoms of disease from the standpoint of clinical recognition or diagnostic detection, the term “latent” is often used.
PREVENTIVE THERAPY TB:	Treatment offered to contacts who are considered to be at risk of developing TB disease following exposure to a possible source in order to reduce that risk. While this treatment is called “preventive therapy” by convention, it is actually treatment for latent TB infection.
STIGMA	is a sign of disgrace or shame often described as a process of devaluation. If one is stigmatized, one is discredited, seen as a disgrace and/or perceived to have less value or worth in the eyes of others. HIV-related stigma often builds upon and reinforces other existing prejudices, such as those related to gender, sexuality and race. For example, the stigma associated with HIV is often based upon the association of HIV and AIDS with already marginalized and stigmatized behaviours, such as sex work, drug use and same-sex and transgender sexual practices. Moreover, HIV stigma also involves internal-stigma which referred to as “felt” stigma or “self-stigmatization”. It is used to describe the way a person living with HIV feels about themselves and specifically if they feel a sense of shame about being HIV-positive

INTRODUCTION

1. Demographic characteristics

The United Republic of Tanzania (URT) is a union of Tanganyika (Tanzania Mainland) and Zanzibar (Tanzania Zanzibar). URT is found in the Eastern part of Africa being bordered by 8 countries. The URT is bordered by Kenya and Uganda in the north; Rwanda and Burundi and Democratic Republic of Congo in the West; Malawi and Zambia in the South and the Indian ocean in the East. URT is between 1° and 11°S latitude and between 29° and 40°E longitude and has the surface area of approximately 945,300 square kilometers. URT has the population of about 45 million according to the National census of 2012¹. The population trend of Tanzania has tripled from 12.3 million in 1967 to about 45 million 2012. Of the 45 million people, women are more than men with estimated populations of 23 million and 22 million respectively. The sex ratio trend of more females than males from the census of 1988 to 2012 is shown in Figure 1.



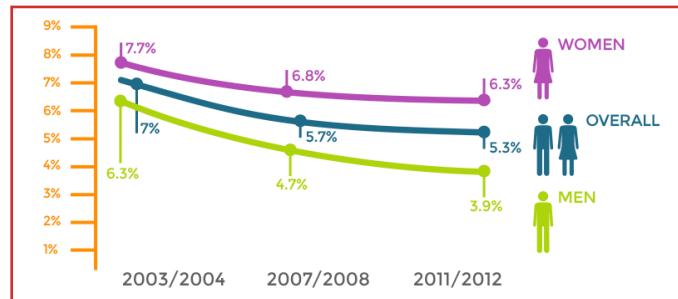
(Source: 2012 population and Housing census)

FIGURE 1. TRENDS IN SEX RATIO FROM 1988 TO 2012 CENSUS.

1.2 HIV Burden

The URT started the efforts to address the HIV/AIDS epidemic in the 1985 as a task force within the Ministry of Health. HIV/AIDS epidemic public health impacts slowly rose and has caused significant morbidity and mortality. The government of Tanzania then established in 1988, the National AIDS Control Programme (NACP) tasked to control the HIV/AIDS epidemic in the country. In the year 2016, estimated number of people living with HIV were 1,400,000 (1,200,000-1,600,000). There were estimated 55,000 (42,000-67,000) new HIV infections, with HIV incidence per 1000 population of 1.19 (0.92-1.45). In the same year, AIDS related deaths were 33,000 (20,000-41,000)². Of the 1.5 million HIV patients, it is estimated that there are 1.5 million people living with HIV out of whom 28% are children aged 0-14; and 11.2% are young people aged

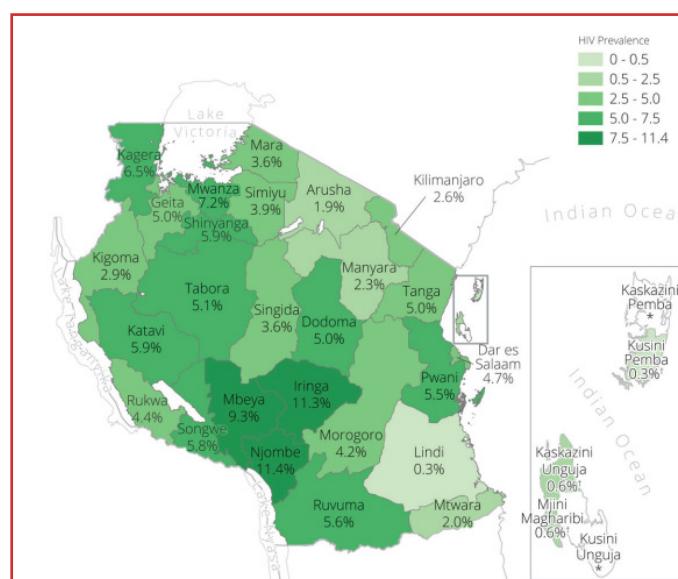
15-24 (Spectrum Estimate, 2013). The HIV/AIDS epidemic is evidently to be higher in women as compared to men. Since 2003/2004 data, women have had higher HIV prevalence nationwide compared to men. Notably, the prevalence of HIV seems to be decreasing faster in men as compared to women (see Figure 2).



(Source: UNAIDS (2014) Tanzania Narrative Report)³.

The prevalence of HIV in adults varies across the regions which is determined various socio-economic and cultural factors from each region as shown in Figure 2. The most recent Tanzania HIV Impact Survey of 2016-2017 shows the three regions with the high HIV prevalence include Njombe, Iringa and Mbeya with HIV prevalence of 11.4%, 11.4% and 9.3% respectively.

Comparing adult women and men HIV prevalence, the highest HIV prevalence peaks at 12 percent among females aged 45 to 49 years. This disparity in HIV prevalence between men and women is highest among younger adults, with prevalence among women in age groups 15 to 19 years, 20 to 24 years, 25 to 29 years, 30 to 34 years, and 35 to 39 years more than double than that of men in the same age groups (see Figure 3)⁴.



(Source: THIS (2016-2017), Tanzania HIV Impact Survey).

1

UNAIDS (2017), UNAIDS data book 2017

3 <http://www.unaids.org/en/regionscountries/countries/unitedrepublicoftanzania>, accessed on 11th November 2017.

4 Tanzania HIV Impact Survey (THIS) 2016-2017.

FIGURE 2. HIV PREVALENCE AMONG ADULTS (15+ YEARS) IN TANZANIA FROM THIS 2016-2017.

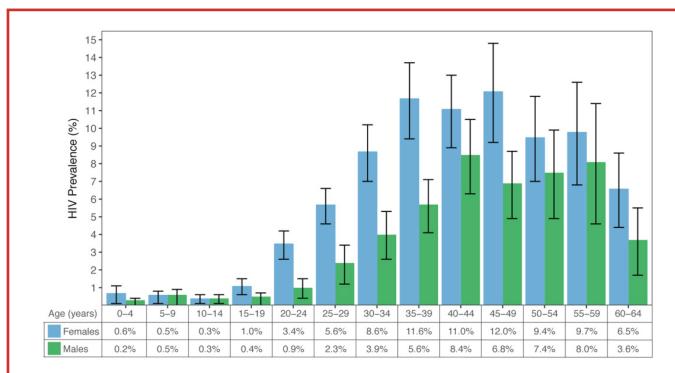


FIGURE 3. HIV PREVALENCE BY AGE AND SEX FROM THIS 2016-2017.

There are several frameworks and plans that are addressing the HIV epidemic in Tanzania. Tanzania Third National Multi-Sectoral Strategic Framework (NMSF III) for HIV and AIDS for 2013-2018 has outlined the impact-level results and outcomes to be achieved by 2017/18⁵ as shown below:

1. The incidence of HIV in the general population is halved by 2018.
 2. A significant reduction in AIDS-related deaths among people living with HIV and AIDS.
 3. Reduced stigma and discrimination among PLHIV.
- . The following indicators are used to measure the impact of the NMSF III with respective to baselines and targets are shown in Table 1.

TABLE 1. INDICATORS FOR MEASURING IMPACT OF THE NMSF III WITH RESPECTIVE BASELINES AND TARGETS

IMPACT	INDICATOR	BASELINE	TARGET 2017/2018
1	HIV incidence rate in the general population	0.32% (2012)	0.16%
2	% of PLHIV on ART are alive after 12 months	74 (2011)	80%
3	% of people expressing or accepting attitudes towards people living with HIV and AIDS	31.9% (2012)	40%

The NSMF III had clearly mentioned the issue of gender as a cross-cutting programme principles that all programmes activities need to address the disparities that result from gender discrimination and gender-based violence. To achieve

the results of the NMSF III with respect to HIV epidemic in Tanzania, the following outcomes are expected:

- i. Proportion of eligible PLHIV on care and treatment increased and sustained.
- ii. Increased access and quality of HIV Testing and Counselling.
- iii. Elimination of Mother to Child Transmission.
- iv. Increased male and female condom use by men and women during risky sex
- v. Elimination of blood borne transmission of HIV.
- vi. Reduced risky behaviour of sexual intercourse among the general, infected, most-at-risk and vulnerable populations.
- vii. Increased prevalence of Voluntary Medical Male Circumcision
- viii. Increased access and quality of treatment of Sexually Transmitted Infections.
- ix. Community Based Care and Support Interventions response to HIV within their local context.
- x. HIV mainstreamed in sector-specific policies and strategies.
- xi. Reduction of all HIV and AIDS related stigma and discrimination

1.3 TB burden in Tanzania

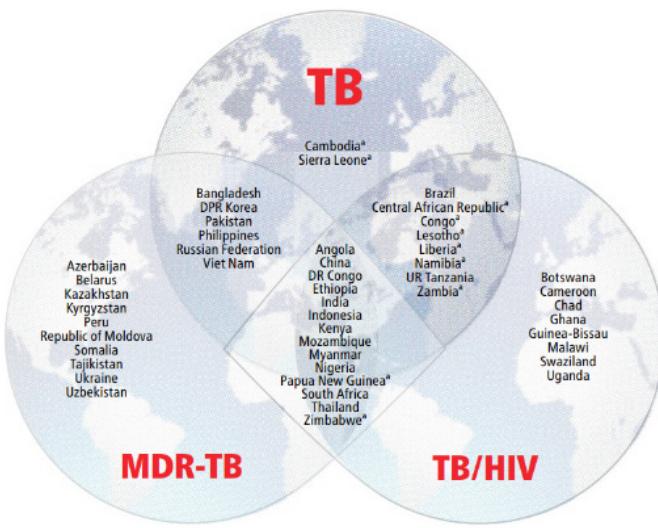
Tanzania is one of the 30 high burden countries in the world, specifically in the sub-categories of TB and TB/HIV burden. Tanzania, therefore, is one of the major contributors to the global burden of TB of around 10.4 million TB cases that were reported in the year 2016. WHO estimates the burden prevalence rate to be 287 TB patients per 100,000 population⁶. In 2016, Tanzania notified 65,908 all forms of TB⁷. Tanzania is one of the many countries in sub-Saharan Africa that has seen a six-fold increase in number of TB patients since early 1980's⁸. The remarkable rise and sustained TB burden in Tanzania is attributed to the concurrent HIV epidemic⁹.

6 WHO (2017), Global Tuberculosis Report

7 NTLP (2016) Annual TB Report

8 Egwaga, S.M., 2003. The impact of HIV on transmission of tuberculosis in Tanzania. *Tuberculosis* 83, 66-67. doi:10.1016/S1472-9792(02)00057-4

9 Chum, H.J., O'Brien, R.J., Chonde, T.M., Graf, P., Rieder, H.L., 1996. An epidemiological study of tuberculosis and HIV infection in Tanzania, 1991-1993. *AIDS* 10, 299-309



(Source: WHO (2017) Global tuberculosis report 2017)

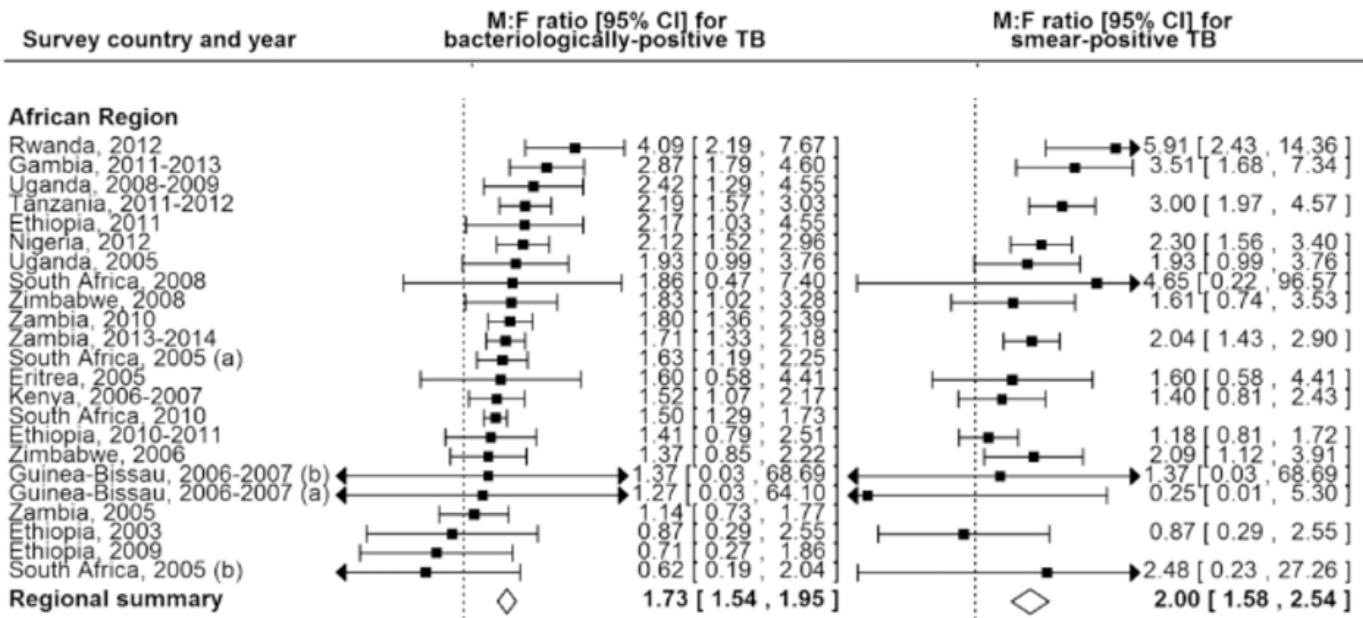
FIGURE 4. COUNTRIES IN THE THREE HIGH-BURDEN COUNTRY LISTS FOR TB, TB/HIV AND MDR-TB BEING USED BY WHO DURING THE PERIOD 2016–2020, AND THEIR AREAS OF OVERLAP.

1.4 TB and gender

Gender issues in health have been treated mostly as being synonymous with women's health. However, it is noted that, for infectious diseases, policy and practice need to be guided by epidemiological data and consideration of transmission dynamics between men and women. TB notification case rates are usually higher in men as compared to women, with strong evidence that men are disadvantaged in seeking and/or accessing TB care in many settings. In a systematic review assessing sex differences in TB burden and case notification had shown M:F prevalence ratios have been shown to be 2.21 (95% CI 1.92–2.54; 56 surveys) for bacteriologically positive TB and 2.51 (95% CI 2.07–3.04; 40 surveys) for smear-positive TB. A summary figure of survey done in Africa region with regional summary of M:F of 1.73 (95% CI 1.54–1.95, 23 surveys) for bacteriologically-positive TB¹⁰. Such findings, informs the global strategies and national TB programmes to recognize men as an underserved high-risk group and improve men's access to diagnostic and screening services to reduce the overall burden of TB more effectively and ensure gender equity in TB care¹¹.

10 Horton KC, MacPherson P, Houben RMGJ, White RG, Corbett EL. Sex Differences in Tuberculosis Burden and Notifications in Low- and Middle-Income Countries: A Systematic Review and Meta-analysis. PLOS Med. 2016 Sep 6;13(9):e1002119.

11 Long NH, Johansson E, Lönnroth K, Eriksson B, Winkvist A, Diwan VK. Longer delays in tuberculosis diagnosis among women in Vietnam. Int J Tuberc Lung Dis. 1999 May 1;3(5):388–93.



(Source: Horton et al, 2016 Sex Differences in Tuberculosis Burden and Notifications in Low- and Middle-Income Countries: A Systematic Review and Meta-analysis)

FIGURE 5. MALE-TO-FEMALE RATIOS IN BACTERIOLOGICALLY POSITIVE AND SMEAR-POSITIVE TB PREVALENCE FOR AFRICA REGION.

Among studies reporting disparities in TB care, women faced greater barriers (financial: 64% versus 36%; physical: 100% versus 0%; stigma: 85% versus 15%; health literacy: 67% versus 33%; and provider-/system-level: 100% versus 0%) and longer delays (presentation to diagnosis: 45% versus 0%) than men¹². The evidence in health-care seeking behavior and ultimate treatment outcomes have been shown in other study findings from different settings. For example, in a study done in India, men had twice the risk of treatment default than females (19% vs. 8%; P <0.01)¹³.

1.5 Gender policies

International, regional and national policies do exist and highlight the human rights issues in the general population and to some specific diseases. Tanzania subscribes to The Universal Declaration of Human Rights (UDHR) drafted by representatives with different legal and cultural backgrounds from all regions of the world, which was proclaimed by the United Nations General Assembly in Paris on 10 December 1948 (General Assembly resolution 217 A). The declaration provides a common standard of achievements for all peoples and all nations.

1.5.1 National frameworks

The frameworks and policies in Tanzania that provide enabling environment to promote human rights, gender equality and social inclusion are here below summarized:

- In 2003, a community based strategic framework for protection of women and children against HIV and AIDS was developed; and a national public campaign to break the silence on the linkages between HIV and AIDS, resources and gender was launched.
- The Constitution of Tanzania (1997, Article 1) and Village and Land Acts (1999) and the Law of Inheritance (1999) in support of women's access to, and control over land to empower women economically and to increase food security and reduce poverty. Though gender sensitive, such laws are rarely being enforced because of customary laws.
- Sexual Offences Special Provisions Act (1998) with special provisions related to sexual and other offences aimed at safeguarding the personal integrity, dignity, liberty and security of women and children.
- Tanzania National Women and Gender Development Policy formulated by the Ministry of Community, Gender and Children (MCDGC) in 2000 to promote

gender equality, diversity and social inclusion.

- Ministry of Health and Social Welfare (2011), National Management Guidelines for the Health Sector Response to and Prevention of GBV.
- The Tanzania National Development Vision 2025 and National Strategy for Growth and Reduction of Poverty (NSGRP) or MKUKUTA (in Swahili), contains specific targets for gender equality, elimination of HIV and gender based violence (GBV) advocating gender mainstreaming in HIV and AIDS programmes.
- Tanzania Commission for AIDS (2016), Gender Operational Plan for HIV response in Tanzania Mainland 2016-2018, Tanzania Commission for AIDS.

1.5.2 Regional frameworks

Tanzania has subscribed to some of the regional framework for gender in HIV rather than TB. However, these frameworks shed light and may be used to drive the development of gender responses in TB. Some of these regional frameworks include:

- African Union Protocol on Human and Peoples Rights and the Rights of Women (Maputo Protocol, 2003) pledging government to review discriminatory laws and amend them to accommodate the rights of women, and enforcement of legislative measures for women's rights in customary courts, to property, inheritance and access to productive resources including land, employment and credit.
- Southern Africa Development Community (SADC, 14 member states) Gender Declaration and its Addendum on the Prevention and Eradication of Violence Against Women and Children to the Southern Africa (1997) and SADC Protocol, which provides for the need for HIV comprehensive testing, treatment and care for survivors of sexual offences in view of the danger of HIV transmission, emergency contraception, access to post exposure prophylaxis, and social/psychological rehabilitation of perpetrators of gender-based violence.
- SADC Gender Policy, gender equality as the fundamental human right and integral part of regional integration, economic growth and social development.
- SADC Gender Mainstreaming Guidelines for HIV and AIDS, Tuberculosis and Malaria.
- SADC Checklists for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS, Tuberculosis and Malaria Programmes.
- Integrating strategies to address gender-based

12 Yang W-T, Gounder CR, Akande T, De Neve J-W, McIntire KN, Chandrasekhar A, et al. Barriers and Delays in Tuberculosis Diagnosis and Treatment Services: Does Gender Matter? *Tuberc Res Treat* [Internet]. 2014 [cited 2017 Oct 22]

13 Balasubramanian R, Garg R, Santha T, Gopi PG, Subramani R, Chandrasekaran V, et al. Gender disparities in tuberculosis: report from a rural DOTS programme in south India. *The International Journal of Tuberculosis and Lung Disease*. 2004 Mar 1;8(3):323–32.

violence and engage men and boys to advance gender equality through National Strategic Plans on HIV and AIDS, Regional Eastern and Southern Africa consultation to strengthen attention to gender-based violence in National HIV and AIDS Plans and other critical policies, Johannesburg, South Africa December 2012. It advocated the access to SRHR to marginalized community, GBV, and involvement of women living with HIV in decision making structures.

1.5.3 International frameworks on gender

Several frameworks, reports and plans that address gender issues in TB and HIV are here below mentioned with their focus.

- Gender and Tuberculosis control: Towards a Strategy for Research and Action (1999) advocate to the TB programmes to minimize gender disparities in access to care and management by re-examining age and sex disaggregated data from past survey, and routine data and design appropriate interventions.
- UNAIDS/Stop TB (2016), Gender assessment tool for national HIV and TB responses: Towards gender-transformative HIV and TB responses.
- UNDP (2015), Discussion paper on Gender and Tuberculosis. Making the investment case for programming that addresses the specific vulnerabilities and needs of both males and females who are affected by or at risk of tuberculosis.
- The Global Fund (2017), Technical brief on Tuberculosis, Gender and Human Rights. The purpose was to assist Global Fund applicants to consider how to include programs to remove human rights and gender-related barriers to tuberculosis (TB) prevention, diagnosis and treatment services within funding requests and to help all stakeholders ensure that TB programs promote and protect human rights and gender equality.
- Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions by WHO (2007).
- Health outcomes are not always equal for people in the world and include within the countries. There are necessary steps to be taken to bridge the gap especially in gender for diseases like TB. Integrating Equity, Gender, Human Rights and Social Determinants into The Work of WHO Roadmap for Action (2014-2019) has three main directions:
 - I. provide guidance on the integration of sustainable approaches, which advance health equity, promote and protect human

rights, are gender-responsive and address social determinants in WHO programmes and institutional mechanisms;

- II. promote disaggregated data analysis and health inequality monitoring;
- III. 3. provide guidance on the integration of sustainable approaches, which advance health equity, promote and protect human rights, are gender-responsive and address social determinants, into WHO's support at country level.

1.6 Gender-based violence in Tanzania

The aim is to increase equity and access to services and the reduction in gender inequalities in providing HIV services and TB services. The NSMF III provides a guide and target of reducing the gender-based violence.

The following are the targets:

1. The Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months reduced to 20% by 2018 (from 40.7% in 2007/08).
2. Decrease in percentage of men and women (aged 15-49) who agree that a husband is justified hitting or beating his wife for specific reasons, from 38% and 54% respectively Tanzania Demographic Health Survey (TDHS 2010) to 30% and 46% respectively by 2018.

The review of the Tanzania Law Society in 2014, noted that the GBV incidents are rampant and occur in various forms in women, children, early marriage, Female Genital Mutilation (FGM), rape, wife beating and abuse of elderly. TDHS Report of 2010 reported about 44% of the ever-married women age 15-49 experienced physical or sexual violence by an intimate partner. Of these, 39% of women had ever experienced physical violence while 20% of women reported having experienced sexual violence

There have been notable changes to the legal reforms social and legal protections of vulnerable groups (women, children and others). The Police Gender and Children's Desk(PGCD) is the initiative to address GBV and is in the Action Plan Recommendations for 2013–2016. PGCDs Action Plan has the following components addressing the GBV plans in Tanzania.

Infrastructure

- A. Establish PGCDs in all police stations in the country
- B. Equip PGCDs to be in compliance with the Standard

Operating Procedures (SOPs) of the Gender and Children's Desks guidelines

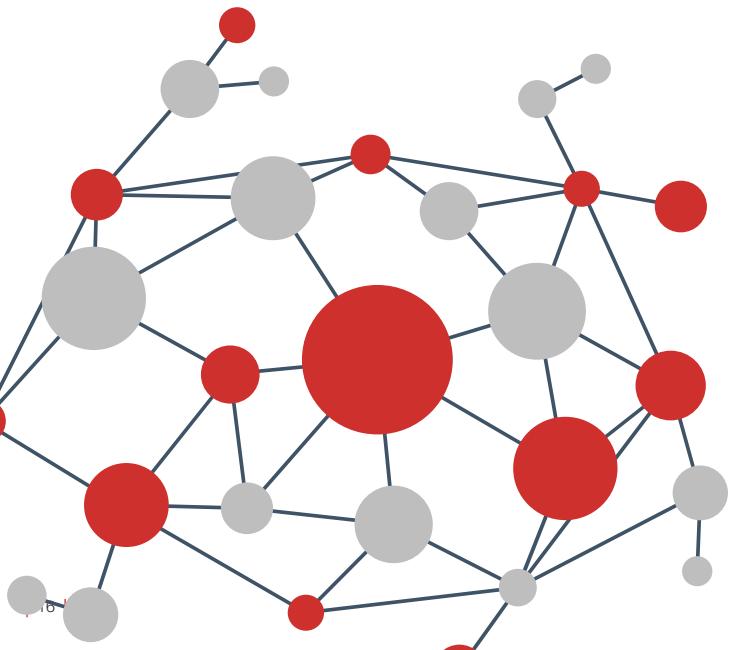
- C. Renovate the existing PGCDs to be in compliance with the Gender and Children's Desks guidelines.

Training and Development

- a) Deliver additional training of trainers to increase the number of trainers beyond the 25 who were trained from the pilot regions
- b) Involve more male police officers in GBV and VAC training at national, regional, and district levels
- c) Conduct more sensitization programs at all levels, including the community level
- d) Strengthen monitoring and evaluation of PGCD activities in the rolled-out regions and districts
- e) Review and update current PGCD training curriculum and tools
- f) Include magistrates, prison officers, social welfare officers, and others in the orientation of law enforcement agencies.

Partnership and Public Awareness

1. Include activities to assess the GBV and VAC interests of partners, such as government ministries, agencies, and departments; community-based organizations; UN agencies; and other development partners and donors
2. Strengthen the existing GBV and VAC partnerships and identify new ones
3. Consider sharing PGCD reports with all partners to increase awareness and promote transparency
4. Engage stakeholders (e.g., community, religious, and political leaders; educators; and legal professionals) to assist in capacity-building and awareness program



2. RATIONALE AND OBJECTIVES

2.1 Rationale of the Gender Assessment

TB thrives in conditions of structural inequity, where the complexities of poverty, social inequity, disempowerment, rights-violations, conflict and patriarchy render communities susceptible to TB and marginalize access to diagnosis, treatment and care. To assess the Tanzanian TB and HIV epidemic context and responses from a gender perspective, will inform the NLTP to design gender-sensitive and gender-transformative interventions to adequately address the TB epidemic in Tanzania as shown in Table 2.

TABLE 2. GENDER INTEGRATION SPECTRUM

TYPE OF INTERVENTION	IMPACT
Gender-negative or gender-blind	Fails to acknowledge the different needs or realities of women and men and transgender people Aggravates or reinforces existing gender inequalities and norms.
Gender-sensitive or gender-responsive	Recognizes the distinct roles and contributions of different people based on their gender; takes these differences into account and attempts to ensure that women, men and transgender people equitably benefit from the intervention.
Gender-transformative	Explicitly seeks to redefine and transform gender norms and relationships to redress existing inequalities.

Source: UNAIDS (2014), UNAIDS/Stop TB Gender Assessment Tool

2.2 Objectives

The main objectives of the Tanzania TB and HIV Gender Assessment were as follows:

- I. To describe the TB and HIV epidemiology with gender consideration in Tanzania.
- II. To assess the extent to which the national TB programmes are gender-responsive.
- III. To document gender-related best practice and lessons learned in TB response.
- IV. To produce recommendations and determine interventions that promote gender.

The guiding principles in undertaking the gender assessment process include:

- engagement of men and boys for gender equality;
- ethical responses based on equity and fairness;
- evidence-informed approach;
- human rights-based approach;
- impartiality;
- meaningful participation of women and girls;
- partnership with civil society, including people living with HIV and/or TB and other key affected populations;
- strategic and forward-looking approach;
- strong and courageous leadership; and
- transparency

(Source: UNAIDS (2014), *Gender assessment tool for national HIV and TB responses*)

3. METHODS

3.1 Stages of TB gender assessment

The TB/HIV gender assessment was conducted under the leadership and coordination of the EANNASO and NTLP. The tool used was adopted from the UNAIDS/Stop TB Gender Assessment Tool¹⁴. The TB and HIV gender assessment tool intends to encourage the TB and responses along the continuum from gender-blind to gender-sensitive, and ultimately to gender-transformative. It makes use of a number of terms common to the HIV, TB and gender responses. The Tanzania TB and HIV gender assessment was purposively focused on TB more than HIV because of the lack of TB gender assessment in Tanzania.

The following steps were followed:

- Stage one “Preparatory Steps”.
- Stage two “Know Your Epidemic” - Knowing your HIV and TB epidemic and country context from a gender perspective whereby demographic and geographic statistics of the two diseases were reviewed and outlined.
- Stage three “Know Your Response” - Knowing your country response from a gender

perspective which entailed exploring using the literature of relevant documents in order to obtain a clearer picture of what is being done to address the two epidemics and how gender is being incorporated into such initiatives and

- Stage four “Using the Findings” – Strengthen TB and HIV response. Here the findings of the assessment were analysed to identify gaps and opportunities and then evidence-based recommendations were made for possible interventions which were then prioritized.

The TB and HIV gender assessment and the utilization of the findings will ensure the gender-transformative responses to be adopted by the NTLP. Table 2 shows the gender integration spectrum as recommended by the UNDP.

3.2 TB and HIV Gender Assessment process and milestones

The preceding activities leading to the country assessment are here below summarized:

3.2.1 Workshop in Bangkok, Thailand

THE MEETING WAS ORGANIZED BY THE STOP TB PARTNERSHIP AIMING AT INTRODUCING THE ON TB/HIV GENDER ASSESSMENT TOOL, THE LEGAL ENVIRONMENT ASSESSMENT (LEA) TOOL AND THE DATA FRAMEWORK FOR ACTION ON KEY, VULNERABLE AND UNDERSERVED POPULATIONS. THE WORKSHOP WAS ATTENDED BY CIVIL SOCIETIES, TB PROGRAMS AND OTHER STAKEHOLDERS FROM SEVEN COUNTRIES NAMELY: BANGLADESH, CAMBODIA, INDIA, KENYA, NIGERIA, TANZANIA AND UKRAINE. THE OBJECTIVES OF THE WORKSHOP WERE TO:

- a. Raise awareness of the key gender issues as they relate to TB.
- b. Train participants on how to conduct a TB/HIV Gender Assessment.
- c. Strengthen capacity to address human rights issues and increase the understanding on how they impact TB programs and people with TB.
- d. Train participants on how to conduct a Legal Environment Assessment.
- e. Develop knowledge of the gaps in TB key population data and provide methods to identify and collect data on key populations.

3.2.2 Sensitization meeting (Workshop 1) in Dar es Salaam, Tanzania

The meeting was organized by NTLP in collaboration with the EANNASO, the coordinating organization. Communities, Rights and Gender TB tools rollout workshop was done in Dar es Salaam inviting the implementers, national programs and civil society including communities affected by TB. The objectives of the workshop were:

- a. To sensitize and provide background information on the three tools including the desk reviews to key national stakeholders.
- b. To develop and agree on the process of collection of data, analysis and report writing
- c. To identify implementation bottlenecks and how to address these issues.

3.2.3 Tanzania TB and HIV gender assessment

Figure 6 summarizes the steps taken to conduct the TB and HIV gender assessment in Tanzania. The description of each of the steps is described below in the subsequent sub-sections.

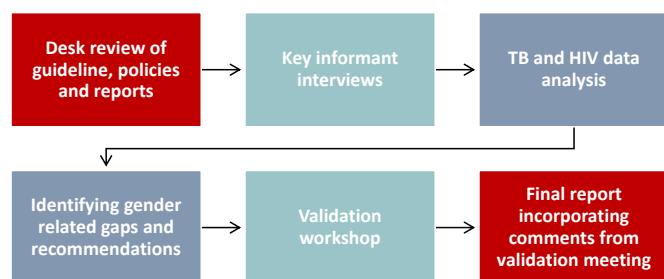


FIGURE 6. SUMMARY OF THE TB AND HIV GENDER ASSESSMENT METHODS

Desk Review

Tanzania has invested in prevention and control of these two epidemics, TB and HIV. The country has adopted international and regional guidelines and policies for control of these two diseases of public health importance. To better understand the country response on TB and HIV, we evaluated the following; policies, strategic plans, reports, published manuscript on peer reviewed journals and reports. The reports came either from the government agencies and programs, development and implementing partners, civil or community organizations. The list of documents reviewed is found in the Appendix 1. The findings of the desk review feed on the several sections of this report and have been referred accordingly.

Key informant interviews

The key informant interviews (KII) were done to add on anecdotal evidence, opinions and reviews of the selected organizations and individuals on the overall TB and HIV responses. The selected organizations were under the guidance of NTLP and included government agencies and programs, development and implementing partners, civil or community organizations. The list of the organization and individuals interviewed in the TB and HIV gender assessment is found in Appendix 2.

TB and HIV data analysis

The routine collected aggregated data were collected from

NTLP. The data included yearly notification data and TB treatment outcomes. The efforts were done to ensure age and sex disaggregated data was collected from NTLP. In addition, we collected data from other organizations to complement data provided by NTLP to further understand the TB and HIV responses in Tanzania.

Data analysis were done using the mixed methods approach:

- Quantitative data analysis: all quantitative data were analyzed using Stata version 14.0 (Stata Corp; Texas, United States of America). In addition, we used Microsoft Excel (Microsoft corporation, Redmond, Washington, United States of America) to draw graphs. Any point estimates were presented with either correspond their inter-quartile ranges or 95% confidence interval wherever appropriate.
- Qualitative data analysis: we summarized the data into thematic areas determined by the consultant to appropriate combine ideas that correctly reflect the TB and HIV responses.

Identifying gender related gaps and recommendations

The gender analysis is central to this assessment that identified gaps and provides recommendations that will support the gender integration to the TB and HIV responses as shown in Table 2. This part of the assessment utilizes the findings from the i) desk review of the policies, guidelines and reports, ii) key informant interviews and iii) data analysis of the TB and HIV data.

Validation workshop

The validation workshop convened stakeholders from Tanzania working in TB and HIV prevention and control. The presented summary of findings from the gender assessment resulted into several comments that warranted additional review and analysis. The following were raised to during the validation workshop in Dodoma between 24th to 25th November 2017. The explanation of the these key points are shown in the Emerging Issues section.

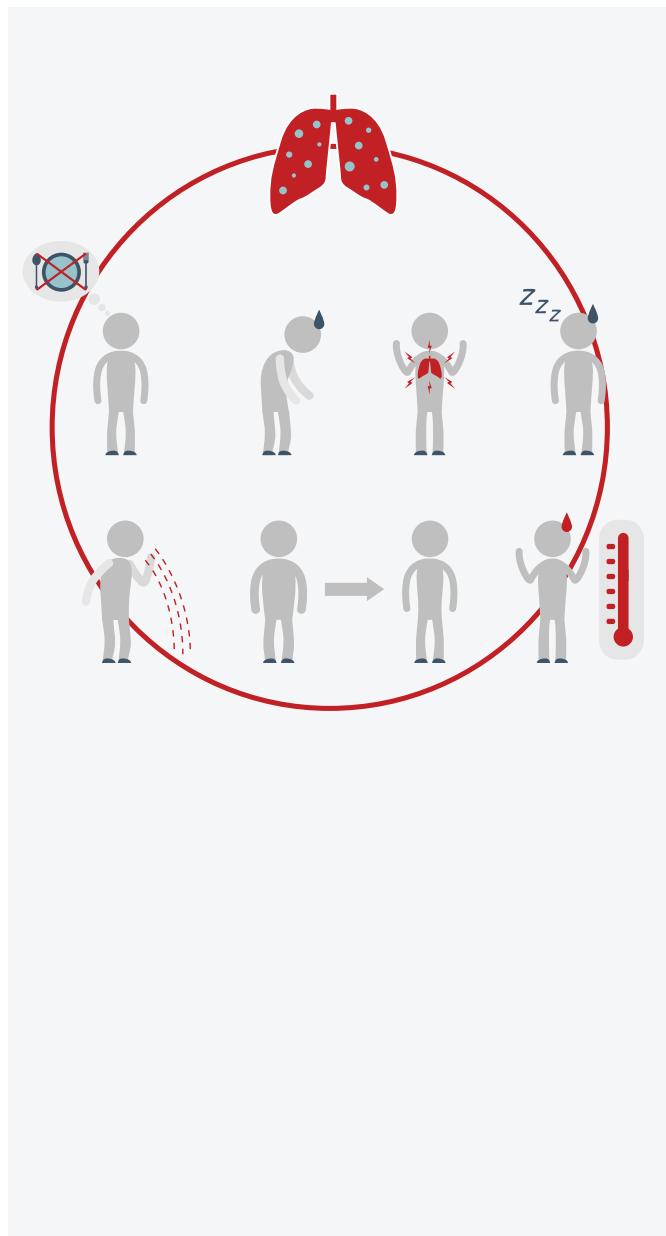
- Vulnerable groups current data collection and best practices.
- TB in prisons especially on MDR-TB patients handling of the uniformed forces.
- Prioritize Gender in the ministry of health.
- TB awareness school programs
- Stigma and discrimination initiatives specifically for TB
- Community organizations partnership frameworks to address the dual burden of TB and HIV.

- Forums to engage community and civil societies in the dialogue of gender mainstreaming in TB responses.
- ACSM strategy amendment to advocate gender and vulnerable groups.

3.3 Limitation of the assessment

The assessment has several limitations which are worthwhile mentioning. However, they do affect significantly the implication of the findings to understanding the gender issues in TB response.

- a. Data are missing for various groups which are segregated by age and sex.
- b. Lack of TB gender mainstreaming programs within the ministry and implementing partners. Therefore, the available information for gender mainstreaming plans are from the HIV responses.



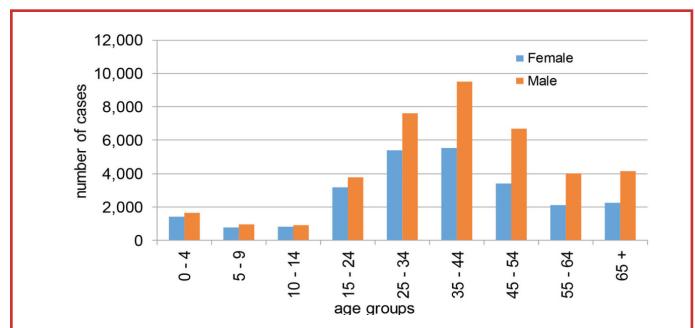
4. SUMMARY OF THE ASSESSMENT FINDINGS

The TB and HIV gender assessment report follows the UNAIDS gender assessment tool. The sub-section of the summary of findings include “Knowing Your HIV and TB Epidemic and Context” and “Knowing Your HIV and TB Response”, emerging issues and summary of recommendation.

4.1 Knowing the national TB epidemic and its surrounding context

4.1.1 Notification of TB, disaggregated by sex, age at national level and by regions

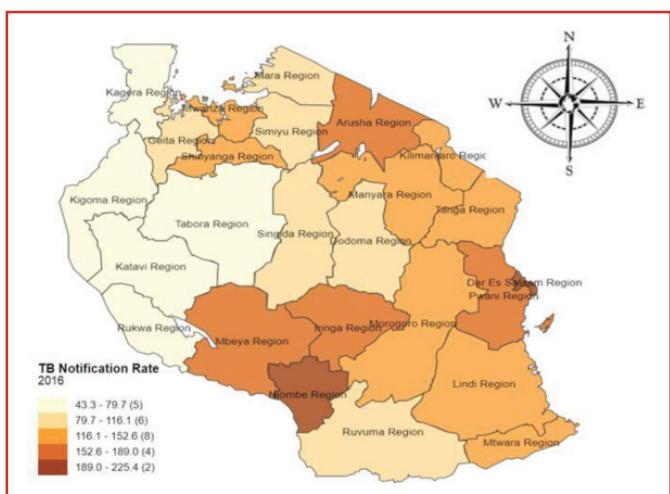
The burden of TB in Tanzania is disproportionately affects the men as compared to women across all the age-groups. In the year 2016, of 65,908 notified TB patients, 39,2017 (61%) cases were males and 24,694 (39%) females with a sex ratio of over 1:1.5. The number of children aged 0–14 years old notified among new and relapse cases were 6,351 (10%)¹⁵. The disease burden is concentrated in the age-groups of 25–34 years and 35–44 years for both males and females as shown in Figure 7.



(Source: NTLP 2016 Annual report)

FIGURE 7. AGE AND SEX DISTRIBUTION OF NEW BACTERIOLOGICALLY CONFIRMED TB CASES NOTIFIED IN 2013

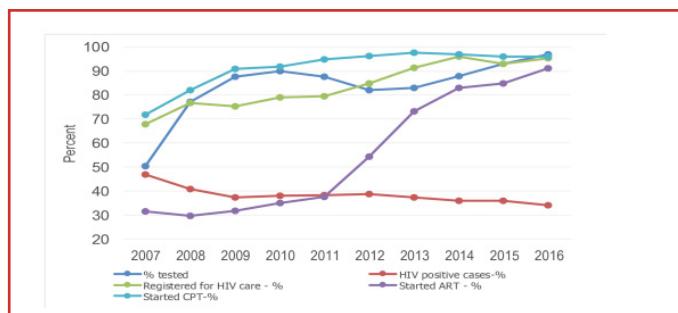
There is uneven distribution of TB burden in Tanzania with seven out of 30 regions contribute to 66% of the TB burden in Tanzania (see Figure 8). Of the seven regions, Dar es Salaam leads in having the highest burden of TB contributing to almost a quarter (22%) of the TB burden in Tanzania in the year 2013 (4).



(Source: NTLP 2016 Annual report)

FIGURE 8. THE MAP OF TANZANIA SHOWING TB NOTIFICATION RATES FOR 2016.

Tanzania has adopted the collaborative TB/HIV services back in 2007 giving both services at a single clinic to embrace a one stop-shop model for TB clinics. HIV testing performance is excellent with 93% of the TB patients are tested for HIV. The cascade of care for TB/HIV patients is good with majority of the patients put on cotrimoxazole preventive therapy and anti-retroviral therapy.



(Source: NTLP 2017 Annual report).

FIGURE 9. TREND OF TB PATIENTS COUNSELLLED AND TESTING FOR HIV, INITIATED CPT AND ART BETWEEN 2007-2016 IN TANZANIA.

4.1.2 Mortality rate from TB disaggregated by sex, age at national level and by regions

Figure 10 shows the overall treatment outcome of TB patients notified in Tanzania in the years 2015. Overall, men have both favourable and unfavourable treatment outcomes. The reason could be by the sheer number of notified TB patients who are mostly men. The proportion of men with treatment outcomes of cured and treatment completed are 64 and 56% respectively. Similarly, death is common to men as compared to women.

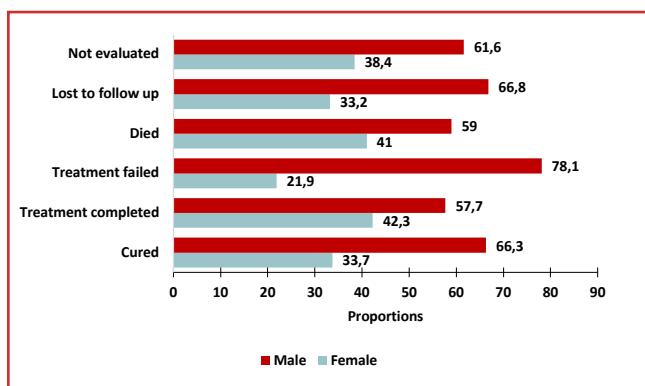


FIGURE 10. THE PROPORTION OF CATEGORIES OF TREATMENT OUTCOME OF NOTIFIED TB PATIENTS IN TANZANIA IN 2011-2012.

4.1.3 Population size estimations been performed for key affected populations?

The Stop TB Partnership has launched a leave no one behind whereby it has launched a focus on key populations which include children, miners, mobile populations, urban populations, prisoners, rural populations and people who use drugs. There is limited data on the size of these populations and quantification of their prevalence of TB and HIV among the key populations.

The UNAIDS has the following estimates for Tanzania with respect to key population HIV prevalence.

4.1.4 Prevalence rate of HIV in key affected populations

No trend of HIV prevalence in Tanzania, it is only now that the population size and HIV prevalence is being done. UNAIDS data and in collaboration with Jhpiego are working towards estimating population sizes of the key and vulnerable populations in HIV programs. However, the data available for key population is not disaggregated by age and sex. Overall, key populations (KPs) are at increased risk for HIV infections, especially injecting drug users (IDUs) because of sharing needles. KPs include Men who have Sex with other Men (MSM), female commercial sex workers (FSW) and also orphans and vulnerable children (OVC) such as street children¹⁶.

The HIV prevalence of some of these KP from the Global AIDS Response Country Progress Report, 2014 are:

- HIV prevalence in IDUs is 16%
- Among Female Sex Workers in Dar es Salaam, HIV prevalence has been reported to be as high as 31.4% (BSS 2010).
- Men who have sex with men: the estimated HIV prevalence is 17.6% as of 2016 UNAIDS estimates.

- Children: there are estimated 10,000 new HIV infections in 2016 and 48% of all HIV-positive children are on ART treatment.

4.1.5 Prevalence of TB in key affected populations of TB?

Key populations are generally most vulnerable to diseases such as HIV and have poor access to the health services either due to economic hardships, or stigma and criminalization. These groups are also at increased risk of developing TB from tuberculosis infection. The quantification of data on TB is still underway for some groups such as miners and IDU. However, the data availability especially disaggregated by age and sex is still a challenge. The following are data of some of the key affected populations.

Children

The diagnosis and management of TB in children is challenging because of the lack of good quality sample especially sputum for small children, to the treatment as there are no friendly drugs. Sputum has been difficult to obtain in younger children, and the country has limited molecular diagnostic facilities. The overall burden of TB in children is lower as compared to the proposed estimates by the WHO of 15%. In Tanzania, the proportion of children as compared to adults has been around 8.7% (5,143) and 8.6% (5,283) in the years 2008 and 2012 respectively. Efforts for active TB case finding is essential in clinical settings where children with HIV receive care have been going on.

Miners

The burden of TB in Tanzania among the miners is largely unknown. There are no available data not on the age and sex distribution of TB burden. In districts with mining activities such as Simanjiro district, it is estimated that 60-70% of TB patients are notified in a year are miners.

4.1.6 Proportion of the population correctly identifies symptoms of TB and where to go for help?

Knowledge on TB symptoms and where to go for treatment are crucial in getting the TB control. Countrywide data are scarce on the knowledge, attitude and practice (KAP) in the general population. However, there are several studies and reports that have assessed KAP on TB. A study done in Iringa had shown only 23.4% of the studied population correctly identified TB symptoms (see Figure 11).

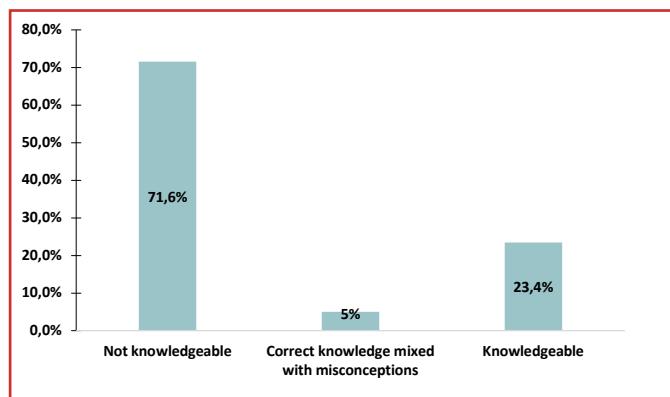


FIGURE 11. KNOWLEDGE OF TB SYMPTOMS AMONG GENERAL POPULATION.

Majority of the interviewed general population in Iringa had indicated that visiting health facility (79.4%) was the first place they would go after getting having TB symptoms. To note, people would also go to the drug store (15.5%) after feeling TB symptoms (see Figure 12).

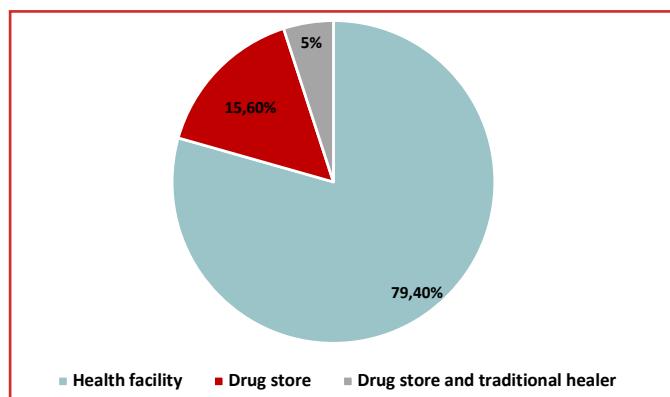


FIGURE 12. DISTRIBUTION OF GENERAL POPULATION WHERE THEY SOUGHT TREATMENT AFTER HAVING TB SYMPTOMS.

4.1.7 HIV prevention to reduce risk of HIV transmission

Table 3 HIV preventions activities are core to halting and control the epidemic of HIV in Tanzania. in the age group of 15-24, 43% of the people were knowledgeable about HIV prevention methods. Condom use is slightly higher in men (60.2%) as compared to women (50.7%)¹⁷.

TABLE 3. HIV PREVENTION ACTIVITIES PERFORMANCE IN 2016

ACTIVITY	PERCENTAGE (%)
Knowledge of HIV prevention among young people (15-24)	43.4%

¹⁷ <http://www.unaids.org/en/regionscountries/countries/unitedrepublicoftanzania>, accessed on 11th November 2017.

Condom use at last higher-risk sex (with a non-marital, non-cohabiting partner)	
Male	60.2%
Female	50.7%
Women aged 15-49 who have their demand for family planning satisfied with modern methods	55.1%
Men aged 15-49 who are circumcised	80.3%
Male circumcision performed according to national standards (2016)	548,390

The factors contributing to condom use are diverse across many regions in Tanzania. A summarized version of the decision-making in most matters in the African setting, belongs to men include sex. Such gender inequalities in the region make, especially for decision making in sex, make it more difficult for African women to negotiate condom use. gender roles in many cultures, Furthermore, sexual violence often times leads to tissues damage, increase the risk of HIV transmission. Figure 13 highlights some of the factors influencing the dynamics of decision making in marital relationship.

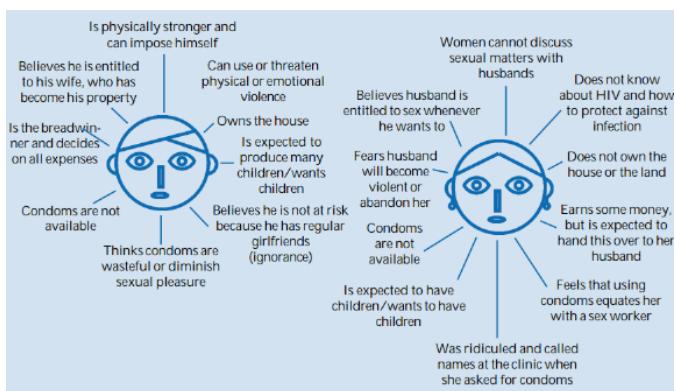


FIGURE 13. FACTORS INFLUENCING THE POWER TO DECIDE ON CONDOM USE IN A MARTIAL RELATIONSHIP.

4.1.8 Understanding relationship between TB and HIV

The general population has been exposed to health promotional messages on TB and HIV. For instance, a recently done study in Zanzibar on KAP on TB has shown more than two thirds (86.6%) of study participants reported that yes HIV positive patients should be concerned about TB. Also, more than half (51.2%) of study participants reported that HIV positive patients should be concerned about TB because they are likely to develop it. As regards to HIV testing for TB patients, majority (85.8%) of study participants responded that TB patients should be tested for HIV. Almost half (46.5%) of study participants reported that it is important for TB patients to test for HIV because TB patients are more likely to have HIV. However, there is no data showing trends of the knowledge of relationship between TB and HIV done in Tanzania.

4.2 Data on intimate partner violence

Tanzania DHS and MIS survey of 2015-2016 report the status of Intimate Partner Violence (IPV). Worth to note is, there has been no change in women's experience of either physical violence or emotional violence since the 2010 TDHS. Tanzania mainland has much higher prevalence of partner violence as compared to Zanzibar.

However, the data is not disaggregated by neither age nor sex.

- **Experience of violence from anyone:** Forty percent of women age 15-49 have ever experienced physical violence, and 17% have ever experienced sexual violence. Although experience of violence is higher among married women, particularly formerly married women, 16% of never-married women have also ever experienced physical violence and 9% have ever experienced sexual violence.
- **Marital control:** Nearly three quarters of ever-married women experienced marital control by their husbands/partners, including 29% whose husband/partner demonstrated at least three of the five specified behaviours.
- **Spousal violence:** Half of all ever-married women have ever experienced spousal violence, most commonly physical violence (39%) and emotional violence (36%); 14% have experienced sexual violence.
- **Injuries due to spousal violence:** Seven in 10 ever married women who experienced spousal violence suffered injuries, usually cuts, bruises, or aches; notably, however, 15% also reported deep wounds, broken bones or teeth, and other serious injuries.
- **Help seeking:** More than half of women (54%) who have experienced physical or sexual violence have sought help. While most women seek help from their families, 9% have sought help from the police.

4.3 Data on stigma and discrimination within the health care system against people living with HIV, with TB, HIV/TB, or DR-TB.

Stigma and discrimination are rampant in practice for both TB and HIV. However, over the years, HIV has received attention and assessment have been done on HIV levels for stigma and discrimination. The National Council of People Living with HIV And AIDS (NACOPHA) in Tanzania conducted a cross sectional study using the PLHIV Stigma Index Survey Questionnaire to conduct interviews, following the accompanying methodology, available at www.stigmaindex.org. Summary of the findings of the assessment in stigma and discrimination are shown below:

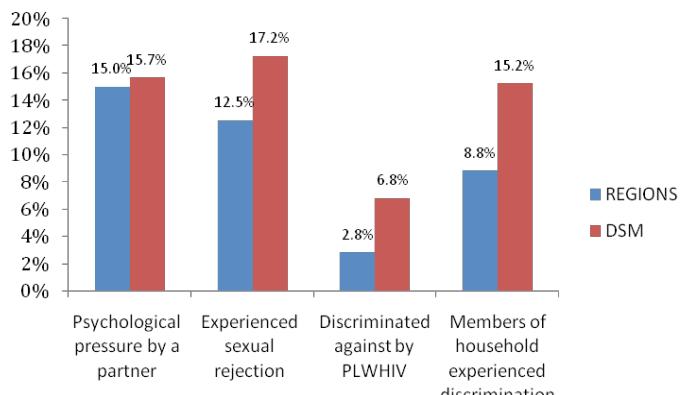
Stigmatization

The levels of stigmatization were compared between Dar es Salaam and other regions in Tanzania. Overall, Dar es Salaam indicated higher levels of stigma of 49.7% as compared to 39.4% from other regions. Women were more likely to be gossiped as compared to men. The reason for perpetuating stigma was that, people have feared of getting infected due to lack of knowledge and misconception on how HIV is transmitted.



Discrimination

The effect of discrimination in are vast and include sexual rejection (17.2%), psychological pressure by husband/wife/partner (15.7%) and discrimination from members of household (15%) as shown in



(Source: NACOPHA (013), The People Living with HIV Stigma Index Report Tanzania)

FIGURE 14. EFFECTS OF STIGMA AND DISCRIMINATION AS EXPERIENCED BY PLHIV BY REGIONS



The consequences of stigma and discrimination included low self-esteem, blamed themselves and felt ashamed, decided not to have (more) children, decided not to have sex, chose not to attend special gathering, and not to get married; afraid of being gossiped, and also were afraid that someone would not want to be sexually intimate with them.

4.4 Monitoring and evaluation (M&E) systems

The Monitoring and evaluations (M&E) systems of Tanzania for TB are implemented and available from the health facility levels. The recording and reporting tools are mostly paper-based and in some areas, are complemented by an electronic data capturing tools ERT.NET. The unit and district unit registers capture the age, sex, HIV status in the demographics. The further other parameters such as place of work, incarceration, pregnancy status, and further clarification to capture the key vulnerable populations grouping are not done.



5. GENDER EQUALITY IN HIV, TB POLICIES AND PROGRAMS

5.1 THE OVERALL HIV/TB RESPONSE

5.1.1 Populations addressed in the HIV and TB national response.

TB responses

The national TB responses are addressed in the National Strategic Plan V for Tuberculosis and Leprosy Programme 2015-2020. The development of the strategic plan was guided by the Third Health Sector Strategic Plan July 2008 - June 2015 (HSSP III) and the mid-term review results. The plan is closely linked with Health Sector HIV and AIDS Strategic III (HSHSP III) for TB/HIV interventions and NMSF III 2013-2017.

The vision, mission and goal of the plan are:

- **Vision:** Tanzania free of Tuberculosis and Leprosy
 - zero deaths, disease and suffering due to tuberculosis and leprosy.
- **Mission:** Provision of high-quality TB and Leprosy interventions with a focus on universal access, equity, gender, and those most at risk through effective and sustainable collaboration with partners and stakeholders at all levels.
- **Goal:** To reduce the tuberculosis epidemic and burden and Leprosy disabilities in Tanzania by 2020.

The specific populations addressed in the NTLP strategic plan include:

- Children
- TB in mining populations
- Elderly population
- Prisoners
- IDU

However, the population estimates for such sub-populations is not available and any available data is not likely to be disaggregated by age and sex. The TB reports are aggregated at the national level with no specific mention of the sub-population such as the vulnerable groups.

HIV responses

Meanwhile in HIV responses which are addressing gender, there are a number of policies, plans and frameworks addressing gender issues and provide gender transformative HIV/AIDS responses in Tanzania. Some of these documents are here below mentioned.



Populations and addressed in the HIV policies and guidelines includes:

- Vulnerable Children that include orphans and street children
- Women and Men
- Men who have sex with men
- Female Sex Workers (FSW) Mobile or migrant workers
- PWID
- Prisoners
- Fishermen

- The National HIV and AIDS Policy 2001
- The Tanzania Commission for AIDS Act 2001
- National First 2003-2007, Second 2008-2012 and Third 2013-2018 Multi-Sectoral Strategic Frameworks on HIV and AIDS
- National Guidelines for the Clinical Management of HIV and AIDS (2007)
- The HIV and AIDS (Prevention and Control Act), 2008
- The Health Sector HIV and AIDS Strategic Plan II (HSHSP) 2008-2012
- Health Sector Strategic Plan III July 2009-June 2015
- Gender Operational Plan for HIV response in Tanzania Mainland 2016-2018, Tanzania Commission for AIDS.

5.1.2 Gender issues in TB response in specific issues

The NTLP strategic plan has noted equality to be the basis of the delivery of the services to the general population in controlling TB. However, there are no specific issues on gender as highlighted below that TB program has specifically mentioned.

TABLE 4. COMPARISON OF TB AND HIV RESPONSES ON GENDER ISSUES.

ISSUES	TB PROGRAMS	HIV RESPONSES
Early and forced marriage	No	Yes
Access to health care services barriers to care-seeking based on religious or cultural beliefs and traditions	No	Yes
Barriers to care-seeking based on religious or cultural beliefs and traditions	No	Yes
Incarceration	No	
Forced displacement, internal or international migration for work	No	Yes
Occupational risks (e.g. mining)	Yes	Yes
Disabilities	No	Yes
Race, ethnicity, indigenous status	No	Yes
Rural/urban specificities	No	Yes
Socio-economic status	Yes	Yes
Smoking and alcohol abuse	Yes	Yes

5.1.3 TB response sources of funding

The TB program is heavily dependent on external resources, and has managed to raise about US \$ 17 million consistently from 2009-2013. TB activities are funded mostly by the

Germany Leprosy and Tuberculosis Relief Association (DAHW/GLRA), World Health Organization (WHO), The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), Centre for Disease Control (CDC) United State Agency for International Development (USAID), Novartis Foundation (NF), Global Drug Facility (GDF), ITECH, International Organisation for Migrant (IOM) and The Netherlands Tuberculosis Foundation (KNCV), through Challenge TB project. Figure 15 shows the total budget funds for TB activities between 2009-2013. Something worth noting is domestic funding contributes a smaller proportion of the overall budget, and a significant proportion remains unfunded over the years. However, the contributions are not further separated into the civil societies or private sector.

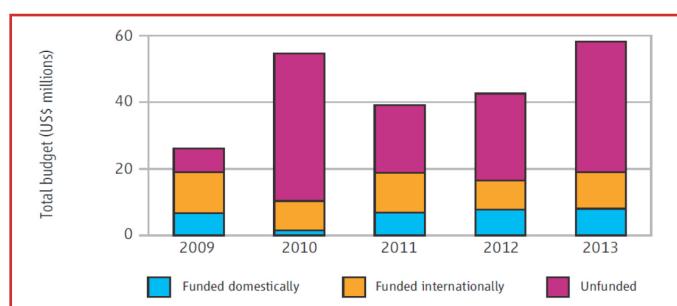


FIGURE 15. TANZANIA'S FUNDING FOR TB CONTROL AS REPORTED BY NTLP

5.1.4 TB investment case

TB funding is key to address the current interventions and new interventions that may come up in the future. For instance, for gender and TB will have financial implications to the overall budget of NTLP. The expected changes will include, but not limited to, new policies and guidelines, training of health care workers, and recording and reporting tools. It is therefore envisioned to consider other means of increasing domestic funding to address the TB epidemic in the country, and reduce the donor dependence. These funding mechanisms should also address the unfunded needs of the TB program as seen in the Figure 15. The following are proposed which have been done in HIV so as to increase funding for TB control programs.

- **TB investment case:** a thorough analysis of the funding trends of NTLP for programs funded and new interventions should be considered.
- **Trust fund:** HIV trust fund aims at soliciting the domestic fund to fund the HIV program. Similar efforts are encouraged to TB program to reduce the funding gap.



Factors hindering community participation include

- lack of awareness on the Comprehensive Council Health Plan (CCHP) among Health Facility Governing Committees (HFGC) members,
- poor communication and information sharing between Council Health Management Teams and HFGC,
- unstipulated roles and responsibilities of HFGC, lack of management capacity among HFGC members

5.1.5 System of accountability for the TB response spending

The TB program accountability of its spending is done by the government including the civil societies. For now, several organizations are working to ensure the government spending is correct and efficient at the district level. The organization like Sikika

, are actively being involved in assessing the spending in health sector as a whole rather than TB programs or gender programs activities. Sikika monitors the expenditure by i) reviewing the MoHCDGEC and Ministry of Finance and Planning reports, ii) dialogues with Members of Parliament (MP), and iii) Parliamentary Budget Committee. The use of Social Accountability Monitoring (SAM) ensures involvement of the community in assessing the expenditures of the allocated budget for various programs including the TB programs. SAM focused on availability of health commodities, human resources for health, health governance, finance systems and structures, health infrastructures, and amenities

There are several factors to that are contributing to the hindrance of the communities to participate in the planning of the council health plans. The factors include lack of awareness and poor understanding the roles in monitoring health expenditures in the districts¹⁸.



On the left, SAM team members during facilities' visit in Kondoa district, on the right. SAM team members conducting an analysis of SAM documents in Kilolo district.

FIGURE 16. PICTURES OF THE SAM ACTIVITIES DONE BY SIKIKA.

6. A COMPREHENSIVE TB RESPONSE

6.1 TB prevention, diagnosis and treatment services

TB and HIV services are provided by both private and public sector. The basic services are provided at no cost at all levels of the health care system. The government covers such costs through either domestic or external funding sources. The following services are including HIV services are provided under the collaborative TB/HIV services.

TABLE 5. HIV AND TB PREVENTIONS, DIAGNOSTIC AND TREATMENT SERVICES

SERVICES	DESCRIPTION OF THE SERVICES
Access to information about HIV and TB prevention, diagnosis, care and support	Provided by NACP, NTLP, CSO, FBO and other implementing partners.
BCG vaccination	Given to all infants on day 0 in all health facilities
INH prophylaxis for people living with HIV and people with latent TB infection	Given at care and treatment clinics (CTC)
Access to free TB diagnostic services including sputum induction or gastric lavage, chest x-ray, and GeneXpert	Provided at all levels for public and private health facilities.
TB contact tracing and treatment	Done by community health care workers and former TB patients groups.
Access to TB treatment support	TB treatment is provided for free equally to men and women.
HIV testing	Done to all TB patients as an opt out approach (provider initiated testing and counseling)
Behaviour change communication	Available at health facilities, and messages given at the radio and television stations
Peer education	Formed peer groups for adolescents and adults for both HIV and TB. Peer education is also by gender in expert mothers (HIV positive at ANC)
Condoms (male and female)	Male condoms are common, but also female condoms are available.
Antiretroviral treatment as prevention	Free of charge given at all CTC
Co-trimoxazole prophylaxis	Given to all TB and HIV co-infected patients.
Drug use harm reduction measures	Methadone clinics have been established in selected districts.
Male circumcision	Done at early age at the hospital, and also being implemented as programs by several implementing partners such as Jhpiego.
PMTCT	Given to all expecting mothers in most of the health facilities. Male involvement
Voluntary testing and counselling services	Available in both public and private health clinics.

6.2 Gender-related impediments to accessing and using prevention services.

TB gender-related issues have not been well studied. However, the communities affected by TB are often times having HIV. Therefore, the presented gender-related issues are from Gender Assessment of The National HIV/AIDS Response in Tanzania Mainland¹⁹. There are several cultural norms and practices that continues to sustain gender inequality and contribute to driving HIV incidences among men and women. Some of these are highlighted below:

1. GBV: is more for women and girls and exhibited forced sexual intercourse through rape. The result potential of HIV infection and transmission is high in such cases especially when knowledge and access to post exposure prophylaxis is low among the general population.
2. Social factors and new civilizations: sexual practices between same sex, commercialization of sex and the use of drugs through injections and sharing of needles contribute to increasing HIV transmission. These mentioned activities are illegal, and hence they are marginalized and may have no poorer access to important preventive services for both TB and HIV.
3. Poverty: women are economically disadvantaged and are prone to engage in risk behaviors and vulnerable to be introduced to commercial sex. Because of that, the decision to use condoms in such circumstances is impaired.
4. IPV:Male control: male tend to exert power on women on deciding the use of condoms, and access to health services.

6.3 Gender-based violence (GBV)

TB responses lag behind the HIV responses in addressing gender-based violence. The link between gender-based violence and HIV has been established. Several reports in Tanzania have addressed the issue of gender-based violence such as i) Addressing the links between gender-based violence and HIV in the Great Lakes region²⁰. The TB program does not have the any gender-based policy or guidelines.

7. EMERGING ISSUES

The following issues have been raised either during the conduction of KII with stakeholders or personal communication, or during the validation meeting. They present best practices in gender programming or reaching out to the vulnerable populations.

7.1 USAID Boresha Afya

Deloitte Tanzania in partnership with FHI360, Engender Health and Management and Development for Health (MDH) is responsible for implementing a five-year (2016 to 2021) program USAID Boresha Afya Program. USAID Boresha Afya is a five-year program funded by the American People through USAID supporting the GoT to increase access to high quality, comprehensive and integrated health services, especially for women and youth, with a focus on maternal, neonatal, child and reproductive health and nutrition outcomes. Emphasis is on comprehensive and integrated health service delivery for preventative and curative services with regard to HIV/AIDS, Family Planning (FP), Tuberculosis (TB), Malaria, Nutrition and Maternal and Child Health (MCH).

- The program guiding principles is the MOHCDGEC National GBV Policies and Guidelines which guides the Gender programming. They include National Gender policy 2002, National Gender strategy 2002, National Management Guidelines for Health Sector Response to and prevention of Gender Based Violence, Gender Operational plan for HIV Response in Tanzania mainland 2016-2018, GBV and VAC for Healthcare Providers and Social Welfare Officers; JOB AIDS etc. Our program is designed to contribute to the National GBV program, implemented by various IPs and coordinated by the ministry. USAID Boresha Afya is selected because of addressing gender in the TB programming which is a cross-cutting issue.

7.2 Community organizations

The CSO and CBO are crucial in implementing the gender related issues at the community levels where changes to the cultural norms and practice will have impact in the overall control of TB. We present a potential collaboration of the two organizations, National Council of People Living with HIV And AIDS (NACOPHA, HIV-based organizations²¹) and MUKIKUTE²² (Former TB patients) that have developed a framework to work together to address the dual burden of TB and HIV. The main objective of the framework between these two organizations is to “bring together the two TB and HIV affected communities for integration of TB and HIV service provision at community level”.

¹⁹ Tanzania Commission for AIDS (2015), Gender Assessment of The National HIV/AIDS Response in Tanzania Mainland.

²⁰ UNESCO (Addressing the links between gender-based violence and HIV in the Great Lakes region

²¹ NACOPHA, www.nacopha.or.tz/

²² MUKIKUTE, <http://www.mukikute.org/>

Validation meeting

There are several issues that were raised in the validation meeting are here below summarized:

Vulnerable groups

- Data is collected by implementing partners and the NTLP but not in a formal data collection system. For instance, NTLP has unit registers in Methadone clinics to notify TB cases from the IDU. However, during district data compilation, the specifics of these vulnerable groups are not evident in the reports that are submitted to the regions and thereafter to NTLP.
- DOT nurse is at Methadone clinic to provide DOT for IDU. They also have unit register available to capture TB data.
- The MOHCDGEC collects data through DHIS2. The current systems only collected aggregated district data. The new developments include adding individualized data of all TB patients, making it possible to further categorize patients into corresponding vulnerable groups.
- Community registers implemented by Challenge TB (KNCV/PATH) can capture some information for vulnerable groups. Currently implemented in 21 districts and to be rolled out to 47 districts.
 - DTLC will assign TB district numbers to the all TB patients registered in the community registers.
 - Quarterly screening of TB done by the community volunteers
 - Explore pastoralists as vulnerable groups.
 - The identification of vulnerable groups will be given in the data framework for vulnerable population session.
 - Use social welfare to get access to the vulnerable groups as they live in the communities they serve. Law is proposed to help formalize their roles and responsibility in health.

TB in prisons

- Experience from Temeke, all those prisoners and reprimands are screened for TB at entry.
- All diagnosed with TB are treated.
- However, for those that are on TB and are released, default treatment for the fear to be arrested by the police.
- Contributed by gaps in the justice and laws that

police do not follow.

- MDR-TB or even TB cases are arrested at times, and are reprimanded without cause and given little access to treatment.
- Institutional change to understand gender and TB issues and their role in management of TB.

Prioritize Gender in the ministry of health

- Government has to identify and prioritize gender to build political commitment. Escalate the gender issue from NTLP, Director of Preventive, PS and Minister.
- Funding exploration to USAID, DFID after the government political commitment.

TB awareness

- TB awareness programmes in schools.
- Symptomatic TB screening of students at schools.

Stigma and discrimination

- KNCV is organizing CSO to do a Stigma Index in TB.
- Countries involved will be known at a later date.

Community organizations

- NACOPHA and MKUTA have developed a framework to work together to address the dual burden of TB and HIV.
- They luck the guiding principles and guidelines to jointly work together especially on gender issues.

Forums

- TB community forums to that can be used to drive the gender issues in TB.
- Stop TB Partnership Tanzania could as well be an important

Patient views and issues with regards to gender

- No patients were involved in this assessment.
- Follow-up assessment will be done on gender issues, GBV, IPV and etc.

ACSM strategy

- Can be amended to include issues such as gender, vulnerable populations

8. GAP ANALYSIS

8.1 Epidemiological context

The TB data of patients notified in Tanzania has the following gaps with respect to the gender issues.

- **Registers:** the unit and district registers record patient's age and sex, but lacks the data on the occupation and if TB patients belong to a certain vulnerable group. The provision such a variable will help to estimate the contribution of these vulnerable populations into the TB burden.
- **Report:** the reports are aggregated and do not include do not capture the vulnerable population.
- **Population estimates and TB burden vulnerable groups:** the vulnerable populations in TB such as miners, IDU, health care workers do not have age and sex disaggregated data. The current recording and reporting tools do not capture the vulnerable populations.
- **Uncollected vulnerable groups data:** several implementing partners including the NTLP do collect the data especially on HIV and TB burden. These are only done as disjointed initiatives by NTLP and other implementing partners. For instance, several districts with Methadone clinics, have placed unit registers to record IDU who get TB. However, such data does not get recorded in the district registers. Therefore, such data gets lost when the district and region reports are compiled.
- **Knowledge, attitude and Practice:** there is no national data summarizing the knowledge of TB symptoms, prevention and transmission segregated by age, sex and geographical location.

8.2 TB policies and plans

- **Gender policy:** there is no TB and gender policy that is existing in Tanzania.
- **Gender-based violence:** TB programs has neither the gender-based violence policy nor any assessment of the links between TB and gender-based violence.
- **Operational plans:** the TB program lacks the gender operational plans for TB responses.
- **Advocacy, Communication and Social Mobilization:** NTLP has the ACSM strategy but it has lacked to address and gender issues in TB programming and responses.
- **Sexual and reproductive health rights:** no policy that recognize and address the linkages between HIV and TB.

8.3 TB responses

- **Gender analysis in TB control:** there is lack of understanding the impact of gender-related impediments like stigma, discrimination, gender-based violence, gender imbalances on the TB control in Tanzania.
- **Compensation for the providers:** the health care workers as one of the vulnerable groups have no clearly defined compensation mechanism once they develop TB disease.
- **Attitudes of public service providers:** TB program has not provision and response which may include information, education and communication (IEC) materials, of the public service providers such as health care workers and policy officers on TB.
- **Partnerships to address gender-based violence:** there are no partnerships that are specific to address gender-based violence against women, children and adolescents. The current efforts to address gender-based violence are from the HIV program.
- **Key populations:** the strategic plan addresses fewer key populations such as children, IDU, miners and prisoners. The need to include other key populations like health care workers, urban poor, mobile populations will be key to reduce the inequities and control TB.
- **Community:** community response should be strengthened in introducing gender-responsive or gender-transformative interventions.



9. KEY RECOMMENDATIONS

The key recommendations are in line with the gaps found from the epidemiological context, policies and responses. A detailed matrix of the gaps and recommendation:

9.1 Epidemiological context addressing gender equity in TB programmes

- **Strategic information in TB:** ensure all data on TB using the NTLP recording and reporting tools to have age and sex disaggregated data to understand gender dynamics and institute appropriate responses.
- **Vulnerable groups:** provide a standardized reporting tool to private sectors and implementing partners to collect vulnerable populations.
- **Operational research:** to conduct operational research to i) address gender-related issues such as gender-based violence and TB, ii) estimate the population size of the vulnerable groups and TB burden with a gender-perspective, iii) determine gender-responsive interventions and evaluate their impact on reducing the TB burden in the country.

9.2 Socio-cultural response in TB programme

- **Stigma and discrimination:** to conduct Stigma Index study to assess to understand the stigma and discrimination in dimension in TB control. Stigma reduction programmes should be implemented in TB responses and much can be learned from the HIV responses in Tanzania and elsewhere.
- **Gender-based violence:** promote understanding and responding to gender-based violence among TB patients and their families. PGCDs should also include and follow-up on GBV happening among TB patients and properly recorded.

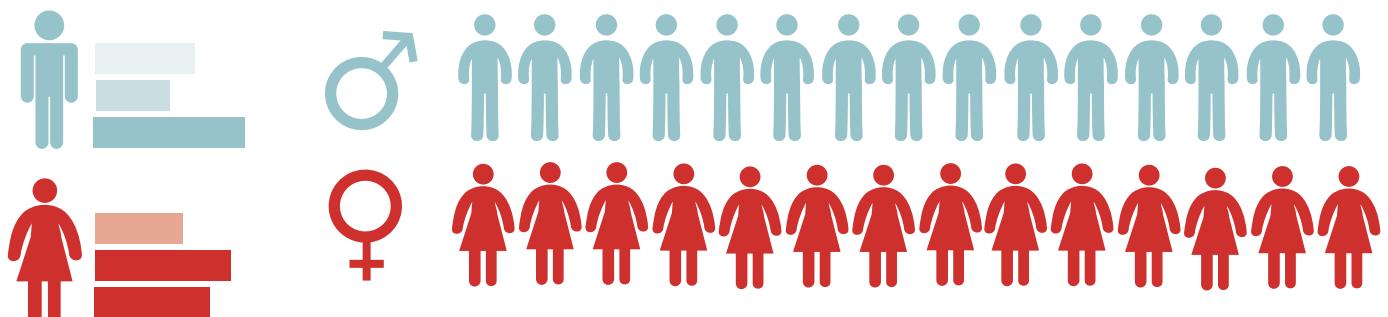
9.3 Policies, coordination and responses

- **Policies:** the NTLP should develop gender-transformative policies and plans to address the gender-related issues in the TB epidemiology and TB responses.
- **Coordination of gender responses:** NTLP to be involved in the coordinating forums and Technical Working Groups (TWG) on gender to drive the gender-related agenda on TB to the national policies and guidelines.
- **Civil societies:** identify CSO and assign their roles in the promoting gender equity in TB responses at the community level. Capitalize on the experience of HIV-centered CSO to build capacity to CSO working on TB.
- **ACSM:** the ACSM strategy of NTLP should be amended to include gender-related issues. It should also be given to the implementing partners so that they get a buy in and implementing key gender-related issues.

APPENDIX 1. LIST OF DOCUMENTS REVIEWED.

Tanzania documents/reports/policies reviewed during the TB gender assessment in Tanzania.

- Manual for the Management of Tuberculosis and Leprosy, National TB and Leprosy Programme, Sixth Edition
- Operational Guidelines for the Management of Drug Resistant – TB in Tanzania, First Edition, 2010
- National Guidelines for the Management of Tuberculosis in Children, National TB and Leprosy Programme, First Edition, 2012
- Implementation Framework for Expanded Decentralization of MDR TB Services in Tanzania, 2015
- National Operational Guidelines for community TB, TB/HIV and DR TB Interventions, 2016
- Annual TB Reports of the National TB and Leprosy Programme from 2000-2015
- Quality Improvement for TB case detection: A toolkit for health facilities
- Health Sector Strategic Plan 2015-2020
- National Strategic Plan for TB and Leprosy (2016-2020)
- National Policy Guideline for Collaborative TB/HIV activities, 2016
- Implementation of HIV/AIDS Care and Treatment Services in Tanzania – NACP (Report no. 4, 2016)
- Tanzania Demographic and Health Survey
- Current National TB Prevalence Survey report
- Manual for the Management of Tuberculosis and Leprosy, National TB and Leprosy Programme, Sixth Edition
- Operational Guidelines for the Management of Drug Resistant – TB in Tanzania, First Edition, 2010
- National Guidelines for the Management of Tuberculosis in Children, National TB and Leprosy Programme, First Edition, 2012
- Implementation Framework for Expanded Decentralization of MDR TB Services in Tanzania, 2015
- National Operational Guidelines for community TB, TB/HIV and DR TB Interventions, 2016
- Annual TB Reports of the National TB and Leprosy Programme from 2000-2015
- Quality Improvement for TB case detection: A toolkit for health facilities
- Health Sector Strategic Plan 2015-2020
- National Strategic Plan for TB and Leprosy (2016-2020)
- National Policy Guideline for Collaborative TB/HIV activities, 2016
- Tanzania Demographic and Health Survey (2015-16) – Key indicator report
- UNAIDS Tanzania HIV Investment Case Reference Report November 2016.
- Tanzania HIV Indicator Survey 2016-2017



Gender and TB Research papers

- Balasubramanian R, Garg R, Santha T, Gopi PG, Subramani R, Chandrasekaran V, et al. Gender disparities in tuberculosis: report from a rural DOTS programme in south India. *The International Journal of Tuberculosis and Lung Disease.* 2004 Mar 1;8(3):323–32.
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- Borgdorff MW, Nagelkerke NJD, Dye C, Nunn P. Gender and tuberculosis: a comparison of prevalence surveys with notification data to explore sex differences in case detection. *The International Journal of Tuberculosis and Lung Disease.* 2000 Feb 1;4(2):123–32.
- Holmes CB, Hausler H, Nunn P. A review of sex differences in the epidemiology of tuberculosis. *The International Journal of Tuberculosis and Lung Disease.* 1998 Feb 1;2(2):96–104.
- Horton KC, MacPherson P, Houben RMGJ, White RG, Corbett EL. Sex Differences in Tuberculosis Burden and Notifications in Low- and Middle-Income Countries: A Systematic Review and Meta-analysis. *PLOS Medicine.* 2016 Sep 6;13(9):e1002119.

Gender-based violence

- AIDSTAR-One. Resources for the clinical management of children and adolescents who have experienced sexual violence.
- AIDSTAR-Two. Technical paper: Review of training and programming resources on gender based violence against key populations.
- UNAIDS. Unite with women Unite against violence and HIV. <http://www.unaids.org/en/resources/documents/2014/name,91776,en.asp>
- UN Women. Virtual knowledge centre to end violence against women and girls.
- WHO. Responding to intimate partner violence and sexual violence against women: WHO Clinical and policy guidelines.

Gender mainstreaming tools

- PEPFAR. Updated gender equality strategy (2013).
- UNDP. On course: Mainstreaming gender into national HIV strategies and plans—a roadmap. <http://livelifeslowly.net/genderinghiv/>
- UNDP. Checklist for integrating gender into the New Funding Model of the Global Fund to Fight AIDS, TB and Malaria.
- SADC Gender Mainstreaming Guidelines for HIV and AIDS, Tuberculosis and Malaria.
- SADC Checklists for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS, Tuberculosis and Malaria Programmes

Gender and HIV

- UNAIDS. Agenda for accelerated country action for women, girls, gender equality and HIV.
- UNFPA. The gender dimensions of the HIV/AIDS epidemic.
- UN Women Gender and HIV/AIDS. Main web portal.
- What Works for Women & Girls. Evidence-based gender-responsive interventions.
- WHO. Engaging men and boys in changing gender-based inequity in health: Evidence from program interventions.
- WHO. Linkages between sexual and reproductive health (SRH) and HIV.

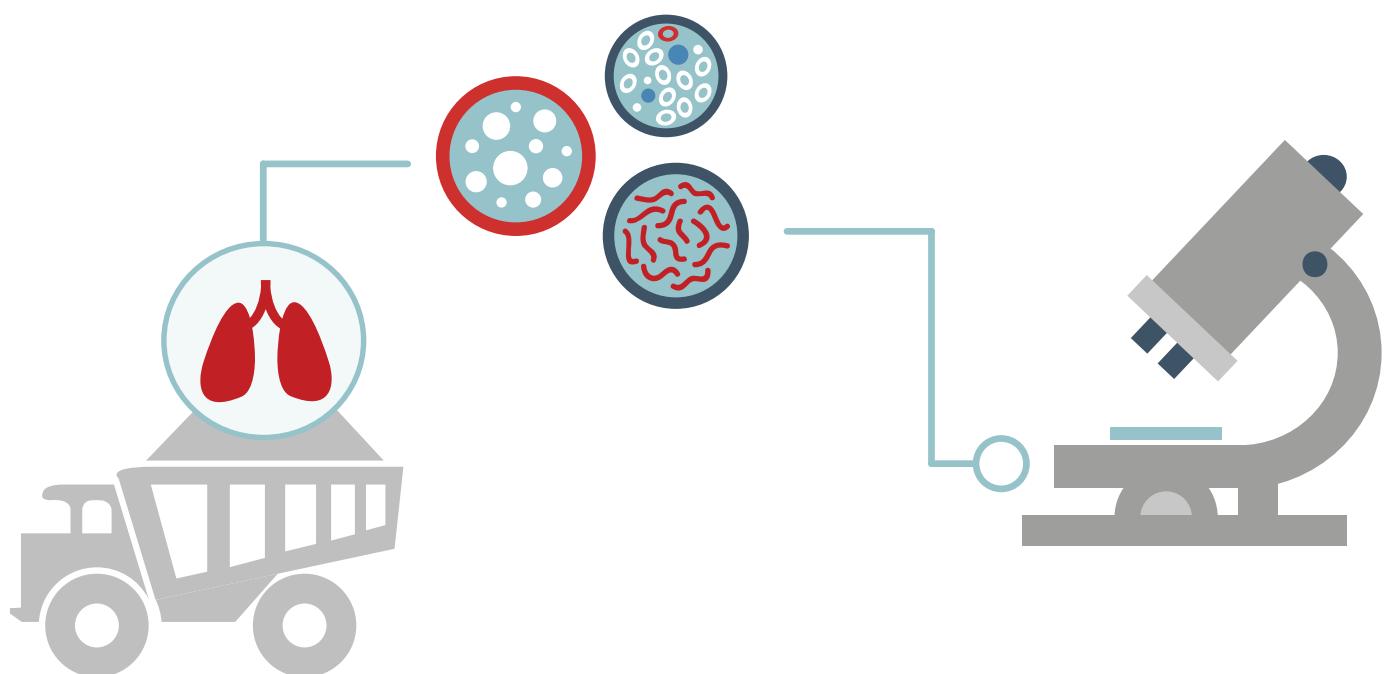
APPENDIX 2. THE LIST OF KEY INFORMANT INTERVIEWS AND AFFILIATIONS

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APPENDIX 3. THE GAPS AND RECOMMENDATION MATRIX

CATEGORY	GAP	RECOMMENDATION	RESPONSIBLE
Policies, Guidelines and Plans	Currently there is no specific gender operational guideline to guide TB /HIV interventions	Develop specific gender operational guideline to support TB interventions	NTLP Manager
Advocacy, Communication and Social Mobilization Plan (ACSM)	No advocacy plan targeting gender and TB in the ACSM	Improve the existing ACSM Strategy to include gender responsiveness in relation to TB / HIV	NTLP Manager
	Interventions to implement the ACSM in relation to gender and TB are currently not very visible	Organize ACSM interventions to enforce its implementation in relation to gender and TB/HIV	NTLP Manager
	The current plans in the ACSM are not targeting gender and TB/HIV issues	Organize stigma and discrimination reduction interventions to address gender imbalance and TB/HIV issues	NTLP Manager
	Currently not many partners are aware of the ACSM	Disseminate the ACSM among the implementing partners to increase its application and highlight it as the prime document to all partners in planning and implementing their interventions	NTLP Manager
Vulnerable population	Missing population size, TB/HIV burden and gender dynamics	Establish mapping and specific registration mechanism per vulnerability population group	NTLP Manager
		Establish burden of TB/HIV	NTLP Manager
TB/HIV Finances	Currently there is insufficient resources dedicated to gender issues in TB/HIV issues interventions addressing gender	Finances supporting the gender and TB/HIV need to be improved and clearly earmarked into the national plans	NTLP Manager
	About 97 percent of all recurrent TB resources come from foreign sources (WHO)	Organize advocacy interventions to increase proportion of domestic resources for TB/HIV interventions that also address gender issues	NTLP Manager
	Existing forums like the Stop TB and the National TB Forum are not involved in advocacy efforts at national level	Involve the Stop TB Coalition and the TB Forum in the advocacy processes for TB resources	Implementing Partners
	Currently the local private sector hasn't been involved in the advocacy for resources	Involve the private sector in efforts to mobilize domestic resources for TB/HIV	Implementing partners
M&E	Currently the outcome data is not disaggregated by age and gender	Improve M&E systems to have fine resolution of gender and age on treatment outcome	NTLP Manager
	Data is not indicating outcomes based on duo infections clients	Indicate treatment outcomes on clients with duo infections	NTLP Manager
Coordination & TWG	NTLP and IP not part of the TWG and gender commissions	Participate in the TWG and other platforms-guided by policies	NTLP Manager
CATEGORY	GAP	RECOMMENDATION	RESPONSIBLE
Policies, Guidelines and Plans	Currently there is no specific gender operational guideline to guide TB /HIV interventions	Develop specific gender operational guideline to support TB interventions	NTLP Manager

Advocacy, Communication and Social Mobilization Plan (ACSM)	No advocacy plan targeting gender and TB in the ACSM	Improve the existing ACSM Strategy to include gender responsiveness in relation to TB / HIV	NTLP Manager
	Interventions to implement the ACSM in relation to gender and TB are currently not very visible	Organize ACSM interventions to enforce its implementation in relation to gender and TB/HIV	NTLP Manager
	The current plans in the ACSM are not targeting gender and TB/HIV issues	Organize stigma and discrimination reduction interventions to address gender imbalance and TB/HIV issues	NTLP Manager
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Vulnerable population	Missing population size, TB/HIV burden and gender dynamics	Establish mapping and specific registration mechanism per vulnerability population group	NTLP Manager
		Establish burden of TB/HIV	NTLP Manager
TB/HIV Finances	Currently there is insufficient resources dedicated to gender issues in TB/HIV issues interventions addressing gender	Finances supporting the gender and TB/HIV need to be improved and clearly earmarked into the national plans	NTLP Manager
	About 97 percent of all recurrent TB resources come from foreign sources (WHO)	Organize advocacy interventions to increase proportion of domestic resources for TB/HIV interventions that also address gender issues	NTLP Manager
	Existing forums like the Stop TB and the National TB Forum are not involved in advocacy efforts at national level	Involve the Stop TB Coalition and the TB Forum in the advocacy processes for TB resources	Implementing Partners





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