
REPORT: TB GENDER ASSESSMENT IN NIGERIA



Communication for Development Centre

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Acronyms

ACSM	Advocacy Communication and Social Mobilisation Strategy
AFB	Acid Fast Bacilli
ARV	Antiretroviral Drugs
CSO	Civil Society Organisations
IDP	Internally Displaced Persons
FMOH	Federal Ministry of Health
LGTBLS	Local Government Tuberculosis and Leprosy Supervisor
DR TB	Drug-Resistant TB
DS TB	Drug Sensitive TB
LGA	Local Government Area
LTFU	Lost to Follow Up
MDA	Ministries, Departments and Agencies
NACA	National Agency for the Control of AIDS
NSIP	National Social Investment Programme
NSP TB	National Strategic Plan for Tuberculosis Control (2015 -2020)
NTBLCP	National Tuberculosis, Leprosy and Buruli Ulcer Control Programme
PLHIV	Person Living with HIV
STBLCO	State TB and Leprosy Control Officers
TB	Tuberculosis
WOW	Wellness on Wheels Truck

Executive Summary

Nigeria has the seventh-largest TB burden in the world and the second-largest in Africa. According to the WHO Global TB Report 2017, of the estimated, 407,000 TB cases (219 per 100,000 people) only 24% representing (97,680) TB cases were notified. This means that a total of 309,320 cases are still missing.¹

In order to assist priority countries in finding the missing TB cases and gathering the required evidence to identify and address the barriers to uptake of TB services, the STOP TB Partnership in collaboration with World Health Organisation (WHO) through funding support from the Community Rights and Gender Unit (CRG) of the Global Fund's Strategic Initiative is providing technical support to selected countries (**Nigeria inclusive**) to conduct a TB Gender Assessment, Legal Environment Assessment (LEA) as well as Key Population Prioritisation and Rapid Assessment.

Unlike some other countries where all three assessments were conducted simultaneously, in Nigeria, the LEA was conducted in 2017 and a follow-up Validation meeting held in 2018. This Gender Assessment draws extensively on the findings and recommendations from the LEA.

Objectives of the Gender Assessment

- To examine and understand the gender barriers in the pathway to Tuberculosis, prevention, diagnosis and treatment services in Nigeria
 - Explore in detail existing gaps and gender norms that prohibit men, women and (transgender groups, where applicable) from seeking care /treatment for TB in Nigeria
- To identify priority interventions to address the identified gaps and opportunities for informing a gender-responsive and gender transformative National TB response
- To facilitate engagements with National level stakeholders to develop a country-owned TB gender assessment report that will inform the submissions of gender-sensitive concept notes to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) as well as assist Nigeria to assess its TB epidemic context and response from a gender perspective, helping it make responses that are gender-sensitive and ultimately contribute to the reduction of the TB burden

Purpose of the Assessment

To conduct a rapid assessment and provide a thorough analysis of the ways that gender impacts TB in several settings in Nigeria, and in various cultural and socio-cultural groups. This gender analysis includes the examination of:

- Awareness and knowledge of TB
- Perceptions and emotional reactions regarding TB

¹ WHO Global TB Report 2017 – Page 180

- Exposure to risk factors for TB
- Barriers and enablers to seeking diagnosis and treatment
- Barriers and enablers to adhering to treatment
- Impact of TB on personal life during and after treatment
- Perceptions of ways in which men, women experience, or are impacted by TB differently
- Public perceptions of ways to improve TB awareness, diagnosis, and treatment success and reducing TB-related stigma for all genders

To identify and recommend effective and promising strategies and interventions that reduce gender-related barriers and improve access to TB services and health-seeking behaviours of men and women.

Approach

The approach utilised in conducting this Gender Assessment is guided by the UNAIDS and STOP TB Partnership Gender Assessment Tool for National HIV and TB responses as well as the CRG Nigeria Assessment Roadmap as agreed with Communication for Development Centre (CCDC) and the Nigeria Assessment Core group. Prior to the commencement of this gender assessment, a Concept note detailing the proposed methodology was shared with CCDC and the StopTB Partnership for review and approval.

A. Planning

- Debriefing and Discussion with the in-country Assessment Core Group
- Development and Submission of Grant Application/Concept Note and Budget to Stop TB Partnership
- Planning for Multi-stakeholder Orientation Meeting
- Facilitating the Multi-Stakeholder Orientation Meeting
- National TB Programme approvals and authorisation for conduct of the State Level Assessments

B. Desk Review

The desk review included data and published official documents including existing Gender policies, National TB Strategic plans, Reports of previous TB surveys/assessments, academic papers published on gender dimensions to TB as well as available gender-disaggregated data. The aim was to establish the state of knowledge in this area and likely gaps as well as provide an evidence base for an emerging consensus or solutions to the identified gaps.

C. In Country Assessment

The in-country assessment utilised qualitative research methodologies particularly site visits, focused group discussions, and key informant interviews. Given the size and diversity of the Nigerian population, as well as socio-cultural contexts that shape gender norms and practices, the qualitative researches were conducted in 4 states representing

4 out of the 6 geopolitical zones in Nigeria. Plans for the assessment were discussed at the consultative multi-stakeholder Orientation meeting involving an array of government and civil society stakeholders, which held in August 2018 in Abuja. The selection of States was guided by the recommendations from that meeting as well as discussions with the National TB Programme Manager.

The report of this Gender Assessment was reviewed and validated by civil society representatives and relevant stakeholders at a Validation meeting convened by Communication for Development Centre which held in Abuja on 28th August 2019.

Study Setting

Assessment sites were identified in order to cover a geographic range of states. Based on the recommendations, key criteria for selection of States include:

- States with a High TB Burden
- States with a Cosmopolitan nature
- States with a high TB/HIV burden
- Presence of IDP Camps
- Geopolitical distribution

The states selected include:

- South-West-**Lagos**
- South-South **Cross River**
- North-Central- **Benue**
- North-West **Kano**

In the states selected, interviews were conducted in LGAs classified either as urban, semi-urban or rural locations.

Qualitative Research

The rapid assessment research used a mixed-methods approach, a combination of facility observations, key informant interviews, and focus group discussions with State TB Programme Staff, healthcare providers, community members and people affected by TB. The research tools were designed to broadly capture the experiences of TB infection, diagnosis, care, access, quality, and treatment completion from the perspectives of people affected by TB (patients and family members), healthcare providers and stakeholders (including civil society advocates and government representatives).

Methods

Research questions:

The qualitative research examined questions related to:

- a. What laws, policies, regulations, and institutional practices influence the context in which men and women act and make decisions pertaining to TB prevention, testing, and treatment?
- b. What cultural norms and beliefs influence people's practices and access to prevention, testing, and treatment of TB?
- c. How do gender roles define responsibilities and how does this affect TB prevention, testing, and treatment?
- d. How does gender affect access to and control over assets and resources, and how does this affect TB prevention, testing, and treatment?
- e. What are the patterns of power and decision-making, and how does this affect TB prevention, testing, and treatment?

Key Findings

Health seeking practices

Findings indicate that while both men and women showed similarities in terms of their first port of call when seeking TB services (oftentimes from neighbourhood chemists), men displayed a higher tendency to delay seeking care at a health facility until it is late, whereas women were more willing to seek care early. However, factors such as financial capacity and the consent /permission of the male partner/ spouse often determined women's ability to access care early enough.

Widely held beliefs about masculinity and strength, the pursuit of their breadwinner/ productive roles, cost considerations and the belief that seeking care from health facilities are a woman's turf strongly influence men's willingness to seek care. On the other hand, **women's** willingness to seek care early was motivated by the need to preserve their homemaker/ caregiver roles and the protection of their children and families from infection/ illness.

Factors predisposing men and women to the risk of TB infection also differed. The reasons provided for men's risk of contracting TB infection were more associated with their social habits, practices, and occupations whereas women tended to be more exposed to TB, mostly due to their caregiver roles as well as based on certain occupations they practiced.

Findings also indicate that despite the high TB burden in the country, accurate information about TB, its symptoms, how it is spread and where services can be accessed is still not widespread. Ignorance, myths, misconceptions, and culturally held beliefs still influence TB health-seeking practices, as well as reactions towards persons with TB.

Local language terminologies about TB also evoke feelings of fear and reinforce misconceptions that TB is incurable. It is noteworthy that ongoing awareness and public information about TB is limited and often centred on the commemoration of World TB Day. This is not unrelated to the fact that several of the State programmes are largely donor dependent with limited State government budgetary support for ACSM focused programmes.

Barriers limiting access to TB diagnostic and treatment services

Findings also revealed that several barriers limit people with TB from accessing the diagnostic and treatment services. These barriers are also context and gender specific.

TB related stigma emerged prominently as a major barrier with gender-specific differences.

Men reported experiencing stigma but had a tendency of managing/keeping information about their TB illness to themselves, avoiding disclosure, isolating themselves or providing wrong phone numbers and home addresses (in order to prevent follow up calls and visits from Community volunteers or health care providers).

Unlike men, women's illness as a result of TB seemed to be more visible and information about their condition was also more open to relatives, friends and other social contacts. They reported experiencing stigma in the form of abandonment, isolation, and avoidance by friends and close family as well as separation, emotional abuse and in some cases physical violence.

Poverty also emerged as a key barrier affecting both men and women with TB. Findings indicated that women tended to be more affected as socio-cultural norms also seem to create additional barriers in terms of women's ability to access diagnostic and treatment services. As a result of cash power differentials, women (particularly the married ones) tended to be poorer and more reliant on the **permission/consent of their spouses** or the decision-maker in the home in order to access TB services whereas men were more financially independent

Findings from the study also suggest that clinic hours as a barrier related more to men than women, though this seemed to be more context-specific as different practical measures are being put in place to ensure men can access their treatment outside the regular clinic hours.

Adherence to treatment

While several programme staff acknowledge the limitations posed by the lack of gender-disaggregated data to inform conclusions on adherence patterns of men and women on TB treatment, findings revealed that women tended to adhere more strictly to their treatment than men. While men tended to abandon treatment once they felt better or provided excuses related to their work demands, women were focused on getting cured in order to be able to cater for their children and families.

Gender-Based Violence and TB

The findings show that TB related Gender Violence occurs and women are often at the receiving end, but the cases seem under-reported, "invisible, yet present due to a culture of silence" and greatly influenced by the culture of patriarchy, myths and misconceptions,

power relations between men and women, stigma, fear of contracting the infection and perceptions that TB and HIV are the same.

Existing policy guidelines on Gender-Based Violence significantly reference the nexus between HIV and GBV, but make no specific reference to TB related GBV. These findings suggest a need for a policy review to highlight the implications of TB related GBV, as well as sensitising TB patients, CSOs, health workers to policy provisions and opportunities for reporting and seeking red

Impact of TB

Findings from the study also indicate that men and women affected by TB viewed the impact of the disease differently; while men described the impact of TB in relation to their lowered productivity, and particularly their inability to engage in economic activities, women described the impact of TB in relation to their struggles with adherence, social life/relationships as well as their economic activities.

Gender Sensitive Practices

Findings also show that there is increasing recognition at the National and State programme levels of the need for gender-sensitive considerations in designing programmes that are patient centred in order to ensure increased uptake of TB prevention, diagnosis, and treatment. Examples of different context-specific initiatives tailored to address some of the barriers men and women face in accessing TB services were highlighted. These include amongst several others, the *Uwar Gida* Housewives Initiative reaching out to housewives in 5 LGAs in Kano State, SMILE TB initiative targeting children, Contact tracing, Engagement of Treatment Supporters, Outreaches targeting men in places where they congregate, and linkages with CSOs and community health workers to bring diagnostic and treatment services closer to the clients doorstep. While these practices have been identified as very valuable and contributing to increasing TB case finding; the need to scale up, and sustain the gains of these programmes after support from external partners has ended is of urgent concern.

Recommendations

To Government (National and State level TB programmes)

- 1. Disaggregate TB Programme data by gender within public and private sector DOTS and health facilities at Federal, State and LGA levels to better inform programming**
 - a. Support the development of relevant and appropriate indicators and use of gender-disaggregated data gathered by healthcare facilities to inform discussions at the routine M and E meetings(such as National and State TB Control Programme Review meetings) as well as support the design and implementation of gender transformative TB policies, plans and programmes
 - b. Ensure implementation of gender transformative policies and programmes, through provision of training and resources to TB Programme staff and implementers at all levels

- 2. Strengthen Interagency and Interministerial collaboration on TB at Federal and State Levels**
 - a. Establish an interagency task team (from the relevant MDAs) on TB at Federal and State levels to guide in the development of clear action plans that address gender related and social determinants of poverty which relates closely with TB disease such as Overcrowding, Poor Housing etc. (Such MDAs would include; Women Affairs, Lands, Housing and Urban Development, Transport, Information, Youth Development, Environment, National Orientation Agency, National Emergency Management Agency etc.)
 - b. Review existing and relevant policy frameworks of these relevant MDAs to ensure that the TB linkages and opportunities for joint programme implementation are addressed in a gender responsive manner
 - c. Address socio-cultural norms and beliefs by initiating educational programmes that continuously promote awareness and accurate information about TB at all levels e.g. through schools especially in primary schools, inter-school debates etc.
 - d. Support and encourage the development and airing of gender-specific messages IEC materials (jingles, posters, drama skits) that address male health-seeking tendencies and encourage men and women to seek TB treatment early.

- e. Collaborate with religious leaders through their established associations such as Christian Association of Nigeria, Supreme Council for Islamic Affairs at various state levels in order to educate religious leaders about the importance of adherence to TB treatment, risks of DR-TB and secure their support and buy-in for promotion of TB treatment adherence /treatment completion in messages to adherents of their respective faiths

3. Address barriers to TB diagnostic and treatment services and ensure ownership and sustainability of TB Programme at Federal, State and Local Government Levels

- a. Ensure dedicated Government funding as well as prompt and timely release of such funds to the TB programmes at Federal, State and LGA levels
- b. Scale up access to National and State Health Insurance schemes for TB patients
- c. Expand access to TB diagnostics and DOTS centres by leveraging on the expertise and reach of other private sector health care providers'; strengthening PPM DOTS as well as cultivating partnerships with unorthodox health care providers who may have a wider reach /clientele base

4. Support linkage of TB patients to poverty alleviation and social protection schemes

- a. Support economic empowerment of men and women with TB through linkages to soft loans and schemes and other initiatives such as the National Social Investment Programme(NSIP) and other social protection schemes that will enable them be self sufficient
- b. Support linkage to school feeding programmes for children with TB
- c. Provide incentives to support TB patients while on treatment (transport/nutritional support etc.)

5. Strengthen capacity of Health care providers, CBOs and community volunteers for improved TB service delivery at facility and community levels

- a. Conduct routine on the job trainings for DOTS providers, relevant health care workers, CSOs and community volunteers in order to improve the quality of pre initiation counselling for TB patients and their family members. Such counselling trainings must address gender specific adherence patterns, attitudes etc.
- b. Provide anonymous client feedback / evaluations forms to clients to enable them routinely appraise and provide feedback on health workers attitudes. Completed evaluation forms would be constantly reviewed by health workers Supervisors
- c. Encourage issuance of recognition of performance certificates and other incentives to deserving health workers

- d. Support the engagement of peer support counsellors/former TB patients both men and women to serve as adherence counsellors within facilities and at community levels
- e. Institute more stringent infection control measures/standards within public health facilities at all levels and ensure the steady supply of requisite protective gear, establish mechanisms for supporting health workers who may come down with TB and collaborate with the Association of Private Medical Practitioners providing TB services to institute similar practices in their respective private health facilities

To States within the North –West, North Central and North East geopolitical zones

- 6. Address security challenges / intercommunal clashes at State levels
- 7. Expand access to and equitable distribution of TB services particularly in crisis prone areas/regions
- 8. Improve the living and feeding conditions in IDP camps and ensure sustained access to TB diagnostic and treatment services for camp residents
- 9. Scale up and expand the reach of context specific and evidence based gender sensitive good practices such as the involvement of male/female adherence supporters, Uwar Gida Housewives Initiative, Outreach programmes for men and flexible DOTS Clinic hours etc.
- 10. Work with community leaders / traditional rulers and institutions to address socio-cultural norms that serve as barriers to men and women’s access of TB diagnostic and treatment services
- 11. Strengthen, support and incentivise DOTS providers, community health workers and community volunteers with necessary tools and transportation equipment (motorcycles) to enable them deliver essential TB services in hard to reach and crisis prone areas

To Donors and Development partners

- 12. Support the development of gender transformative TB policies and programmes and implementation guidelines
- 13. Support the scale up and equitable distribution of GeneXpert machines and other relevant TB diagnostic services across the country
- 14. Support National and State programmes to ensure timely delivery of drugs/ test kits and other relevant commodities at State and LGA levels as well as resources to support drugs/commodities redistribution
- 15. Support the implementation of TB related ACSM Interventions that address socio-cultural norms across Federal, State and Local Government levels.
- 16. Strengthen the capacity of media (particularly local language reporters) and support the convening of regular post training media engagement platforms to debunk context specific myths and misconceptions and promote TB information in a sensitive, non-stigmatising manner
- 17. Strengthen the capacity of advocates(patients communities, civil society groups, human rights organisations , media to understand and address all forms of TB

related Gender Based Violence, and demand access to justice for TB patients whose rights may have been violated using the various existing legal instruments

To Civil Society Organisations and Community groups working on TB

18. Leverage on traditional methods of communication and platforms, mobile outreaches (e.g. Use of the WOW trucks), community dialogues, problem tree, etc. to educate communities about TB related stigma, its manifestations and to develop community-oriented solutions for addressing stigma
19. Develop and encourage the emergence of a corps of TB Champions (both male and female) to share experiences and highlight information about TB being curable
20. Create demand for TB Services through community-based outreaches, house-to-house mobilisation and integration into existing community structures
21. In collaboration with Governments, development partners and implementing agencies, leverage on community structures to expand the access to services reach to people in hard to reach settings and key populations

To Media

22. Promote awareness through multiple channels and reinforce messaging on TB signs, symptoms, TB predisposing factors and gender dynamics, available services and curable nature of TB
23. Develop gender sensitive human interest stories, case studies and local language reports that debunk TB related myths and misconceptions, address societal norms about male/female health seeking practices and educate the audiences about TB services and where they can be accessed

Nigeria Community Rights and Gender Assessment

1. Introduction

Tuberculosis is the ninth leading cause of death worldwide and the leading cause from a single infectious agent, ranking above HIV/AIDS. In 2016, there were an estimated 1.3 million TB deaths among HIV-negative people. However, more deaths from TB could be prevented with early diagnosis and appropriate treatment. Millions of people are diagnosed and successfully treated for TB each year, averting millions of deaths (53 million from 2000–2016), but there are still large gaps in detection and treatment.²

Closing these large gaps requires additional progress in specific high TB countries which have a high gap between TB incidence and reported TB cases in order to find these ‘missing TB cases. In 2016, ten countries accounted for 76% of the total gap between TB incidence and reported cases; the top three were India (25%), Indonesia (16%) and Nigeria (8%).³

Nigeria has the seventh-largest TB burden in the world and the second-largest in Africa. Of the estimated, 407,000 TB cases (219 per 100,000 people) only 24%, representing 97, 680 TB cases were notified. This means that a total of 309,320 cases are still missing.⁴

Many gaps still exist. Accelerating efforts to find the missing TB cases will require a better understanding of the factors that influence individual health-seeking behaviours as well as barriers that limit individuals from approaching the health systems to seek TB diagnostic and treatment services in Nigeria.

Based on the WHO Global Report, of the 407,000 TB new cases in Nigeria in 2017, it is estimated that 267,000 are males and 140,000 are females.⁵ Globally, over 60% of TB incidences occur in men. Various studies indicate that despite higher HIV prevalence among women in Sub-Saharan Africa, the incidence of TB is higher in men, except in women who are 15-24 years old in areas of high HIV prevalence.

Male-specific risks of becoming ill with TB differ from female-specific risks. On the one hand, studies indicate that while men tend to have more social contacts, work in high-risk settings, smoke, consume higher quantities of alcohol and display poor health-seeking

² WHO Global TB Report 2017 –Page 1

³ Ibid – pg. 1

⁴ WHO Global TB Report 2017 – Page 180

⁵ Ibid –pg. 180

behaviour which puts them at a high risk of TB, females, on the other hand, encounter higher stigma, delayed diagnosis and less access to treatment services amongst others.⁶

Clearly, the health-seeking behaviours of men and women differ and require a systematic assessment from a gender perspective to inform a robust, effective, gender-responsive and patient centred TB response that truly leaves no one behind.

A gender assessment that seeks to explore the gender-related factors that influence health-seeking services for TB care in Nigeria and provides a clear understanding of these issues is thus critical to guide evidence-informed TB programming going forward.

In order to assist priority countries in finding the missing TB cases and gathering the required evidence to identify and address the barriers to uptake of TB services, the STOP TB Partnership in collaboration with World Health Organisation(WHO) through funding support from the Community Rights and Gender Unit(CRG) of the Global Fund's Strategic Initiative is providing technical support to selected countries (***Nigeria inclusive***) to conduct a TB Gender Assessment, Legal Environment Assessment (LEA) as well as Key Population Prioritisation and Rapid Assessment.

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Purpose of the Assessment

To conduct a rapid assessment and provide a thorough analysis of the ways that gender impacts TB in several settings in Nigeria, and in various cultural and socio-cultural groups. This gender analysis includes the examination of:

- Awareness and knowledge of TB

⁶ Discussion Paper – Gender and Tuberculosis –UNDP December 2015

- Perceptions and emotional reactions regarding TB
- Exposure to risk factors for TB
- Barriers and enablers to seeking diagnosis and treatment
- Barriers and enablers to adhering to treatment
- Impact of TB on personal life during and after treatment
- Perceptions of ways in which men, women experience, or are impacted by TB differently
- Public perceptions of ways to improve TB awareness, diagnosis, and treatment success and reducing TB-related stigma for all genders

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Assessment sites were identified in order to cover a geographic range of states. Based on the recommendations, key criteria for selection of States include:

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- States with a high TB/HIV burden
- Presence of IDP Camps
- Geopolitical distribution

The states selected include:

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- South-South **Cross River**
- North-Central- **Benue**
- North-West **Kano**

In the states selected, interviews were conducted in LGAs classified either as urban, semi-urban or rural locations.

3. Qualitative Research

The rapid assessment research used a mixed-methods approach, a combination of facility observations, key informant interviews, and focus group discussions with State TB Programme Staff, healthcare providers, community members and people affected by TB. The research tools were designed to broadly capture the experiences of TB infection, diagnosis, care, access, quality, and treatment completion from the perspectives of people affected by TB (patients and family members), healthcare providers and stakeholders (including civil society advocates and government representatives).

Methods

3.1 Research questions:

The qualitative research examined questions related to:

- a. What laws, policies, regulations, and institutional practices influence the context in which men and women act and make decisions pertaining to TB prevention, testing, and treatment?
- b. What cultural norms and beliefs influence people’s practices and access to prevention, testing, and treatment of TB?
- c. How do gender roles define responsibilities and how does this affect TB prevention, testing, and treatment?
- d. How does gender affect access to and control over assets and resources, and how does this affect TB prevention, testing, and treatment?
- e. What are the patterns of power and decision-making, and how does this affect TB prevention, testing, and treatment?

3.2 Research Methods and participants

Qualitative Research Methods and Participants			
Method	Participants	Gender	Location
Observations	Health Care workers attending to TB patients	Mixed	Lagos, Cross River, Kano
Focus Group Discussions	Representatives of PLHIV Support groups	Female	Lagos
	Representatives of PLHIV Support groups	Male	Lagos
	TB patients in Incarcération (Prisons)	Male	Lagos
	Community Members	Mixed	Benue (Rural)
	Current/Former TB	Male	Lagos

	Patients		
	Current /Former TB Patients	Female	Cross River (Urban)
	Current/Former TB Patients	Mixed	Kano (Urban)
Method	Participants	Gender	Location
	Community Health Volunteers (Uwar Gida)	Female	Kano
	CSOs working on TB	Mixed	Benue
	CSOs working on TB	Mixed	Cross River
	IDP Camp residents	Mixed	Benue (Rural)
	Urban Slum Dwellers	Male	Cross River
Key Informant Interviews(KII) with TB Programme Staff	4 nos. State TB Programme Managers *One of the States also had their State Team members in attendance)	Male	Lagos, Cross River, Kano, and Benue
	2 nos TBLS	Male	Lagos
	1 no TBLS	Female	Lagos
	2 nos TBLS	Female	Benue (Rural)
	1 DOTS Provider	Male	Benue (Rural)
	1 TBLS	Female	Cross River
	2 TBLS	Male	Kano
	1 DOTS Provider	Male	Kano(Semi Urban)
	DOTS Provider, Prisons	Male	Cross River
KII with Health Care Providers	2 Doctors in charge of TB/HIV clinics	Male	Lagos
	Doctor, Male Prisons	Male	Lagos
	Development Partner staff	Male	Benue
	Officer in Charge of DR TB Ward	Male	Benue
	Nurse, DOTS clinic	Female	Cross River
	Matron in charge Female Prisons	Female	Lagos
	Doctor in charge of IDP Camp	Male	Benue
KII with People affected by all forms of TB including MDR-TB	7 nos People affected by all forms of TB including MDR-TB in urban, semi-urban and rural communities	Female	Lagos, Cross River, Kano, and Benue
	5 nos People affected by all forms of TB	Male	Benue and Kano

	including MDR-TB in urban, semi-urban and rural communities		
Community / Religious Leaders	5 Community /Religious Leaders	4 Males & 1 Female	Cross River and Kano

3.3 Analysis

Key Informant Interviews and focus group discussions were audio-recorded and transcribed verbatim. Quotes from the focus group discussions and KIs were used to illustrate each important theme identified during data analysis. Thematic review of qualitative data was performed, connecting the data to the research questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perceptions of those involved.

3.4 Approval/ Ethical Considerations

Following consultations with the National Coordinator of the National Tuberculosis, Leprosy and Buruli Ulcer Control Programme on the States identified, approval was granted for the assessment to commence, and letters introducing the Gender and KP Assessment as well as the Consultants was prepared for the TB Programme Coordinators of the respective States.

The Consultants also followed up via telephone and email correspondence with the State TB Programme Coordinators prior to the visits.

Visits to the States were determined primarily by the availability of the State TB Programme Managers. Prior to the conduct of the site visits and interviews with respondents at State levels, initial introductory meetings held with the State TB Programme Managers or their delegated representatives in each of the 4 States in order to:

- Brief them on the scope of the work
- Discuss the groups/ respondents to be interviewed and criteria for selection of the populations as well as geographical locations, LGAs, and contacts of the TBLS
- The State TB Programme Managers also provided links to the Prison Officials in charge of the TB Programmes (in Lagos and Cross River) and guidance on the security situation in the state at the time of the visit, given that the assessments were conducted within the period when National and State level elections were taking place in Nigeria. The security situation was also a key consideration that informed LGAs visited.

3.5 Confidentiality and Privacy

The research team conducted the interviews in locations that ensured privacy and maintained interviewees’ anonymity. Researchers maintained the confidentiality and anonymity of respondents, by not using names or other ways of identifying the participants.

Consent

Consent was obtained from all participants by the research team reading them the consent form, which explained the purpose of the assessment, its objectives, and informed participants of their right to confidentiality and to withdraw from the study at any point during the assessment. Participants gave verbal consent if they were willing to volunteer for the study.

3.6 Limitations of the Study

Gender Minorities: This assessment focused mainly on the gender-related disparities, defined using binary male/female gender categories, given the limited documented data on Transgender in Nigeria

Limited geographic coverage: This Assessment draws on available literature pertaining directly to TB in Nigeria as well as the rapid, qualitative assessment, which was conducted in 4 out of the 6 geopolitical zones.

Selection bias: We accessed some of our research participants through links provided by non-profit organisations active in the sphere of TB as well on the basis of links provided by the management of TB programme at the State and LGA levels or facility staff.

4. Background: TB Burden in Nigeria

Country Context

Nigeria is the most populous country in Africa and the seventh most populous country in the world with a projected population of 190 million⁷. The country has an expansive type of population pyramid with 41% of the population who are less than 15 years old⁸. Nigeria's population is young and growing rapidly with an estimated 3.2% per year. This population distribution has implications for the dynamics of TB transmission and for the approaches to TB education, case finding, and case holding⁹.

Poverty and malnutrition, important social determinants of risk and outcomes of TB are widespread with more than 50% of malnourished children ¹⁰and 67.1 % of the total population below the poverty level.¹¹ The country is also ranked as a low-middle income (LMI) country.¹²

The National Tuberculosis and Leprosy Control Programme under the Department of Public Health was established in 1988 by the Government of Nigeria to coordinate TB and Leprosy Control efforts in Nigeria. Its mandate was further expanded to include Buruli Ulcer in 2006. The operations of the NTBLCP are in line with the three levels of governance in Nigeria; National, State and Local Government Areas (LGAs).

At State level, the TB and Leprosy Control Programme functions under the State Department of Disease Control and is known as the State TB and Leprosy Control Programme. The programme is headed by the State TB and Leprosy Control Officer who coordinates TB and Leprosy Control activities in the respective states and provides secondary care and technical assistance to the LGA levels.

4.1 Nigeria TB Profile

Nigeria is among the 14 countries globally that are in all the three lists of high burden countries for TB, TB/HIV, and MDR-TB¹³. The country has the 2nd largest burden of TB and HIV in the continent and the second highest under-five and maternal mortality rate in the world¹⁴. Nigeria's TB case notifications have been on a consistent rise from 2002 to 2009 when it plateaued until 2014 and consistently increased again by about 10% from 90,584 TB

⁷ 2018 National Projected population

⁸ Live Nigeria population (2018), <https://www.countrymeters.info> > Nigeria

⁹ National Strategic Plan for TB Control : 2015 -2020 Pg. 15

¹⁰ Nigeria Multiple indicator cluster survey 2016 -17, survey finding report, October 2017

¹¹ <http://www.nigerianstat.gov.ng/library#content5-6>

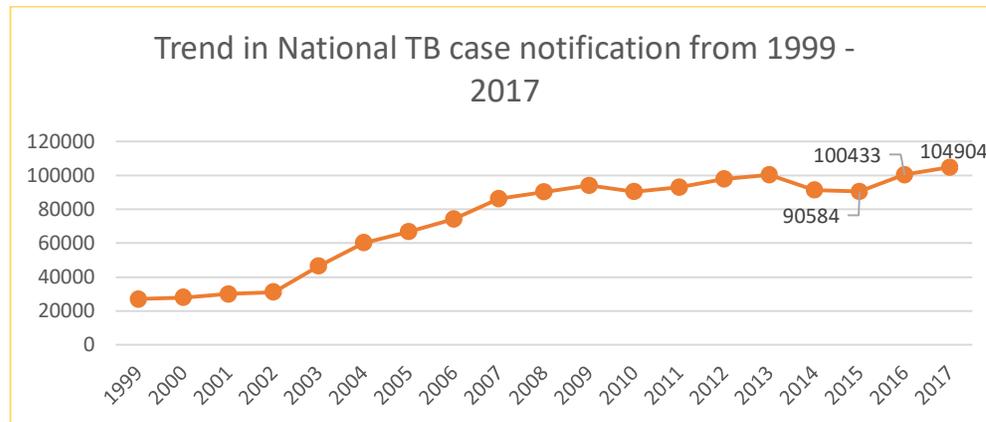
¹² World bank list of country classification in 2018

¹³ 2017 WHO Global TB Report

¹⁴ https://www.unicef.org/nigeria/children_1926.html

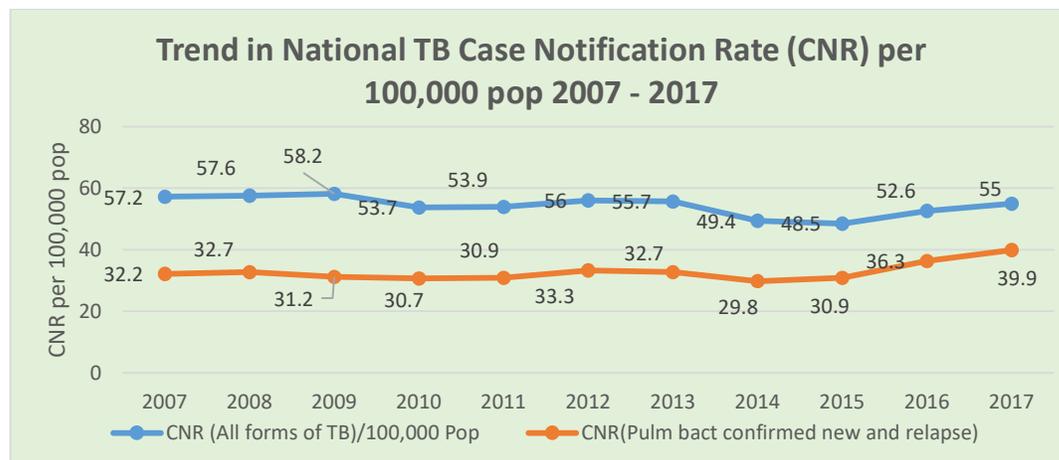
cases in 2015 to 100,433 TB cases in 2016, and by another 5% from 100, 433 cases notified in 2016 to 104,904 TB cases in 2017¹⁵ partly due to the adoption and the expansion of GeneXpert MTB/RIF assay as the primary diagnostic tool for TB in the country and other case finding interventions.

Figure 1: Trend in TB notification, all forms (1999-2017)



The Case Notification Rate (CNR) for All forms of TB increased from 52.6/100,000 pop in 2016 to 55/100,000 pop in 2017 (figure 2), the current achievement is far below the target of 131/100,00 pop for 2017 in the 2015 – 2020 TB National Strategic Plan.

Figure 2: Trend in National TB case notification rate per 100,000 pop 2007 -2017

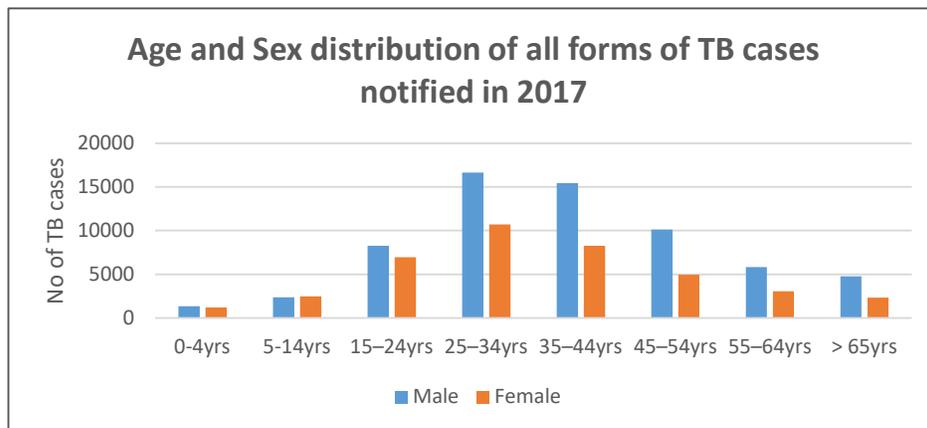


The disaggregated breakdown of the notified TB cases in 2017 by age and sex revealed that males account for 62% of notified TB cases. This is in line with the findings from the National

¹⁵ NTBLCP Annual reports

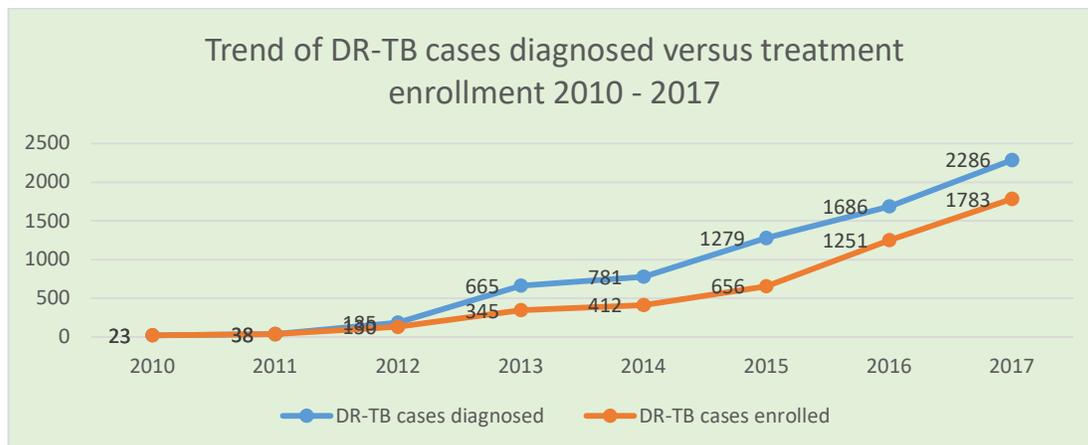
TB prevalence survey conducted in 2012 which “aimed at determining the prevalence of bacteriologically-confirmed (sputum smear-positive and/or culture-positive) TB among the general population aged fifteen years and above. The 2012 survey found that prevalence rates of bacteriologically-positive TB among men were higher (751 per 100,000 men) than in females (359 per 100,000 women)¹⁶

Figure 3: TB notification in Nigeria by sex and age in 2017



Nigeria’s treatment coverage rates are the lowest in the world, with approximately 76% missed cases¹⁷ and is among the 10 countries that account for 76% of the missed TB cases globally. 12% of the missing TB cases in Nigeria are from 2 states (Kano and Lagos).

Figure 4: Trend of DR-TB cases diagnosed and enrolled from 2010 – 2017



The TB case-finding gap is much higher among drug-resistant TB, even though there was a 36% increase in the number of diagnosed DR-TB cases from 1,686 in 2016 to 2,286 in 2017

¹⁶ Report of the 1st National TB Prevalence Survey 2012 – Pg. 55

http://indexmedicus.afro.who.int/iah/fulltext/First_National_TB_Prevalence_Survey_Report.pdf

¹⁷ 2017 WHO Global TB Report

(figure 4). However, 89% of the estimated MDR/RR-TB cases in 2017 are still being missed and not notified, thereby fuelling the continuous transmission of drug-resistant TB in the community. The huge number of missed DR-TB cases is due to low TB treatment coverage rate and suboptimal access to GeneXpert MTB/RIF tests among notified TB cases despite the policy of using GeneXpert MTB/RIF assay as the primary diagnostic tool.

4.2 Finding the Missing persons with TB

Nigeria contributes 8% to the global 4.1M missing TB cases after India (25%), Indonesia (16%). Part of the strategic approaches of the National TB Programme as outlined in the National Strategic Plan is a shift from passive to active case finding in key affected populations; including People Living with HIV (PLHIV), contacts to TB cases, urban slum dwellers, men, prisoners, migrants, internally displaced people, nomadic populations, children, people with diabetes, and facility-based health workers, in order to target those most at risk of TB ¹⁸

In spite of children making up 41% of the population, notification rates for children remain far lower than expected, only 13% of the estimated TB cases among children were notified in 2017 with 87% of them still being missed contributing to the low treatment coverage rate (low TB case detection rate).

In addition, the TB incidence rate of 814/100,000 population among prisoners in 2017 was four times more than the estimated 219/100,000 among the general population¹⁹. Pockets of TB services provided to IDPs have shown a significant contribution to TB case notification, indicating the urgent need to address TB among key populations in ongoing interventions.

The national response continues to confront the issue of low case detection driven by an unrelenting TB-HIV epidemic, massive funding gap (64%) for TB²⁰, weak public health systems and infrastructure, weak engagement of the private health sector where 60% of health consultations take place and a large number of poorly engaged Primary Health Care (PHC) facilities. TB services coverage in health facilities is as low as 5% among private for-profit hospitals and clinics²¹ and 19.6% among the PHCs in the country²². Other issues include low capacity and poor attitude of healthcare workers to data management.

¹⁸ NSP-TB 2015-2020 Pg. 3

¹⁹ 2017 NTBLCP Annual Report

²⁰ 2017 WHO Global TB report

²¹ National TB Control Programme Public Private Mix Action Plan 2018-2020

²² FMOH National Health Facility survey 2016

4.3 Context of States where the Assessments were conducted

Benue

Benue state was created in 1976 out of the then Benue Plateau State. The state is one of the seven states comprising the north-central zone of the six geopolitical zones in Nigeria²³. Benue state has a population of 6,354,344 (3.0% projection from 2006 National population figures of 4,219,244). This makes Benue the 9th most populous state in Nigeria.

Benue State is bordered by Nassarawa State in the north, Taraba State to the east, Ebonyi and Cross River states to the south and Kogi State to the west. There are three main ethnic groups; Tiv, Idoma and Igede. Other ethnic groups include Etulo and Jukun. The Benue people are mostly farmers engaged in subsistence and commercial farming; that is why the state is recognized as the 'Food-basket of the nation'. Few people are engaged in civil service jobs and as petty traders.

In recent years, several communities in the State have experienced incursions of armed militant herdsmen causing tensions, growing insecurity and significant levels of violence with thousands being displaced and taking refuge in various Internally Displaced Persons (IDPs) camps established by the State Government to cater for the need of the victims of the crisis. There are varying accounts of the total number of persons displaced in the State but the figures quoted by the State Emergency Management Agency as of January 2019 indicated that 483,699 IDPs exist in various camps across the state.²⁴

The health services organisation of the state is in conformity with the National policy on health. The Benue State TBL Control Programme (BNSTBLCP) is one of the disease control programmes being executed by the Benue State Government, through the State Ministry of Health, within the framework of the National TBL Control Programme (NTBLCP) at the federal level. The State Tuberculosis and Leprosy Control Programme (STBLCP) is the responsible body that coordinates TB and Leprosy control activities in Benue State. The overall goal of the control programme is to reduce significantly the burden, socio-economic impact, and transmission of TB in Benue State.

Benue has a high TB burden which is attributable to high HIV prevalence. The TB DOTS programme was started in 2001 as a pilot project in four LGAs; Gwer, Otukpo, Logo and Ohimini. This involved the General hospitals with St Vincent's Hospital, Aliade as the only Mission hospital. Since then the programme has been expanded strategically to cover the 23 LGAs. By the end of 2018, the State had 433 DOTS centres and 135 Microscopy centres

²³ National Population Commission: 2006 Population and Housing Census, Population Distribution by Sex, State, LGA and Senatorial District, Priority table, vol. III (2010): <http://www.population.gov.ng/index.php/benue-state>

²⁴ <http://saharareporters.com/2019/01/26/sema-483699-idps-affected-herdsmen-attacks-benue-state>

spread across the 23 LGAs. There were also 28 GeneXpert machines. USAID through KNCV/CTB supported outreach campaigns in some LGAs and through the CRS/SMILE project supported the active case search of childhood TB in some LGAs from 2017 -2018.

The STBLCP²⁵ in 2018 identified 26591 presumptive TB cases which was a 6.4% increase compared to the 24887 presumptive TB cases identified in 2017. Out of this number 1082(4.0%) were presumptive DR-TB cases. From this pool of presumptive TB cases, the programme registered 4652 all forms of DSTB cases for treatment and 101 DRTB cases in 2018. Of the 4652 DSTB cases notified (2845 males (61.2%); 1807 females (39.6%)), 4568(98.2%) were Pulmonary TB cases and 84(1.8%) were extra pulmonary TB cases. The notified cases had 4467(96.0%) incident (New & relapse) cases and 185(4.0%) retreatment TB cases.

In 2018 the bacteriologically diagnosed TB case proportion was 67.1% (3121) while the clinically diagnosed was 32.9% (1531). Of the 4634(99.6%) TB cases whose HIV status was known, 1162(25.0%) were TB/HIV co-infected.

A trend analysis of the TB/HIV data has shown demonstrable gradual decline in TB/HIV co-infection rate from 46.5% in 2011, 40% in 2010, 32.6% in 2015, 31.5% in 2016 and 26.1% in 2017 to 25.0% in 2018. Of the 1162 TB/HIV co-infected patients placed on treatment 1127(97.0%) had access to CPT but only 1052(90.5%) had access to ART. Generally, the proportion of co-infected clients that had access to CPT and ART care has been gradually increasing.

The community contribution to TB case finding in Benue State has been declining whereas the community participation in treatment has been increasing. Of the registered TB cases in 2018, 91.3 %(4245) were managed at the community level by treatment supporters whereas TB cases identified from community referral were only 18.9 %(878). The community referral has crashed remarkably over time.

Trend analysis shows that the community referral rose from 14.5 %(838) in 2011, 38.3 %(2255) in 2013, 61.3% (2704) in 2014, 12.4 %(533) in 2015, 8.8% in 2016, 20.4 %(996) in 2017 and now just 18.9% in 2018.

Community TB volunteers (CVs) engaged in 16 LGAs were probably responsible for the initial increase in community level TB referral. The CVs were engaged in 2017 and 2018. However, over time, the engaged CVs were not sustained in terms of motivation identifiers and other logistic support. Consequently, the activities of these CVs waned over time. Data has shown demonstrable gains in case search over time when the community volunteers were engaged. With the exit of the CVs, the programme has witnessed a general declining TB case notification over time. It is hopeful that bringing back on board the CVs will turn the tide in case notification.

²⁵ Data on Benue State referenced here is based on information provided by the State TB Programme to the researchers during the visit.

In 2017 and 2018 the State programme notified 581(11.9%) and 513(11.0%) childhood TB cases respectively. Although, this is an improvement from 166(3.5%) in 2016, it is a huge gap from the 12% of the 14484 (1738) expected of the State TB programme. This means there were 1157 and 1225 missed children who were not notified in 2017 and 2018 respectively.

The number and proportion of under six-year-old contacts of bacteriologically confirmed pulmonary patients who were clinically assessed for eligibility for INH prophylaxis have been increasing gradually with the continuous sensitization of the DOTS staff.

Of the 742 under six-year contacts of infectious TB patients documented in 2018, only 494(66.6%) childhood contacts were screened and 321(43.3%) were found eligible for INH but only 271(36.5%) children accessed INH prophylaxis. The data demonstrates the limitation of access to TB prevention among this vulnerable population.

The programme successfully treated 4018(82.4%) out of the 4879 TB patients that were registered in 2017. The cure rate was 43.0% (2100) and the treatment completion rate was 39.3% (1918). Unfortunately, the programme had poor outcome rates of 17.6%. This poor outcome was made up of 278(5.7%) deaths, 32(0.7%) had failed treatment, 451(9.2%) were lost to follow up during treatment, 91(1.9%) were not evaluated because they were transferred out and their treatment outcome status was not readily available and 9(0.2) were removed from the register because they developed drug-resistant TB.

Of the total 278 TB related deaths documented in the year 47.5% (132) were TB/HIV co-infected. The death rate was also higher among the TB/HIV co-infected; 9.5% (132) persons compared to the non-co-infected TB persons 4.2 % (146).

The number and proportion of diagnosed TB patients opting for community-based care through treatment supporters have steadily been on the increase. In 2017, of the registered TB cases in the year, 86.7% (4228) had community-based treatment. The treatment success of these patients that received treatment under community-based treatment supporters was lower 81.8% (3460) compared to those that were managed by facility DOTS providers 85.7 % (558). Similarly, the community level care had worse outcomes of 18.2% (death rate, failure, LTFU and NE) compared to the facility care of 14.3%.

In 2018, the 28 GeneXpert machines in the State (which were four modular types' collectively analysed 22,893 sputa and detected 2777(14.3%) DS-MTB cases and 123(0.8%) RR-MTB cases. Several of the machines performed sub-optimally as a result of several challenges experienced in the daily running of the machines from modular shut down, to back up power failures, staff fatigue and de-motivation.

The programme enrolled a total of 101 DRTB cases in 2018 out of which 69 passed through the treatment centre and 32 were enrolled on PMDT. The DRTB cases had a co-infection rate of 28.7% (29). A total of 29(100%) of the co-infected patients were documented as having had access to ART & CPT care.

Cross River State

Cross River State was created in September, 1987. It is situated in the south-south geopolitical zone of Nigeria with a 2015 population of 3,643,459 people (2006 National

population census as projected). The major occupation of the people of Cross River State is farming. It has a total of 18 Local Government Areas (LGAs) with 18 Tuberculosis and Leprosy Supervisors (TBLs), each overseeing an LGA in the state. The Cross River State Tuberculosis and Leprosy Control Programme (STBLCP) was formally established in 1994.

The state has 265 Directly Observed Short course strategy (DOTS) centres (200 are active) and 75 acid-fast bacilli (AFB) microscopy centres in public and private health facilities across the state. The LGA microscopy and DOTS Coverage is 100%.

The STBLCP²⁶ in 2017 identified 16,605 presumptive TB cases. Out of this number 659(3.97%) were presumptive DR-TB cases. From this pool of presumptive TB cases, the programme registered 2020 persons (1147 males -56.8%; 873 females – 43.2 %) all form of DSTB cases for treatment.

Of the 2020 DSTB cases notified, 1882 (93%) were Pulmonary TB cases and 138(6.83%) were extra pulmonary TB cases. The notified cases had 1964 incident (New & relapse) cases and 56 retreatment TB cases.

In 2018 the bacteriological diagnosed TB case proportion was (61.5%) 1243, while the clinically diagnosed was 38.5% (777). Of the 2016(99.8%) TB cases whose HIV status was known, 410(20.3%) were TB/HIV co-infected.

Out of the registered TB cases in 2017, 86.2 %(1742) were managed at the community level by treatment supporters whereas TB cases identified from community referral was only 29 %(586).

In 2018 the State program notified 418 childhood TB cases. Of the 385 under six-year contacts of infectious TB patients documented in 2018, only 308(80%) childhood contacts were screened and 214(55.6%) were found eligible for INH but only 145(37.7%) children accessed INH prophylaxis. The data demonstrates the limitation of access to TB prevention among this vulnerable population.

In 2018, the State reported 50% GeneXpert coverage with 9 out of the 18LGAs namely Calabar South, Calabar Municipal, Akamkpa, Yakurr, Obanlik, Bekwara, Boki East and Ogoja having GeneXpert machines.

Lagos State

Lagos is a port city and the most populous city in Nigeria, created in May 1967. The Lagos State Government estimates the population of Lagos at 17.5 million, although this number has been disputed by the Nigerian Government and found to be unreliable by the National Population Commission of Nigeria, which put the population at over 21 million in 2016.²⁷ It

²⁶ Data on Cross River State referenced here is based on information provided by the State TB Programme to the researchers during the visit.

²⁷ <http://worldpopulationreview.com/world-cities/lagos-population/>

is situated in the southwest geopolitical zone of Nigeria and has the smallest landmass among the 36 States in Nigeria.²⁸

Lagos State accounts for 8.4% of Nigeria's TB burden and is responsible for about 11% of the registered TB cases in the country. The primary focus of the Lagos State TB Control Programme is to ensure people have access to TB services in all areas of the State. To this end, all 20 local government areas (LGAs) had at least one DOTS centre by 2006.

Currently, all 57 LGA/local community development areas (LCDAs) are covered. As of April 2017, there were 470 DOTS centres in the State—289 public and 181 private centres, constituting 89.2% of the 324 public health facilities and 5.9% of the 3,088 private health facilities, respectively.

The DOTS centres per person ratio in the State is 1 per 23,557 people, slightly less than the 1 per 25,000 people target set by the NTBLCP. As of April 2017, Lagos State had 102 AFB microscopy service centres and 25 GeneXpert MTB/RIF assay diagnostic machines. Each of the 20 LGAs in the State has at least one GeneXpert machine; Lagos Mainland has 3 and Oshodi-Isolo and Eti-Osa LGAs have 2 each.

The number of registered TB cases in Lagos State rose from 4,307 in 2003 to 8,976 in 2014. In 2016, the State TB Control Program reported 8,757 TB cases, as compared to 4,117 notified by Disease Surveillance Officers, indicating a need for data reconciliation between these institutions.

The TB case cure rate in Lagos State increased from 64% in 2003 to 76% in 2014. However, a 2012 study found very low rates of adherence to the national TB testing and treatment guidelines by both public and private DOTS providers in Lagos State: only 19% of people at public facilities, 25% at private not-for-profit facilities, and none at private for-profit facilities were treated in full.²⁹ (This segment of the report; Context of TB in Lagos State relies on the LEA report on Lagos State as responses to requests and follow up emails to the State TB Program on relevant programme data were not received as at the time this report was being compiled. The STBLCO interviewed as at January 21st 2019 has since been transferred to another department within the Ministry of Health)

Kano State

Kano State was created in May 1967. It is located in the North Western geo-political zone of Nigeria with a 2006 NPC population of 9,401, 288 people and 11,215,688 as at 2012 based on projected figures and a 3.1% growth rate. Kano is a predominantly Hausa/Muslim State, but also cosmopolitan with varieties of religious /ethnic groups and has an influx of people from other states.

²⁸ https://en.wikipedia.org/wiki/Lagos_State

²⁹ Tuberculosis Legal Environment Assessment Nigeria Full Report July 2018 –Page 25

Kano State has been a commercial and agricultural State, which is known for the production of groundnuts as well as for its solid mineral deposits.³⁰ The State has more than 18,684 square kilometres (7,214 sq. metres) of land and is the most extensively irrigated State in the country. It has a total of 44 Local Government Areas (LGAs)

Kano State is among the 6 States with the highest burden of TB in Nigeria. In 2017, the TB incidence was 29, 231 with all under treatment but with an estimated 30,000 expected annual cases, average annual notification in the State leaves a huge gap of 75% missed cases.³¹

DOTS centres increased from 381 in 2006 to more than 770 in 2019; 86 AFB laboratories in 2016 to 255 in 2019, The State currently has 18 GeneXpert Machines³²

This report relies on information sourced online as responses to requests and follow up emails to the State TB Program on relevant programme data were not received as at the time this report was being compiled.

³⁰ <http://www.nigeria.gov.ng/index.php/2016-04-06-08-39-54/north-west/kano-state>

³¹ <https://www.slideshare.net/HFGProject/kano-state-health-profile-nigeria>

³² <http://saharareporters.com/2019/03/28/tuberculosis-kills-355-persons-kano-2018>

4.4 Gender in Nigeria

The term gender is used to describe a set of qualities and behaviours expected from men and women by their societies. A person's social identity is formed by these expectations. These expectations stem from the idea that certain qualities, behaviours, characteristics needs and roles are 'natural' to men while certain other qualities and roles are 'natural' for women.³³

Gender is a social construct and the result of social relations. Gender norms and roles are not set in stone. They are contested, changing and changeable. The way gender is defined is closely related to the construction of ethnic identities, each rooted in its own geographical, social and historical context.

Promoting gender equality is now globally seen as a development strategy that seeks to help women and men escape poverty, and improve their standard of living. Hence, the attainment of gender equality is not only seen as an end in itself (being a human rights issue) but as a prerequisite for the achievement of sustainable development.

Nigeria was ranked 122 out of about 144 countries in the 2017 Gender Gap index, (the Gender Gap Index was developed in 2006 by the World Economic Forum to capture the magnitude and scope of gender-based disparities around the world³⁴. Nigeria is a highly patriarchal society, where men dominate all spheres of women's lives. Women are in a subordinate position (particularly at the community and household levels), and male children are preferred over the female. The influence of the mother and the father is particularly significant in shaping and perpetuating patriarchy. The mother provides the role model for daughters, while the father demonstrates to sons what it means to 'be a man' (World Bank 2005:6)³⁵

Nigeria is a signatory to all major conventions on human', women's and children's rights, and further, to agreements on international goals regarding education, health, and poverty eradication. The legal frameworks are strong but are perceived to lack implementation and linkages to successfully achieve strong positive outcomes. International, Regional and Local Policies and frameworks exist to streamline women empowerment and harmonise responses.

Nigeria ratified the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) on 13 June 1985, although efforts to operationalise its 30 articles locally have faltered. The country also adopted the 1995 Beijing Platform of Action and signed up to the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the

³³ Gender Equality Briefing Kit – The United Nations System in Nigeria (2013)

³⁴ <https://www.weforum.org/reports/the-global-gender-gap-report-2017>

³⁵ National Gender Policy, Situation Analysis/Framework –Federal Ministry of Women Affairs and Social Development – Pg. 18

African Charter on Human and People's Rights and, crucially, the Protocol on the Rights of Women in Africa (The Maputo Protocol).

Local laws and policies include the Constitution of the Federal Republic of Nigeria 1990, National Gender Policy (2006), and the Violence against Persons Prohibition Bill (VAPP), 2013. Despite these, gender inequality is high.³⁶ This is reflected in economic outcomes as well as political representation. 31% of currently married women participate in decisions regarding their own health care, major household purchases, and visits to their family or relatives.³⁷

Available literature suggests that the gender imbalances observed in Nigeria are often premised on factors such as poor level of education of women, patriarchy, poor access to information, lack of experience and financial opportunities compared to men. In addition to this, adolescent girls and women are often systematically excluded and disadvantaged and this has hampered development across Nigeria and particularly in the North of the country.

Gender relationships shaped by decades of patriarchy has seen women with less education than men, with less voice and opportunities to participate, all these impact on their health and wellbeing as well as that of their families. Achieving universal access to health requires the transformation of these many cultural and gendered barriers that limit better health outcomes for all Nigerians. Education also has a key role to play. A woman's educational status correlates closely with her health-seeking behaviour and better health outcomes. Making schools more attractive and less costly places for all adolescent girls can influence decisions to delay marriage and childbirth.³⁸

Many socio-cultural gender norms and practices are detrimental to girls and women albeit with significant geographical and cultural variations. These socio-cultural norms and values limit girls' and women's capabilities and undermine concerted efforts aimed at helping women and girls realise their full potentials. Among key socio-cultural barriers to girls and women's empowerment in Nigeria are the institutions of culture and religion that are also the custodians of deeply entrenched religious and traditional practices that reinforce discriminatory access to basic services and act as barriers to economic participation and opportunities; limit visibility, voice and agency among adolescent girls and young women to mention a few.³⁹

4.5 Socio-Cultural Barriers and Health Outcomes

Nigeria still has a disproportional share of global infant, child, and maternal deaths. Apart from inadequate infrastructure and poor quality of care, women's access to health is compromised by user fees, informal charges, and levies that deter or delay women and

³⁶ The fourth World Conference on Women. Action for Equality, Development and Peace was held in Beijing, China - September 1995 and sought to achieve the Advancement of Women by removing all obstacles to women's active participation in all spheres of public and private life through a full and equal share in economic, social, cultural and political decision-making. (United Nations, 1995) (National Agency for the Control of AIDS and United Nations Development Programme, 2014)

³⁷ (National Population Commission Nigeria and ICF International, 2014)

³⁸

³⁹ Gender Equality Briefing Kit – The United Nations System in Nigeria Pgs. 20-21

decision-making members of their families from seeking essential lifesaving health care.⁴⁰ In addition, gender, cultural norms and value systems remain critical barriers to better health outcomes in Nigeria. Women in some parts of the country require explicit permission of family gatekeepers (Husband, father and mother in law), for example, to deliver in facilities and or take their children for healthcare. Education has a role to play in redressing the gender power imbalance that currently costs the lives and health of many young women. If these changes are not made, women and adolescent girls in Nigeria will continue to face serious challenges to their health and well-being.

4.6 Decision Making

The ability of women to make decisions that affect their personal circumstances is an essential aspect of their empowerment. The 2013 NDHS asked currently married women about their participation in three types of household decisions: her own health care, making major household purchases, and visits to family or relatives. Nearly half of women reported having sole or joint decision making power about visiting family or relatives, while only 38% participate in decisions about major household purchases. Nearly four in ten married women participate in decisions about their own health care. Half do not participate in any of the three decisions; less than one-third report that they participate in all three decisions.⁴¹

4.7 Resource Management and Utilization:

Gender imbalance substantially limits women's access to control over and use of service and productive resources. Women face numerous challenges within the agricultural sector, including lack of control over land, capital, and even their own labour. Other challenges include lack of access to appropriate technologies, exploitation by marketers or service providers and lack of access to productive opportunities (FMWAASD, 2006).

Although women represent between 60% and 79% of Nigeria's rural labour force, men are five times more likely to own land than women. In general, land ownership is very low among women, a factor that limits their ability to exploit a land-based livelihood strategy. It affects their ability to access finance, for example, and often delays investment decisions or reduces the earning potential of agriculture (Aluko and Amidu 2006). Women's access to land, a key productive asset, is limited by patrilineal inheritance (from father to son), traditional authority structures that tend to give men decision-making control over all spheres of life⁴²

4.8 Gender and Tuberculosis

Gender is an area often neglected by those seeking to end the TB epidemic. According to the World Health Organisation, globally men are significantly more at risk of contracting and

⁴⁰ Gender in Nigeria 2012 – Improving the Lives of Girls and Women in Nigeria 2012, British Council Pg. 61

⁴¹ Gender in Nigeria –Data from the 2013 Nigeria Demographic Health Survey

<https://dhsprogram.com/pubs/pdf/DM52/DM52.pdf>

⁴² *Ibid* Gender in Nigeria – British Council Report (2012)

dying from TB than women, but TB has a significant impact on women worldwide. ⁴³ TB can, however, have particularly severe consequences for women especially during their reproductive years and during pregnancy. TB was one of the top three causes of death among the women of reproductive age (WHO 2015). ⁴⁴In some regions such as Sub-Saharan Africa, these numbers are even higher, where TB is the third leading cause of death for women.

The Global Fund maintains that addressing gender inequality and human rights barriers with concrete programmes and gender-responsive human rights-based programming and implementation is essential to ensuring that quality TB services are available and accessible to all in particular key and vulnerable populations. Several factors account for the Gender differences in TB:

Men	Women
More social contacts	Face higher stigma
Work in high-risk settings	Delayed diagnosis
More likely to smoke	Less access to treatment services
Consume more alcohol	High rates of extra pulmonary TB among women meaning they are harder to screen and diagnosis
More likely to mitigate for work and face treatment interruptions	

Gender dynamics in TB enrolment, treatment and cure rates are not uniform. In some countries, men have better outcomes than women while in other countries, it is women who do.

Within the Nigerian context, the National Gender Policy makes no direct reference to Tuberculosis. It, however, recognises the gender aspects of HIV and the risks and vulnerabilities of women and girls and some key affected populations. The policy’s broad goal in relation to HIV and AIDS is to promote *systematic and consistent gender mainstreaming into HIV/AIDS policies, plans, programmes, and activities at all levels; build gender analysis capacity of coordinating agencies; and create an enabling gender-inclusive environment in the fight against HIV/AIDS as well as address the differential impact of the pandemic on women and men at all levels.* ⁴⁵

The Gender policy’s objectives in relation to HIV also include:

1. Promote gender mainstreaming into HIV/AIDS policies, plans, programmes, and activities at all levels towards the prevention, treatment and care for sexually transmitted diseases, and HIV/AIDS.
2. Create an enabling gender-inclusive environment in the fight against HIV/AIDS, and address the differential impact of the pandemic on women and men

⁴³ <https://www.results-resultats.ca/en/events/canada-and-the-high-level-meeting-on-tb-gender-matters/>

⁴⁴ WHO (2015) “TB in Women” (http://www.who.int/tb/publications/tb_women_factsheet_251013.pdf)

⁴⁵ National Gender Policy – Page 75

3. Promote gender-responsive workplace prevention and care programmes in the public and private sectors

Given that the NSP- TB prioritises working with the National Agency for the Control of AIDS (NACA) and the National AIDS and Sexually Transmitted Infections Control Programme (NASCP) to scale up integrated TB and HIV services, it can be inferred that the Gender policy would also impact on the activities of the NTBLCP.

Furthermore, the goal of the National Strategic Plan for TB Control (NSP-TB) 2015 -2020 is to ensure universal access to high quality, patient-centred TB prevention, and diagnosis and treatment services for Nigerians with all forms of TB, regardless of the geographic location, income, **gender**, age, religion, tribe or other affiliation.⁴⁶ .

The Strategic plan further recognises that interventions aimed at reaching men and women at risk of tuberculosis must take into account the specific barriers to care that they face while acknowledging that all Nigerians are facing significant barriers to accessing TB services unrelated to gender.

It further notes that in general, males' access to TB services is likely influenced by working hours and locations, incarceration, stigma, competing priorities and lack of perceived threat to their health. Women likely face access issues because of religious and cultural restrictions on their independent movement, a lower family priority placed on their health, stigma, and fear of being outcasts from the family or considered unmarriageable, competing priorities and perceived lack of threat to their health.⁴⁷ The plan also acknowledges that there is a need to further confirm this.

Data from the National TB prevalence survey (2012) shows a significantly higher burden of TB among men than women. In adult males, the prevalence of the bacteriologically confirmed TB is estimated at 751/100,000 and in adult females at 359/100 000. The ratio of observed prevalence in the survey to smear positive case notification rates also differed by gender. For men, the ratio was 7.25 whereas for women it was 4.63⁴⁸.

The 3rd NSP strategic approach in order of priority particularly identifies men among the undeserved group to be focused on as it states;

*Shift from passive to active case finding in key affected populations including PLHIV, contacts of TB cases, urban slum dwellers, **men**, prisoners, migrants, and internally displaced people, nomadic population, children, people with diabetes and facility-based health workers in order to target those most at risk for TB⁴⁹*

Programme data from implemented Global Fund grants as well as feedback from some of the States visited in the course of the assessment speak to interventions addressing TB in male-dominated settings such as TB awareness creation targeting football viewing centres, (Commercial Motorcyclists (Okada riders' associations) etc. while the USAID/KNCV

⁴⁶ NSP-TB Pg. 2

⁴⁷ Ibid Pg. 78

⁴⁸ First National TB Prevalence Survey 2012 Pg. 59

⁴⁹ Ibid NSP_TB Pg. 5

supported Uwar Gida Housewives Initiative in Kano State being implemented in selected local government areas are recording success in reaching out to women.

More of such gender-sensitive services are needed to capture the different needs and gender dynamics in TB diagnosis, enrolment, and treatment. However, understanding the health-seeking behaviours of men and women through a systematic assessment is a critical step to supporting this.

The findings from this assessment conducted in the 4 States provides perspectives from literature as well as a broad range of stakeholders including TB programme staff, health workers, persons affected by TB, PLHIV, prisoners, urban slum dwellers, and Religious/Community leaders which will hopefully inform a robust effective, gender-responsive and patient-centered TB response that truly leaves no one behind.

5. Findings

This section provides the gender related findings of the qualitative research.

5.1 Laws, policies and institutional practices influencing how men and women seek TB services

A general overview of the Nigerian health sector shows that the country is not lacking in the number or quantity of legal and policy frameworks required for the effective delivery of quality health services to the citizens. Two major challenges with health sector laws and policies in Nigeria have always been:

- I. the quality and scope of health laws and policies with regard to how such laws and policies effectively meet the health needs of all groups of citizens particularly those socially excluded by gender, age, disability, or those termed as key populations
- II. the capacity of public health care institutions to effectively and sustainably implement health laws and policies; ensuring that health needs of all citizens including vulnerable ones are adequately met⁵⁰

Nigeria adopted and is guided by the End TB Strategy which aims to end the global TB epidemic, with targets to reduce TB deaths by 95% and to cut new cases by 90% between 2015 and 2035, and to ensure that no family is burdened with catastrophic expenses due to TB.

The laws instituting public health generally in Nigeria, as well as the various guidelines of the Federal Ministry of Health (FMOH,) through the National TB Programme, informs TB control measures carried out at State and Local Government levels through the health facilities or at community levels.⁵¹

Health care workers at all cadres and civil society groups working at community levels interviewed allude to the fact that guidelines, strategic documents, and directives from the National Programme guide institutional practices with respect to the delivery of TB services. Strategies are often provider-initiated and cover a broad range of services.

In one of the facilities visited in Lagos State for instance, the health worker interviewed, explained that health education on Tuberculosis is routinely carried out in the clinics particularly at the Maternal and Child Section (which caters for women attending antenatal care as well as the General Outpatient Patient Department (GOPD) which offers primary medical care to outpatient adults from 18 years and above (both male and female).

⁵¹ Please refer to the TB Legal and Environmental Assessment Report (July 2018) which provides an extensive review of the public health policies guiding the TB response in Nigeria

“In the course of health education, patients who have been coughing for more than two weeks are promptly identified and attended to first. It’s a directive from NTBLCP as Lagos is a high TB burden state so we conduct regular TB screening for all patients. Routine screening of HIV patients, particularly those at risk of TB is done, and we place them on Cotrimoxazole or INH if they are at risk of TB infection.” – KII with Health care provider, Lagos

At community levels various examples of outreaches (TB awareness and sensitisations in market places, during social and religious gatherings, peer group meetings, WOW trucks etc.), routine immunisation programmes, house to house visits, community dialogues, lunch hour meetings etc.were cited as examples of avenues being used to influence and draw people to seek TB diagnostic and treatment services.

Respondents in the states noted that in some communities, the outreaches are targeted and focused ways of getting the men who ordinarily won’t go to the facilities.

However, beyond the outreaches, where sputum is often collected at the community level, it is standard practice that the clients are expected to visit the health facility once the test indicates that the individual is confirmed positive for TB.

Respondents noted that often, men and women differ in the **acceptance of the results** of the TB diagnosis and note that women are often more responsive than men

- *“This is really the essence of the outreaches conducted because the men don’t go to the health facilities; when the outreach is conducted in the communities, we collect the samples , collect their addresses and follow up such that if it tests positive; we have to follow them to where they work; it is preferable to collect samples there and then from men, because the moment you refer, them, you may lose them(men) and the disease will continue spreading” - FGD with CSOs, Kano*
- *“Women easily accept the outcomes of the TB diagnosis. Men may think something else is the matter, they may be hesitant and take time to be convinced. Some may suspect that it’s caused by something else, or someone is coinfecting with HIV” – KII with STBLCO, Cross River*
- *“In my experience when we issue women referrals they often come (over 90% of them) even if you don’t offer them any money, but for men’s referrals, most of them don’t want to come to the facility. Even when you say you work with an NGO and offer them transport. Men believe coming to the facility equals spending money and they don’t want to spend any money. Men are hustling looking for what to eat” – FGD with CSOs, Kano*

5.2 Beliefs, socio-cultural norms and gender inequities influencing TB health-seeking practices

Respondents generally agreed that women’s health-seeking practices as it relates to TB services was better than those of men because they were more responsive, though their

responsiveness is not necessarily optimal as both women and men encounter challenges in accessing care. Several male and female TB patients interviewed admitted that their first port of call for treatment for TB was the nearby chemist. Several respondents had described the local chemist (patent medicine vendor) as *nearer, "cheaper and a place that can quickly provide assistance before you come to the hospital."*

Health care providers and CSOs working at the community level also provided varying reasons that influence the health-seeking attitudes of both men and women. While men's health-seeking attitudes were influenced by their breadwinner roles; work/pursuit of their means of livelihood, access to resources and lack of perceived threat to their health, women were more responsive to seeking health care because they tend to make out time and are concerned about their homemaker roles, the wellbeing of their family/ children and being healthy to take care of them. Cultural and religious beliefs about TB as well as socio-cultural norms also play a major role in influencing health-seeking attitudes,

Men delay because seeking TB diagnosis and care because:

- *"They are going about their normal hustle (work/ business)and this will continue until they can no longer cope with the condition "* –**KII with STBLCO, Lagos**
- *'It is difficult for men to seek care, it's a nonchalant attitude until they are down and emaciated. They will start to self-medicate for as long as they are healthy'".* – **FGD with male PLHIV, Lagos**
- *"They don't want to come to the facility. Rather they opt for all sorts of concoctions"-***KII with TBLS Benue**
- *"They lack funds to seek care and often delay because they prefer their wives and children over themselves. They would rather brace up and hope the condition will go away"* –**FGD with CSOs, Benue**
- *"They want to avoid embarrassment from health care workers who are unfriendly and attend to them from behind locked windows. A client was referred to IDH and because he saw mainly women, he was discouraged, and he stopped treatment because he was feeling okay and better"* - **FGD with male PLHIV**

Women are responsive to seeking TB diagnosis and care because:

- *"They complain and voice out much earlier than men. They speak for their children and themselves earlier than the men"* – **KII with STBLCO Benue**
- *"They usually seek care early, particularly because of the children. Women are likely to get sicker from TB, but men die more"* – **KII with STBLCO, Lagos**

- *“The responsibility of sustaining the household lies solely on women; so they need to be strong, that is why they need to go to the hospital; sometimes men will insist that their wives go to the hospital so that they can be healthy enough to prepare food; if men don’t eat, there will be problems at home, so they will insist that the wife goes for treatment. Also, a woman’s ability to be productive on the farm is critical for the household”- FGD with Community members, Benue*
- *“Women are usually receptive, take their drugs as at when due, and are unwilling to affect others in the household. They always have time to come to the facility.” – KII with TBLS, Lagos*
- *“Apart from thinking about how to get tested; women are also thinking of the wellbeing of their children since they stay closer to them” –KII with STBLCO Kano*

Beliefs about TB often stem from culture and religion and these beliefs are often pervasive. Across the 4 states visited, beliefs about the nature of the cough influence health-seeking behaviours. There is a general trend of dismissing persistent cough (which is a major symptom of TB) as either a condition that is common to a particular age group, prevalent in the family or hereditary.

Programme Managers interviewed across the states acknowledge that while awareness programmes to address myths and misconceptions exist, there is limited funding support for the continuous airing of jingles and informational programmes on TB through the traditional media such as radio and television channels.

While many of the health workers and CSOs working on TB across the states note that the targeted outreaches and interpersonal communication are helping to draw both men and women to the health facilities for TB screening; reactions of men and women about TB are mixed and influenced by various beliefs and perceptions depending on the context.

5.2.1 Beliefs

- *“Benue is divided into 3 zones (Zones A, B, and C). People from Zones A and B particularly have the belief that not every cough is TB related which is true, but the generalization is such that it may affect actual TB cases. There are beliefs in **hereditary cough, if you’re born into a family that suffers that kind of cough, it may be overlooked.** There is a belief in Twins Cough. There is also a type of cough known as HAMPUR which is believed to be treated traditionally thus there may be a delay in seeking care. Such beliefs influence and delay health-seeking. They may also wave it off, if its Hampur, they’d go to the herbalist if there is a history of twins in the family, they may also wave it off and describe it as due to ‘Twin Cough’ locally referred to as Hoe Anyinaa.”*
KII with STBLCO, Benue

- *“In the communities where we work, some people believe that they inherited the cough, Sometimes when we ask that they be screened for TB, they challenge us while others refuse saying that they inherited the cough from their grandparents. Often when we test those who agree, and based on the signs and symptoms we see, in most cases, its TB” – FGD with CSOs, Kano*

Respondents cited various myths and misconceptions which fuel superstitious beliefs about TB. Beliefs that everyone who has TB also has HIV cuts across in many of the sites assessed.

- *“There is the perception that anyone who has TB has HIV. In particular, people in Biahe believe that only HIV positive people have TB and they are stigmatized.”- FGD with CSOs,- Cross River*
- *“Rejection of the TB services occurs; some people think that whenever you are giving free service, maybe it is because you have bad intentions, while others accept it and are happy” –TBLS, Kano*

Local language terminologies used to describe TB mentioned by several respondents also evoke fear and reinforce beliefs that TB is incurable. Respondents explained that in Igbo language spoken by many residents in the South-Eastern part of the country, TB is termed **Ukwara nta**. In Hausa, TB is referred to as **Tarin Fuka** (which literally means, cough till you die).

- *“The Igbos describe TB as Ukwara nta or **the chronic cough that never ends** – Even that term puts fear in the hearer. In Cross River State, TB is described as **Akpai-kpai Ikong** which is literally described as **the incurable cough that leads to death**. It is a stigmatising term and implies that the individual would eventually die. - FGD with CSOs Lagos and Calabar*
- *“There are beliefs that TB can never be cured even in the health facilities and that it’s still there even after treatment. In some parts of the State there is the belief that boiling and eating the Agama Lizard can cure TB,” – FGD with CSOs – Benue*

Religious and superstitious beliefs are also closely related to the culturally held beliefs about TB and influence health-seeking patterns. For instance, some respondents noted that *TB is often described as God’s way of punishing someone who has done something wrong.*

- *“We had an experience when we were implementing the Active Case Finding project in 2016. There was a particular house which had been rented by an individual who had MDR-TB, it’s a communicable disease, maybe because the place is poorly ventilated, the bacteria can last for more than 24 hours; the community members*

realised that those who rented the apartment subsequently (3 different individuals) were always coughing and coming down with symptoms of TB, so they labelled the house as being evil. When we learned about it we notified the Village Head and the State TB Programme and with their support, we were able to fumigate the house; we also did some renovation and added another window, that was one of our success stories in the last quarter”- FGD with CSOs, Kano

Respondents’ particularly health care workers also noted that religious beliefs often hinder a client’s adherence to TB treatment.

- *“When a patient stops coming for their TB treatment and you call to ask why, and they tell you God has taken control, it simply means, don’t call me again” – KII with Health Care Provider, Lagos*

5.2.2 Socio-cultural norms

Feedback from respondents indicate that socio-cultural norms that define expectations about men and women’s behaviours also play a major role in shaping and influencing health-seeking practices.

Men

Culturally, men are expected to be strong (and almost invincible) and possess the capacity to endure pain. Several respondents also shared the view that seeking health care services in a hospital is viewed as a feminine practice. In addition, there is the belief that health initiatives in hospitals are designed for women. Given their traditional role as breadwinners, men are expected to be productive on the job and seeking care in a health facility may disrupt their capacity to earn money. In some contexts, however, state policies and laid down rules are now prompting men to go to the health facility to undergo certain tests as a prerequisite for marriage.

- *“I go to the hospital whenever I am sick, but most of my guys (people who use drugs) like to get high, and after the effect of the drugs wear off, they go low, so they ascribe some of their weaknesses/body pains to effects of the drugs they have taken, so it may not be considered a hospital-related issue” – FGD with Community members, Benue*
- *“Hospital Na woman thing. Na dem dey go hospital to commot belle, do tests. Man no dey go hospital (The hospital is the woman’s thing. They go there to deliver when they are pregnant and go often for all sorts of tests. Men don’t go to the hospital) “- FGD with men in Urban Slums, Cross River*
- *“I think it’s an African thing - If a man falls sick, instead of going to the hospital he’d rather discuss with and inform his friend who may advise him either to go to the hospital or to seek other alternatives. It’s more like a referral-based decision. I talk to*

3 or 4 friends and based on their recommendations, I decide whether to seek health services or not “– **FGD with CSOs, Benue**

- *“Men usually don’t go to the hospital early because of their commitment to work, business, etc. There is a general perception that it is difficult for men, to drop those responsibilities and come to the hospital” - **FGD with women (Uwar Gida), Kano***
- *Men are easily cajoled into accepting and buying these medicines sold by mobile medicine sellers that address general health problems such as those that promote ejaculation and cure body weaknesses. They often consider the value of the time they will spend in the hospital - **Female Community Leader, Cross River***
- *“A lot of people particularly men are now going to the facility because they want to know their status and that of whom they want to marry. The State policy in place through HIZBAH as a segment of Government is trying to push this, to cater for intermarriages. It is now a rule from the Emirate Council, down to every Ward Head that whoever wants to marry in this community must bring the certificate of his/her status; HIV and other underlying conditions. To ensure a safe community the HIZBAH will not join discordant couples (HIV positive and HIV negative). They will advise the positive partner to look for a partner elsewhere” – **KII with Community Leader, Kano***

Women

Socio-cultural norms dictate that women are expected to be weak, submissive, prone to illness and physically/ financially dependent on the men for their health. Their homemaker and caregiving role and the desire to protect their children/families from being infected, also predisposes them to seek care early. Though women may desire to seek care early, lack of resources and obtaining the permission /consent of their husbands (for married women in some socio-cultural contexts) pose challenges and could delay their health-seeking practices.

Oshi *et al* in the study on Gender-related factors influencing Women's health-seeking for Tuberculosis care in Ebonyi State, Nigeria further notes that gender relations prohibit women from seeking care for symptoms of TB and other diseases outside their community without their husbands' approval. Gender norms on intra-household resource ownership and control divest women of the power to allocate money for healthcare-seeking.⁵²

⁵²Oshi et al, Gender related factors influencing women’s health seeking for TB care
<https://www.ncbi.nlm.nih.gov/pubmed/26627885>

- *“Sometimes men and women may not have equal access to health care systems because of beliefs that men are on top, and are ahead and have the resources “- KII with STBLCO, Kano*
- *“Woman’s blood is not as strong as the man’s blood. A man is a man. You cannot compare children and grown-up people. We take and treat women as children” – FGD with IDP Camp residents, Benue*
- *“I was sick for about 3 weeks before coming to the hospital.”*
Probe: Why did you wait that long?
“I was having throat pain with aches. I was also having an active productive cough, but I was told it’s a condition that requires traditional medicine, so I was taking traditional medicine until the cough refused to subside and I eventually came to the hospital. I did not come to the hospital first. It was as a result of financial challenges. My husband said he didn’t have money to take me to the hospital until my husband’s parents had to intervene financially, since I wasn’t getting better with the traditional medicine. I had to seek her husband’s permission to come to the hospital”– Woman with TB, Benue

“For many women, the husband’s consent and approval is critical and getting that permission can delay her ability to access care early. Finances also affect a man’s ability to give permission. If his wife wants to go to the hospital and he doesn’t have the resources to give her, she may not be able to go even if he consents unless she is financially empowered to do so. Permission is a big issue even for operations (surgeries), if the man doesn’t consent and sign, the woman will die “- FGD with CSOs, Benue

5.2.3 Gender inequities and inequalities

Respondents agree that inequalities exist which often impact particularly on women and children’s ability to seek care. They note that in many of the communities, women are not economically empowered and when women are not empowered there is a differential, as men tend to have more cash power. Oftentimes, the individual with cash power is the family decision-maker and determines what the priorities should be and who gets what.

- *“Women don’t have a voice. Once we had a client and we had asked her husband to be her treatment partner. The man refused. The man is from Cross River State while the wife is from one of the South Eastern States. He asked her to go back to her village saying ‘witches are pursuing her’. She is not working, she can be suppressed because she is not earning her own income, although she is a graduate, she collects everything from her husband” – KII with, Health worker, Cross River State*
- *“Some of us men don’t allow our women to go to the hospital on her own. If her husband is not around, she may not be able to go. The man may attach his wife to someone else if he cannot take her” – KII with Muslim leader, Cross River State*

- *“Most of the people in this area are peasant farmers and the men often control the resources. Before a woman/child goes to the hospital, they need the consent of the man in the family. If the man doesn’t consent and provide the necessary resources, accessing care may be difficult. This is a common issue” – KII with TBLS, Benue*
- *“Most of the women are unable to come to the facility as a result of financial issues as they have to wait for their husbands, who may refuse saying no, I don’t have money for transport; they may also be expecting that TB treatment may cost a lot so they may fear coming to the hospital” – DOTS Provider, Kano*
- *“Transactional sex occurs because men have more money. Sometimes for a woman to get the resources that she needs a man may demand sex, sometimes even without protection (condoms). Transactional sex is quite prevalent. Here, the females work hard sometimes more than the men by farming and engaging in other activities but the cash at hand is disproportionately distributed. It's more for the males so sometimes to make up for that some of the female folks may be led to engage in transactional sex that exposes them to sexually transmitted infections, including HIV. They can also be at the risk of TB because TB and HIV are closely related” – KII with Health worker, Benue*

5.3 Gender and Predisposing factors to TB

Respondents highlighted several factors that predispose individuals to the risk of TB. Some factors cut across while some are gender-specific. Cross-cutting factors identified include:

- Poverty
- Presence of HIV infection
- Poor Housing conditions/ Congested settings with poor ventilation
- Urban/Rural Slums
- Crisis situations which result in individuals being displaced or having to live in camps that may be congested and overpopulated.
 - *The camp setting could be a predisposing factor –the risk is in the congestion, the way in which people live can easily spread the infection. Things are a bit better now (the camp population had reduced from over 15, 0000 to over 2000 residents at the time of the visit). Now some IDPs have relocated, otherwise, there was a lot of overcrowding before that could predispose people to TB - KII with IDP Camp Health Care Provider, Benue State*
 - During the FGD with camp residents, respondents noted that some of the camp residents who were being housed in temporary tents opted to carve out only one window in their house. The tents (made of tarpaulin) are given to each household (comprising of a minimum of 5 people) and households have the options of carving out as many windows as they desire. The respondents explained that because some households plan to utilise these

tents later outside the camp they usually limit the number of windows they carve out in their tarpaulin tent.

- Malnutrition
- Physiological conditions and malignancies of any form. Malignancies and the drugs administered to patients with such conditions lower immunity and can bring up cases of TB
- **Incarceration** – Inmates with TB and prison officials interviewed in the Male prisons visited emphasised that the overcrowding in the prison cells poses a risk of infection/ reinfection
- **Age:**
 - “We are missing out on childhood TB cases as well as TB in the elderly/geriatrics There are a lot of old people abandoned in the huts who are coughing and no one cares to look out for them, they are perceived as marking time to die and there are no interventions for them.” – **KII with STBLCO, Benue**
 - Particularly noteworthy in Calabar, Cross River State as mentioned by CSOs in the FGD discussions and as observed in movement around the city was the presence of street kids (both male and female) who often beg for food during the daytime and sleep together at night in slums areas, crowded settings, etc. The boys are referred to as **Skolombos** while the girls are referred to as **La Casera**. Respondents described them as *mobile and difficult to trace populations*

Men

Generally, respondents believed that men were more at risk of TB infection because of their social habits, practices and due to certain occupations. Several instances of health workers and community volunteers who had come down with TB were also cited.

Men have so many social gatherings such as football matches, bars, clubs, village meetings, associations, etc. where men often congregate and socialize. They tend to gather in crowded/ shielded locations with limited ventilation such as football viewing centres.

- “Men tend to engage in communal drinking, practices such as 20 people sharing one cup, arrangements of sitting together in congested places where they are coughing, smoking and, spittle is released when coughing. Often, they are not as hygiene conscious as women. Men who drink the locally brewed alcohol known as *Burukutu* or *BKT* may be at risk of TB infection because one calabash is passed around so many people and they rarely wash the calabash. It is often laced with thick saliva as it passes round” –**KII with TBLS, Benue**
- “A lot of young men share Indian hemp, take local gin (*Ogogoro*) and only use one cup. Based on our traditional practices using one cup signifies love and sharing” - **KII with Traditional Leader, Cross River**

It was also highlighted that men's occupations sometimes expose them to the risk of TB. For instance, men who work in quarries or in dusty areas e.g. Commercial Motorcyclists, Bus conductors. Cattle herders were also commonly cited as part of those who were most likely at risk of TB.

Women

Respondents associated women's risk of TB with their caregiving roles, as well as certain occupations. In addition, pregnancy, a physiological condition that lowers a woman's immune system was also highlighted.

- *“My father's wife also had TB. Maybe I contracted it from her. People ran away from her and I was the only one that took care of her”*

KII with Woman with TB, Kano

- *“Most women are street sweepers, healthcare workers and even the orderlies in the hospital are women. These occupations can expose women more to the risk of TB infection” - KII with Health worker, Cross River*

- *“Female Sex Workers are also exposed to TB in Makurdi. For many of them, their first predisposition is their living conditions because they come in groups and have a tendency of staying in groups and conditions of overcrowding. They are also at risk of STIs and HIV and the relationship between HIV and TB is also a factor. Climatic factors also play a major role. Most of them come around from the neighbouring towns and they stay in open places sometimes till the middle of the night looking for clients so they are sometimes exposed to harsh weather. In areas where they stay, you often find people smoking and they are really exposed to adverse conditions” –*

KII with Health worker, Benue

5.4 Gender-related Barriers in accessing TB diagnostic and Treatment Services

The nature of TB as a disease prevalent especially among the poor and those affected by inequality creates barriers as people affected by TB often have inadequate access to TB diagnosis and care services compared to the general population. Many of the respondents interviewed noted that given the various myths and misconceptions that are often prevalent in different contexts, people with chronic, infectious diseases such as TB and HIV are generally avoided, isolated or stigmatised. Individual, societal and health system-related factors also pose significant barriers. Studies show that barriers limiting access to TB care have context-specific gender-related differences.⁵³

⁵³ Gender Related Barriers and Delays in Accessing Tuberculosis Diagnostic and Treatment Services
A systematic review of qualitative studies <https://www.hindawi.com/journals/trt/2014/215059/>

Several barriers were cited by respondents namely; poverty, stigma, myths and misconceptions; cultural and religious beliefs, permission / consent of spouse; level of education, clinic hours, distance/ access to health facilities, crisis, attitude of health workers, as well as programmatic challenges (spread of DOTS centres, drug and commodities stock out, limited spread of diagnostic equipment particularly AFB microscopy and GeneXpert machines).

While most of the identified barriers are cross-cutting and have no gender bias, a few such as Stigma tended to have more significant effects on women more than men. Permission/Consent of Spouse and Financial dependence stood out as major barriers for women while clinic hours was a barrier more related to men.

5.4.1 Stigma

Stigma as a cross-cutting barrier affecting TB diagnosis and treatment tends to affect men and women differently. FGD respondents from the community noted that the community reactions towards persons with TB include avoidance, keeping a distance from the individual, dissociating from the individual or affected family because of the belief that TB is an infection that cannot easily be cured and its linkage with HIV. According to them, these reactions are often borne out of **myths and misconceptions** as well as fear of contracting TB.

For instance, in one of the States visited, a community health care worker had stressed that the side effects of a drug trial following a meningitis outbreak in 1996 which resulted in the loss of lives and disability of young children was still impacting some individual's beliefs' till date.⁵⁴

“There are still fears about the failed drug trial which took place in 1996. Some of the community members are fearful about giving their children these drugs because they think it is a kind of drug trial, so they refuse the drugs and won't allow their children to take the anti TB drugs even when they (the children) have tested TB positive. Sometimes we have to educate the families' concerned extensively or we invite the Community leaders to wade into the matter and reassure the families”. – **FGD with Uwar Gida (Housewives/Health Volunteer, Kano**

Stigma also impacts on how people access TB diagnostic and treatment services. Although the NTBLCP guidelines require that DOTS providers refer clients to DOTS centres that are closer to their homes, some individuals still prefer DOTS centres which are far off for fear of being identified by health workers or family members who know them, and as a result of stigma.

“Oftentimes, midway into the treatment, they may be unable to continue with the treatment because of the distance and associated transport costs which puts a strain on their pockets.

⁵⁴ Trovan Drug Trial <https://www.bbc.com/news/world-africa-14493277>

They may eventually abandon the treatment once they feel better and this may lead to drug-resistant TB” – KII with Health worker, Benue

Awareness and accurate information about TB infection, signs and symptoms and the fact that TB is curable is still low. Local language terminologies about TB also evoke fear and portray the condition as incurable.

- *“Cultural beliefs about TB don't change overnight. Beliefs that the disease is spiritual and it has a familial history still persist” – KII with Health worker, Benue*
- *“In a particular street, we had identified 7 people with TB; the community members avoid passing that street; we went there and we were told there is some strange disease in that street, and they don't want to be a part of the problem, hence they isolated that street and people living there” - FGD with CSOs , Kano*
- *“People still stigmatize those with TB, particularly those who have wasting because they think they have HIV even when they don't have HIV- KII with STBLCO, Kano*

While both men and women with TB interviewed reported experiencing varying degrees of stigma, community members, CSOs and health workers were of the opinion that women are more often at the receiving end of stigma than men

- *“People associate TB with someone smoking, so females are more stigmatised than men. Culture forbids a woman from smoking. It's a man thing to smoke” – FGD with PLHIV, Lagos*
- *“From my view, stigma is more or less on the women's side, they are the recipients of stigma because men are often more matured in their responses, but women when they gather will talk /gossip about the person with TB” – KII with TBLS, Kano*
- *“Hardly do people know that **men** have TB, because they are always going out and can be very secretive about taking their drugs. Men tend to hide the disease that they have from the people that they are mingling with” - KII with TBLS*

Men

Men reported experiencing stigma but had a tendency of managing and keeping information about their TB illness to themselves, avoiding disclosure, isolating themselves or, providing wrong phone numbers and home addresses (in order to prevent follow up calls and visits from Community volunteers or health care providers).

- *“When I learned I had DR-TB, I dissociated myself from the family until I came to this facility” – KII with male DR TB patient, Benue*
- *“I work as a driver and I can go to work. My boss is a doctor but doesn’t know that I have TB” – FGD with Male TB patients, Lagos*
- *“After my diagnosis and the community knew I was taking TB treatment they started running away from me and when I noticed they have been stigmatizing me, I started isolating myself from them. But now I am better and if I did not tell anybody that I am coughing nobody will know. I am better now and the stigmatization has stopped since I am no more coughing” - KII with male TB patient, Kano*
- *“Smoking among the male prison inmates is common practice and as a patient on TB treatment, you are forced to inhale the smoke (even if you don’t want to join them. It’s a general cell and if you complain, you’ll hear remarks like Wetin dey worry you, (what’s worrying you) why don’t you mind your business? We are about 75 people in a cell and we can’t tell them to stop because we have TB” – FGD with Male inmates with TB, Lagos*
- *“I am in business and I rear cattle. Only my family members know that I have TB and they have been quiet about my condition since then. Whenever I go for social gatherings such as weddings and I feel like coughing, I just have to excuse myself from the midst of others” – KII with male TB patient, Kano*
- *“Most of the people in Logo have farmlands in Taraba (Logo in Benue State borders Taraba State), but when they come to start treatment they do not disclose that they reside in Taraba, they give addresses that they are staying in a particular place nearby, eventually they abandon the treatment and go back to Taraba, that is what the men mostly do “– KII with TBLS, Benue*

Women

Unlike men, women’s illness as a result of TB seemed to be more visible and information about their condition was also more open to relatives, friends and other social contacts. They reported experiencing stigma in the form of abandonment, isolation, and avoidance by friends and close family as well as separation, emotional abuse and in some cases physical violence. While some of the married women reported having supportive husbands who ensure that they adhere to their treatment, the extended family influences/ dynamics and the culture of patriarchy seemed to reinforce the stigma experienced by several married women with TB.

- *“The day I was diagnosed, people started stigmatising me (in the IDP camp) so I was forced to move to my brother’s place outside the camp. I left the camp about 2*

months ago. I have young children and I was advised not to stay with them, coupled with what people were saying. I come daily to the camp to see my children.” **KII with TB Patient, Benue**

- *“My father’s wife had the same problem (TB), people also ran away from her and I was the only one that took care of her. After my diagnosis, my husband’s relatives didn’t enter my house because they heard that TB can be transmitted, so people avoided my house. After I was taken to the clinic and I started taking the drugs, I felt better. When my husband came to the facility, he was counselled about TB, so after two months of treatment, even when I cough the disease cannot be spread to anyone. Some of my relatives now enter my house”- **KII with TB patient, Kano***
- *“My husband and his sister sent me away to my family, but now that I am better, he has gone to pay my bride price and my parents have said I should go back to him” -**FGD with women with TB, Cross River***
- *“Hardly do people know that men have TB, because they are always going out and can be very secretive about taking their drugs but we women stay at home most times with children, friends come visiting and when they see you with drugs (or even open your bag and find drugs in there)they ask you what type of drug it is and why you are taking them; they keep asking questions ” – **FGD with men/women with TB, Kano***
- *“My 3 brothers left me; I didn’t have much money; I was labelled as having HIV; now everyone (my family) has come close to me because they can see that I am getting better “– **FGD with women with TB, Cross River***

5.4.2 Poverty

Both men and women with TB reported poverty-related issues as a factor that influences their health-seeking options. Even when a client has been diagnosed as having TB, considerations for expenses such as baseline fees, transport costs to the facility, hidden costs and feeding emerge. Inequalities exist in terms of male / female empowerment coupled with cash power differentials. Socio-cultural norms also seem to create additional barriers in terms of women's ability to access diagnostic and treatment services because they are poor and also need to in most cases rely on the **permission/consent of their spouses** or the decision-maker in the home.⁵⁵

⁵⁵ Refer to previous section on beliefs, socio cultural norms and gender inequities influencing TB health seeking practices

- *“Most of the people here are poor. There are no differences regarding transport costs for both men and women. When you tell people to go for Chest X-ray, come for diagnosis, they complain that they don’t have money, meanwhile, they are very sick. When you come, you need to buy a hospital card for N500. It may be an impediment even though treatment is free, and the diagnosis AFB/ Gene Xpert is free. The hospital may ask the client to do other tests such as blood count, urinalysis and other investigations that may cost more money” - KII with STBLCO, Cross River*
- *“The financial limitations of the husband might put him in serious arguments with his wife and he refuses to allow her to go to the hospital because he doesn’t have money” -- KII with Community Leader, Kano*
- *“A lot of indigent patients are from the lower socio-economic class, as a result of poverty, and low educational levels they often will prefer to go to trado- medical healers first” - KII with Health care provider, Lagos*
- *“It is happening, in our society, if you tell your wife not to step out of the door of your house, she can’t go anywhere, even if she has the money “–KII with Former TB patient Kano*
- *“Once I was diagnosed, I told my husband about my problem, when the treatment began me also told my husband. I informed him that they will come and trace the house in order to treat me; my husband doesn’t have any problems with my going to the hospital; he gives me money for transport and sometimes he takes me to the hospital” - Female TB patient, Kano*
- *“Patients often lack funds for baseline tests for DR-TB. Without these tests, treatment cannot be initiated. Women and children often trek long distances to come to this facility“- KII with DR TB Focal person, Benue*
- *“In this facility, men complete treatment more than women based on the records (a man that you advise very well will complete treatment) but women always have excuses such as no transport money” – KII with Health worker, Calabar*
- *Sometimes I have to trek for about 1 hour to the facility because I don’t have money. It’s not easy. The drugs make me vomit the food I have eaten. For the first two months, I was vomiting because of other complications (also taking BP drugs). When I first came, I was like a broomstick” – Female TB Patient, Calabar*
- *“The cost of transport that we spend daily is high. We spend N600 daily on Okada (Commercial Motorcycle) in order to come to the hospital and go back daily. We also face stigma from the neighbours “ - KII with spouse of a female TB patient, Lagos*

5.4.3 Poor Nutrition

Several TB Programme staff interviewed noted that people who are malnourished are at the risk of coming down with TB. Consequently, it is expected that people on TB treatment feed well in order to be able to complete treatment. Several respondents on treatment noted that the drugs require that they eat a lot. While some people may be able to afford good meals, others are unable to because of factors such as crisis, incarceration, and poverty. Respondents from the FGD held with CSOs in Calabar cited the case of a woman who's TB has prolonged for years because she cannot afford good food.

- *“Sometimes the drugs make you feel hungry (you search for anything to eat), you also feel thirsty, weak and sleepy”- FGD with TB patients, Kano*
- *“The food that we are given is not enough. The drugs are toxic and we take them 2 hours before eating. The food given here is no food”- FGD with TB patients, Male Prisons, Lagos*
- *“Another factor affecting many of the clients is poor feeding. They feed on one particular food and that is the fermented cassava and sometimes pounded yam mixed with vegetables. That is the only food that their diet comprises of; they don't eat all the things required to have a balanced diet. We are encouraging that the leafy vegetables that they grow for sale they should also eat so that they can benefit nutritionally and not only focus on the economic returns from the sales “-KII with TBLS, Benue*

5.4.4 Religious beliefs

Religious beliefs also featured as a major barrier identified by health care workers and CSOs working on TB that affects the adherence patterns of both men and women on TB treatment. Many of the respondents noted that they often encountered more difficulties from adherents of the Christian faith, although a respondent highlighted the case of a client who had just started drugs, who was also co-infected and who had insisted he had to partake in the Muslim Ramadan Fast. The health worker in question had to discuss with the client extensively about exemptions during fasting and advised the client to consider almsgiving instead. In the case cited, the ARVs were stopped for some time so that the client could commence TB treatment.

- *“We have numerous instances where people claim that their religious leaders/ God has told them that they are healed. They stay in the church and prefer to die in the church. It's difficult to convince them and difficult to change their minds from those beliefs. We had an instance of a Pastor who was diagnosed with DR-TB who stopped taking his drugs based on the belief that he (the Pastor) is testing God's faithfulness by taking the DR-TB drugs” - KII with STBLCO, Lagos*

- *“I recall a patient with TB who stopped treatment saying, my pastor has prayed for me, however, when the disease came back, he came back to the facility and he tested positive again, now he has been taking the drugs” - KII with TBLS, Kano*
- *“Some denominations such as Apostolic Faith don’t believe in taking drugs. In Ikom, a similar situation happened (not taking drugs) until a Pastor came down with TB” – KII with STBLCO, Cross River*

5.4.5 Level of Education

Many respondents described the level of education as a barrier that cuts across both men and women, and affects individual health-seeking practices. It was noted that those who are uneducated if affected with TB will often start with traditional medication and report late at the health facilities. Respondents were of the opinion that men were generally more enlightened and educated than women, but that level of education does not necessarily translate to informed health decisions. Individuals who are educated tend to be more receptive to information about TB and about their treatment.

- *“When people are not enlightened they accept/imbibe many traditional beliefs”- KII with Community Leader, Cross River*
- *“The level of education is critical. Educated prisoners seem to adhere more than the uneducated ones” – KII with Health worker, Kirikiri Lagos*
- *Oftentimes, where a person will seek care for TB is dependent on the level of knowledge of the family decision-maker - KII with STBLCO, Lagos*

5.4.6 Clinic Hours

Feedback indicated that clinic hours as a barrier related more to men than women. A few male respondents in some of the urban and rural communities’ had noted that clinic hours were barriers to accessing care but this seemed to depend on the context as some programmes seem to be addressing this and others have resorted to practical measures such as collecting the contact numbers of the DOTS provider so that they can be reached after work hours.

- *“Clinic hours are a barrier for me as stopping by the clinic in the mornings means I could be late for work. I am a driver, anytime my boss sends me to run an errand, I use that opportunity to come and pick up my drugs before I go and pick the children from school”– FGD with men with TB, Lagos*
- *“Clinic hours is a barrier here because Benue is an agrarian community, By the time persons with TB go in the morning and come back in the afternoon and rest for a while before coming for the drugs most PHCs that are government-owned which form more than two-thirds of the DOTS facilities that we have would have closed.*

They are the ones nearest to the people. Most PHCS close by 2 pm, though some may run shifts till the night, not all of them do so. By the time clients get to the facility and they don't meet anybody and they try severally they will lose hope and won't come back again”- KII with Health worker, Benue

- *“The clinic hours can be a barrier particularly during the rainy season for those who go to the farm; but in private sector facilities they hardly close because they run shifts and even if the DOTS provider closes at 2 pm, another one will be available. Normally they administer the TB drugs in the morning, but if a treatment supporter comes late for any reason even if they come later in the day they will still be able to access the treatment.”- KII with TBLS, Benue*

In areas where programmes supporting Community Health workers are in place, these serve as a bridge between the client and the public health facility even, when the clinic may have closed.

- *“ We can't say that it is a major a problem for men (it could be for some), but the work of CTWs has made that easier, we have direct contacts with the DOTS officers , so if this kind of problem arises, if the client gives us permission, we can liaise with the DOTS officer to collect his sample even at night; CTWs can go directly to the house of the clients,(meet him in the comfort of his house, collect sputum, and take to the hospital” – FGD with CSOs, Kano*

5.4.7 Attitude of Health workers/ Health Care Settings

Respondents noted that health workers' attitudes could have both positive and negative consequences; negative attitudes could be a turn off to patients and could drive them away while positive attitudes tend to draw more clients to a facility. While several persons with TB interviewed expressed satisfaction with the level of care they were receiving, others affected by TB noted that negative attitudes may not be unrelated to the fears of contracting TB and the limited availability of protective gear for the health workers.

- *The attitudes displayed by healthcare workers to patients or clients make them come and when they go back they also advertise the facility and the quality of care that they receive. I always wonder why people from areas such as Gboko, Vandekiya, Kwandei and neighbouring LGAs come to this private facility. The attitude of the health care workers and the facility makes more people patronize them. Yesterday I had a TB client from a far distance and I was trying to convince him to go to any other facility but he said no, he preferred the General Hospital because of the way they treat people. The attitudes of workers to the patient also determines and influences care” – KII with TBLS, Benue*
- *“The attitude of health workers in the Chest Clinic also needs to improve (particularly the way they talk to clients), - they issue out commands; ‘Cover your mouth, go and sit there, even when you are there to assist someone to get sputum. I detest helping*

people to go to the Chest clinic. Sometimes, the patients will rather die, than face the ridicule” - FGD with PLHIV, Lagos

Programme staff at the various levels had cited occupational exposures and pockets of cases of health care workers who have come down with TB, despite stressing the implementation of infection control measures in the health care setting. Poor triaging of patients in some of the health care settings offering TB /HIV services were also cited as areas of concern.

- *“Health workers’ discriminatory attitudes are also tied to the Government’s provision. Sometimes, they don’t provide the supplies that the health care providers need e.g. N95 Face masks (This was also corroborated by a Prison official interviewed). I would be defensive as a health worker if this is not available. For how long would they tie handkerchiefs around their noses?” – FGD with PLHIV, Lagos*

5.4.8 Intercommunity tensions /Crisis

Intercommunity clashes, crisis situations, and their aftermath pose barriers to access diagnostic and treatment services.

In Lagos and Benue State for instance, examples were cited of gangs/ communities that create boundaries. Inter-boundary clashes occur and often for fear of reprisal attacks, gang members don’t cross boundaries even when a TB treatment centre is close to a boundary area. Rather they prefer to go to distant facilities in order to seek treatment. Cases were cited of TB patients who have DOTS facilities close to their home but for fear of being beaten by gangs, will prefer to go to distant facilities.

In addition, communal clashes/crisis in Benue as well as the North-Eastern parts of the country, have resulted in the destruction of some DOTS facilities and some areas are now cut off from TB treatment services, making it difficult for people in those locations to access diagnostic and treatment services.

5.4.9 Programmatic Challenges

Several programme related challenges which are limiting uptake of services were also highlighted and they include; insufficient government funding, limited spread of diagnostic and treatment services; drug and commodity stock-outs, poor state of the roads; poor road network particularly in hard to reach locations; mobility/transport issues which hinder monitoring and loss to follow up and also impact on the programmes’ ability to find the missing TB cases.

Strikes /Staff Motivation

Strikes by health care workers which often result in the total or partial closure of services were identified as a barrier that deters people from coming to seek health care services.

“When strikes occur frequently and clients don't meet the health facilities open, they will stop coming to the facility. Staff motivation is also an issue when the local government staff

themselves are not motivated and don't come to the facility regularly.”- **KII with Health worker, Benue**

5.5 Gender and TB Treatment Outcomes

TB Programme staff at State levels and health workers noted that there is currently no gender-disaggregated data for treatment outcomes, adding that they have not been monitoring the patterns to be able to provide sufficient data to support a particular conclusion. They suggested the need to conduct a cohort analysis of patients on treatment over a period of time as well as review secondary data in order to assess trends.

Respondents acknowledged the important role of providing accurate treatment information and counselling as well as the place of treatment supporters in ensuring that those on treatment comply with and complete their treatment regimen. They, however, identified several factors that tend to influence the adherence patterns and outcomes of men and women on TB treatment. They noted that the patterns are the same for DS-TB and DR-TB.

- *“They (the health workers in the facility) advise us (men and women)together on adherence and request us to promise to stay on the treatment There is no discrimination and we are given the same treatment equally” – KII with Male TB Patient , Kano*
- *“When I fell ill, I wasn't thinking of coming to the hospital, it was my husband that insisted I come. After it was confirmed that I have TB, my husband has been coming to pick drugs for me. My husband has played a major role in supporting me on my treatment – KII with female TB patient, Benue*

Men

Addictions such as (alcohol, smoking), peer pressure and beliefs that they are now healthy (particularly after the first two months, intensive phase) were identified as factors that interfere with men's treatment. Responses on men's adherence were also context-specific. The peculiar case of prisoners who start TB treatment while awaiting trial in prisons but are released midway was also highlighted.

- *“Men drink alcohol so if the drug hinders them from taking alcohol regularly, they may stop the drugs. I knew a man who is confected (TB/HIV), yet he takes Oogoro (local gin) daily, but he is late now. Men are difficult to handle. I have a DR-TB patient who has been taking drugs for 17 months, he has only 3 months left to complete treatment) and he has abandoned treatment, drinks alcohol, he has been*

threatened. We are hopeful he will comply. I have seen him and encouraged him to comply"- **KII with STBLCO, Cross River State**

- *“Several male prisoners have a background of active smoking during and after treatment. The food served is also inadequate. Some have stopped after the intensive phase of treatment and there have been cases of inmates starting treatment all over again because of smoking habits or poor adherence”* - **Health Care Provider, Kirikiri Maximum Prisons, Lagos**
- *“Some of our TB patients who are awaiting trial may be on treatment. Once they are released, there is a likelihood that they may interrupt their treatment as contact addresses they provide are often not real, which makes tracing them a problem”* – **KII with DOTS provider, Calabar Prisons**
- *“For DR-TB the patients are kept in the facility under observation and compelled to take their drugs for 4 months. Once they leave after 4 months there are those who stop taking their drugs at home saying that they are feeling better and there’s no one to monitor them anymore. Usually, the clients are given 2 weeks of drug supplies once they are discharged to enable them to continue treatment at home, but the men usually wait until that 2 weeks supply is finished and will report at the facility later and they may even have been taking the drugs inconsistently. Another challenge is that once they leave confinement, they also start taking alcohol which interferes with the drugs”* – **DR-TB Focal person, Benue**
- *“The men are likely to stop their drugs after about two months because they claim they have other responsibilities and taking the drug daily for 6 months is too cumbersome. Once they begin to feel better, they stop the drugs”* - **KII with TBLS, Kano**
- *“Men in this State have a tendency of supporting their wives as much as possible to use the drugs to get well on time because women in Benue state in most cases are the hard workers in the home. They often work harder than the men so the men would want them to get well so they can continue their duties and they support them to make sure they get well. On the flip side, the women don't really have that same level of influence on their husbands because alcohol intake is high in Benue. The men tend to drink more than women, and alcohol affects some of these drugs their metabolic pathway; there is drug-drug interaction with alcohol and this may affect the efficacy of the drugs”*- **KII with Health worker, Benue**
- *“From our experience, men usually complete their 6 month treatment, they often come to the DOTS centre early in the morning on their way to work to take their*

treatment, but in the case of women even if you make an arrangement with them to come and collect their drugs; sometimes they say they have much to do at home so they can't come, unless you call their husbands and report them; sometimes the man will come to pick the drugs or other times he may go home and bring her with him " –
KII with DOTS provider, Kano

Women

While many respondents acknowledge that women with TB often adhere more strictly to their treatment than their male counterparts, factors such as concerns about staying healthy for their family, religious beliefs, permission/consent of their husbands(for married women) were identified as key influencers.

- *"Religious beliefs often come up, which tend to influence those on treatment to abandon their TB treatment and women seem to be more susceptible in this area"*
KII with Health worker, Lagos
- *"Women, are often at home and they have that tendency to finish the drugs. They are the ones that are closer to the children so they have a lot of things to think about and they are reminded of what the hospital tells them about finishing the drugs and completing treatment and the complications from non-completion which can lead to death. They are concerned about who will help them take care of their children, so that cultural and traditional family bond is there for the women to consider and this makes them adhere to instructions and complete the drugs" –KII with Health worker, Benue*
- *"Women are more likely to complete their treatment. Women tend to attend clinics more and they need just a little push to be responsive compared to the men. For married women, there might be challenges because they would usually want to seek the consent of their husbands. We have to open up to the patient about their treatment modalities etc., at that point when they get to know the diagnosis that is when they have to make a decision. So, when they are married, they usually choose to get consent from their husbands in order to report back to the hospital for their results and for treatment. For single women, it's usually not the case" - KII with STBLCO, Cross River State*

5.6 Gender and Loss to follow up

Respondents reasoned that loss to follow up is tied to general factors such as treatment information/literacy levels and quality of counselling at the initiation of treatment, individual behavioural patterns, socio-economic conditions of the individual on treatment (such as lack of resources to transport oneself to the facility) distance, delays at the health

facility and stigma amongst others. How these factors impact on loss to follow up differ from one gender to another.

“The Programme relies on DOTS providers for counselling or on the Treatment centre for the DR-TB patients and some of these people are not trained on counselling. If the counselling is suboptimal, then you can find challenges with adherence issues and it doesn’t matter if it’s a male or female client, so that has no gender bias. Again those who already feel stigmatised may likely be the ones that have adherence issues. The main issue is whether the counselling is effective or not” – KII with STBLCO, Benue

Men

There is a consensus among the respondents that men’s traditional roles as breadwinners play a significant role in influencing their behavioural patterns. They note that the pressure to return quickly to their productive lives often influences men’s ‘disappearance’ from the health facility once they feel better, after the 2 months intensive phase of DS-TB treatment.

- *“Men sometimes, change their workplaces, some are transferred, and some men feel it is okay to stop treatment once they feel better. The provision of false addresses or phone numbers is common among men. Follow up of men can be challenging, adherence can be difficult. They often provide excuses about work and complain of having no money to feed, especially with men who have families. They also hate disclosure and don’t want family members to know that they are ill” – KII with STBLCO, Cross River State*
- *“Men often have to hustle to feed the family. Delays in attending to clients may cause them to drawback. If you’re a Commercial Motorcycle rider, you don’t want to be delayed by a health worker when you are ready to hustle” – KII with Health care provider, Lagos*
- *“Men usually give false addresses (which are difficult to locate), even though they sign an undertaking that they would not miss their drugs, yet they don’t comply. Some even go to different DOTS centres and change their names, abscond and return months after. They often expect immediate results” – KII with TBLS, Lagos*
- *“Men are more prone to disappear and to be lost to follow up. I have a case of a man who had taken drugs for 2 months and abandoned his treatment and went back to his business. Whenever you call him, he says I am OK, I am no longer sick. We even went to his house and didn’t see him. About 4 weeks later, he came back complaining of chest pains claiming it’s due to his playing football. I told him no, it’s because you ran away, he requested for drugs, but I refused and insisted he has to go for a test*

again. Thankfully he was negative so we just placed him on the continuation phase “- KII with TBLS, Kano

Women

Socioeconomic factors, distance from the facility and consent/permission of their husbands were identified as the factors influencing women. The desire to be healthy for their families and to be able to return back to their productive roles were also areas of consideration.

- *“The challenges with the women are often financial because they need to depend on and obtain consent /permission from their husbands/ male figures” - KII with DOTS Provider, Kano*
- *“Businesswomen/market women can be challenging too, the moment they feel better, they want to make all the money they have lost while they were ill “- KII with STBLCO, Cross River*
- *“We have fewer challenges following up female patients because we often contact them through their husbands or elderly male figures” – KII with TBLS, Kano*

5.7 Gender and Impact of TB

Former and current male TB patients interviewed generally viewed and ascribed the impact of TB in relation to their lowered productivity, and particularly their inability to engage in economic activities.

- *“I am a mechanic. Since I was diagnosed with TB, I have decided not to visit my workshop until I am totally cured” - KII with Male TB patient, Kano*
- *“I can’t work for now. My productivity is reduced. I can’t carry heavy stuff. Now I have to do less strenuous work. My strength is reduced. If you are working for someone else and they can’t cope with the pace of your work they will tell you to stop working” - FGD with Male TB patients, Lagos*
- *“I was on treatment for 20 months; I couldn’t do any work or any business during the period. I was selling textiles before I fell ill. I didn’t encounter stigma but I was so weak and dizzy, I couldn’t do anything; friends and relatives were supportive because I was treated in the community. As a result of my experience, I developed articles on TB to educate others” – KII with former DR-TB patient, Kano*
- *“I was a farmer before coming to this facility. I lacked strength and energy. TB affected my lungs. I was losing weight and farming work deserves real strength and I don’t have the energy. Initially, I was feeling lonely as I am away from family, but I know that health is wealth so it’s better I endure it now” – KII with DR-TB patient, Benue*

Female TB patients interviewed described the impact of TB in relation to their struggles with adherence, social activities as well as their economic activities.

- *“The odour of the drugs causes nausea/ feeling of vomiting. The drugs are also taken along with the daily injections” – KII with DR TB patient, Benue*
- *“When the teacher is speaking in class, oftentimes, I am dozing and I have to ask someone else to write the notes for me. I have difficulty concentrating and the drugs make me feel drowsy. The teachers don’t know I am taking drugs. Whenever they see me dozing, they just take me out of the classroom and flog (beat) me.” FGD with TB patients, Kano*
- *“It has been challenging taking the drugs and adhering for more than one year, the drugs have to be taken according to weight. TB found my spine the favourable place to settle. As a health worker, I used to give health talks and challenge people to take and adhere to their treatment, but it’s not easy. I still encounter pains and I am taking pain relievers” - FGD with female TB Patients, Cross River*
- *“Since I started treatment, I haven’t been going out. My relatives come to see me. If I go to social events I go and leave quietly. No one disturbs me. I am not bothered since I was told during the counselling that if I adhere to the treatment I will be cured.”- KII with TB patient, Kano*
- *“I used to work in a pharmacy but the drugs are making me weak so I stopped working there” – FGD with TB patients, Kano*

5.8 TB and Gender-Based Violence

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person’s will, and that is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many, but not all forms of GBV are illegal and criminal acts in national laws and policies.⁵⁶ Bloom (2008) also defines GBV as a term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society. GBV often includes all acts of violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private.

⁵⁶ Inter-Agency Standing Committee Guidelines on GBV Interventions in Humanitarian settings 2005 - <https://www.unhcr.org/453492294.pdf>

Within the Nigerian context, various reports show a high incidence of GBV with varying prevalence rates across different geopolitical zones. According to the British Council Nigeria, 2012 Gender Report, one in three of all women and girls aged 15 – 24 has been a victim of violence.

Data from the 2013 National Health and Demographic Survey (NDHS)⁵⁷ also indicate that Violence against women is a common practice in Nigeria. The most pervasive form of GBV women and girls suffer is domestic violence, which cuts across all socioeconomic and cultural backgrounds. This usually takes place in the home and is perpetrated by family members or relations. Among Nigerian women, nearly three in ten women have ever experienced physical violence since age 15, and 7% have ever experienced sexual violence. Spousal violence is also high, with one in four ever-married women reporting that they have ever experienced physical, sexual, or emotional violence by their husband/partner. A higher proportion of women (35%) believe that wife-beating is justified for any of the specified reasons compared to 25% of men.

Policy documents and guidelines reviewed such as the National Gender Policy (2008) and the National Guidelines and Referral Standards on Gender-Based Violence in Nigeria make reference to GBV as it relates to HIV and health broadly; however, there is no specific mention of GBV in relation to TB.

Findings from the qualitative research reveal that none of the Community leaders interviewed could recall any incidences of gender-based violence experienced by persons with TB as they noted that none had been reported to them. They all reasoned that community members often support the individual with TB who require treatment.

However other respondents (health workers, TB programme staff, CSOs, and TB patients cited instances of GBV which were perpetrated against women with TB. They observed that oftentimes the GBV was of a psychological/emotional nature (though a few instances of physical violence were mentioned) and often influenced by the culture of patriarchy, myths and misconceptions, power relations between men and women, stigma, fear of contracting the infection and perceptions that TB and HIV are the same.

- *Such incidences often happen because HIV and TB look alike, people and relatives will put pressure on a man that he should leave his wife so that she does not spread the disease further. I met a woman at the facility in the course of my TB volunteer work; the woman was crying because she was being stigmatized by her husband. He had been maltreating her for about 2 years (lacked adequate knowledge about TB). I visited her husband, but I did not go as if I was reporting what his wife had told me. After the discussions, his wife confirmed that his attitude has since changed and he is more supportive in providing for her needs .- KII with Former TB Patient, Kano*

⁵⁷ Gender in Nigeria, Data from the 2013 NDHS , ibid

- *“Culture plays a large role and where there is limited information and a mother is exposed to TB the husband may take away the children from the woman. I know of the case of a man who was beating the wife because she has TB. The husband had spent so much money and no improvement in health was forthcoming. Violence occurred as a result” - FGD with CSOs, Cross River State*
- *“In the course of our community work, we had identified a woman who was screened and she tested positive for TB. She was placed on treatment. After a few weeks, we went for follow up and she was absent from the house, we were told the husband sent her to the village; we investigated and found that he learned that TB is a communicable disease and can be spread, that was the reason why he sent her to the village. We sat down to re-educate him that since she is on treatment, she can no longer spread the disease. After that, he was convinced and requested that she return home” – FGD with Male CSOs, Kano*

5.9 Gender-Sensitive good practices

In line with the End TB strategy’ of ensuring patient-centered care in providing services, several programmes and initiatives are being implemented to take TB diagnostic and treatment services closer to the patients. Several respondents outlined practices such the engagement of treatment supporters, community volunteers, civil society engagement in active TB case finding, Wellness on Wheels (WOW) truck outreaches, SMILE TB Initiative targeting childhood TB cases, referrals through patent medicine vendors and community pharmacists, targeted outreaches during social gatherings and community events as well as social support through provision of incentives and transport stipends to DR TB patients as good practices that were helping to increase access to TB diagnostic and treatment as well as retain people in care.

Men

Several respondents noted initiatives such as targeted outreaches to men’s associations (Commercial Motorcyclists), as well as the Community Outreaches, and Community Volunteers who go from door to door as good practices that were helping to educate men, who ordinarily won’t go the health facilities, about the signs and symptoms of TB.

Women

Apart from health programmes targeted at educating married Muslim women attending Koranic schools, the **Routine Immunisation** programmes which occur at regular intervals across the country, as well as the **Uwar Gida Housewives Initiative** being implemented in Kano State, were identified as gender-sensitive good practices which are being leveraged on in order to reach the women and children.

“We leverage on those who go to do Immunisation (they ask questions about whether people have been coughing in the community etc. and those people are sent to the facility), even children are sent for X-ray and it’s free. We also do contact tracing to identify children who may be at risk of TB so we can place them on INH, but often parents/guardians refuse

to bring them and that's a major challenge. It may be because of the transport costs of bringing their contacts; but sometimes they bring them and we start them on INH, for adults we just screen, if positive we start them on treatment” - TBLS, Benue

“Uwar Gida TB (Housewives TB) Care Initiative being implemented with the support of the KNCV Challenge Facility /State TB Programme focuses on bringing TB case finding to the doorstep of women and children who are among the vulnerable as part of the SDGs. It is engaging housewives in 5 high burden LGAs in Kano, putting surveillance on women/ children coughing over a period of time, particularly in places where women congregate often for one thing or the other, bereavement, weddings etc. Women stay in their communities and know their neighbours. The Uwar Gida volunteers are also housewives who live in the same community with the women so they identify anyone coughing, and they have been trained to enter the women's houses to collect the sputum or ask them to go for screening, link them to a nearby facility and in the event they have TB, they support the women for their enrolment, treatment, and investigation of their close relatives and contacts” - KII with STBLCO, Kano

6. Discussions

Nigeria's Tuberculosis burden has clear gender dimensions; varying factors influence and accounts for how men and women seek TB diagnostic and treatment services. Within the Nigerian context, men account for more of the reported TB cases than women. The NTBLCP through its Strategic document, NSP-TB prioritizes universal access to high quality, patient-centred TB prevention, diagnosis, and treatment services for Nigerians with all forms of TB and emphasises gender as a key consideration.

Health seeking practices

Findings indicate that while both men and women show similarities in terms of their first port of call when seeking TB services (oftentimes neighbourhood chemists) men displayed a higher tendency to delay seeking at a health facility until it is late, whereas women were more willing to seek care early. However, factors such as financial capacity and the consent /permission of the male partners/ spouses often determine women's ability to access care early enough.

Widely held beliefs about masculinity and strength, the pursuit of their breadwinner/ productive roles, cost considerations and the belief that seeking care from health facilities are a woman's turf strongly influences men's willingness to seek care. On the other hand, women's willingness to seek care early is motivated by the need to preserve their homemaker/ caregiver roles and the protection of their children and families from infection/ illness.

Factors predisposing men and women to the risk of TB infection also differed. Reasons provided for men's risk of contracting TB infection were more associated with their social habits, practices, and occupations whereas women tended to be more exposed to TB as a result of mostly their caregiver roles as well as based on certain occupations they practiced.

Findings also indicate that despite the high TB burden in the country, accurate information about TB, its symptoms, how it is spread and where services can be accessed is still not widespread. Ignorance, myths, misconceptions and culturally held beliefs still influence TB health-seeking practices, as well as reactions towards persons with TB.

Local language terminologies about TB also evoke feelings of fear and reinforce misconceptions that TB is incurable. It is noteworthy that ongoing awareness and public information about TB is limited and often centred on the commemoration of World TB Day. This is not unrelated to the fact that several of the State programmes are largely donor dependent with limited State government budgetary support for ACSM focused programmes.

Barriers limiting access to TB diagnostic and treatment services

Findings also indicate that several barriers limit people with TB from accessing the diagnostic and treatment services. These barriers are also context and gender-specific.

TB related stigma emerged prominently as a major barrier with gender-specific differences.

Men reported experiencing stigma but had a tendency of managing/keeping information about their TB illness to themselves, avoiding disclosure, isolating themselves or, providing false phone numbers and home addresses (in order to prevent follow up calls and visits from Community volunteers or health care providers).

Unlike men, women's illness as a result of TB seemed to be more visible and information about their condition was also more open to relatives, friends and other social contacts. They reported experiencing stigma in the form of abandonment, isolation, and avoidance by friends and close family as well as separation, emotional abuse and in some cases physical violence.

While poverty also emerged as a key barrier affecting both men and women with TB, findings indicated that women tended to be more affected as socio-cultural norms also seem to create additional barriers in terms of women's ability to access diagnostic and treatment services. As a result of cash and power differentials, women (particularly the married ones) tended to be poorer and more reliant on the **permission/consent of their spouses** or the decision maker in the home in order to access TB services whereas men were more financially independent

Findings from the study also suggest that clinic hours as a barrier related more to men than women, though this seemed to be more context-specific as different practical measures are being put in place to ensure men can access their treatment outside the regular clinic hours.

Adherence to treatment

While several programme staff acknowledge the limitations posed by lack of gender-disaggregated data to inform conclusions on adherence patterns of men and women on TB treatment, findings revealed that women tended to adhere more strictly to their treatment than men. While men tended to abandon treatment once they felt better or provided excuses related to their work demands, women were focused on getting cured in order to be able to cater for their children and families.

Gender-Based Violence -TB

The findings show that TB related Gender Violence occurs and women are often at the receiving end, but cases seem under-reported, “invisible, yet present due to a culture of silence” and greatly influenced by the culture of patriarchy. Myths and misconceptions, power relations between men and women, stigma, fear of contracting the infection and perceptions that TB and HIV are the same also contribute to this. Existing policy guidelines on Gender-Based Violence significantly reference the nexus between HIV and GBV but make no specific reference to TB related GBV. These findings suggest a need for a policy review to highlight the implications of TB related GBV, as well as the importance of sensitizing TB patients, CSOs, health workers to policy provisions and opportunities for reporting and seeking redress.

Impact of TB

Findings from the study also indicate that men and women affected by TB viewed the impact of the disease differently; while men described the impact of TB in relation to their lowered productivity, and particularly their inability to engage in economic activities, women described the impact of TB in relation to their struggles with adherence, as well as their social and economic activities.

Gender Sensitive Practices

Findings also show that there is increasing recognition at National and State programme levels of the need for gender-sensitive considerations in designing programmes that are patient centred in order to ensure increased uptake of TB prevention, diagnosis and treatment. Examples of different context-specific initiatives tailored to address some of the barriers men and women face in accessing TB services were highlighted in the course of this assessment. These include amongst several others, the Uwar Gida Housewives Initiative reaching out to housewives in 5 LGAs in Kano State , SMILE TB initiative targeting children, Contact tracing, Engagement of Treatment Supporters, Outreaches targeting men in places where they congregate, and linkages with CSOs and community health workers to bring diagnostic and treatment services closer to the clients doorstep. While these practices have been identified as very valuable and contributing to increasing TB case finding; the need to scale up, and sustain the gains of these programmes after support from external partners has ended is of urgent concern.

7. Recommendations

To Government (National and State level TB programmes)

1. **Disaggregate TB Programme data by gender within public and private sector DOTS and health facilities at Federal, State and LGA levels to better inform programming**
 - a. Support the development of relevant and appropriate indicators and use of gender-disaggregated data gathered by healthcare facilities to inform discussions at the routine M and E meetings(such as National and State TB Control Programme Review meetings) as well as support the design and implementation of gender transformative TB policies, plans and programmes
 - b. Ensure implementation of gender transformative policies and programmes, through provision of training and resources to TB Programme staff and implementers at all levels
2. **Strengthen Interagency and Interministerial collaboration on TB at Federal and State Levels**
 - a. Establish an interagency task team (from the relevant MDAs) on TB at Federal and State levels to guide in the development of clear action plans that address gender related and social determinants of poverty which relates closely with TB disease such as Overcrowding, Poor Housing etc. (Such MDAs would include; Women Affairs, Lands, Housing and Urban Development, Transport, Information, Youth Development,

Environment, National Orientation Agency, National Emergency Management Agency etc.)

- b. Review existing and relevant policy frameworks of these relevant MDAs to ensure that the TB linkages and opportunities for joint programme implementation are addressed in a gender responsive manner
- c. Address socio-cultural norms and beliefs by initiating educational programmes that continuously promote awareness and accurate information about TB at all levels e.g. through schools especially in primary schools, inter-school debates etc.
- d. Support and encourage the development and airing of gender-specific messages IEC materials (jingles, posters, drama skits) that address male health-seeking tendencies and encourage men and women to seek TB treatment early.
- e. Collaborate with religious leaders through their established associations such as Christian Association of Nigeria, Supreme Council for Islamic Affairs at various state levels in order to educate religious leaders about the importance of adherence to TB treatment, risks of DR-TB and secure their support and buy-in for promotion of TB treatment adherence /treatment completion in messages to adherents of their respective faiths

3. Address barriers to TB diagnostic and treatment services and ensure ownership and sustainability of TB Programme at Federal, State and Local Government Levels

- a. Ensure dedicated Government funding as well as prompt and timely release of such funds to the TB programmes at Federal, State and LGA levels
- b. Scale up access to National and State Health Insurance schemes for TB patients
- c. Expand access to TB diagnostics and DOTS centres by leveraging on the expertise and reach of other private sector health care providers; strengthening PPM DOTS as well as cultivating partnerships with unorthodox health care providers who may have a wider reach /clientele base

4. Support linkage of TB patients to poverty alleviation and social protection schemes

- a. Support economic empowerment of men and women with TB through linkages to soft loans and schemes and other initiatives such as the National Social Investment Programme(NSIP) and other social protection schemes that will enable them be self sufficient
- b. Support linkage to school feeding programmes for children with TB
- c. Provide incentives to support TB patients while on treatment (transport/nutritional support etc.)

5. Strengthen capacity of Health care providers, CBOs and community volunteers for improved TB service delivery at facility and community levels

- a. Conduct routine on the job trainings for DOTS providers, relevant health care workers, CSOs and community volunteers in order to improve the quality of pre-initiation counselling for TB patients and their family members. Such counselling trainings must address gender specific adherence patterns, attitudes etc.
- b. Provide anonymous client feedback / evaluations forms to clients to enable them routinely appraise and provide feedback on health workers attitudes. Completed evaluation forms would be constantly reviewed by health workers Supervisors
- c. Encourage issuance of recognition of performance certificates and other incentives to deserving health workers
- d. Support the engagement of peer support counsellors/former TB patients both men and women to serve as adherence counsellors within facilities and at community levels
- e. Institute more stringent infection control measures/standards within public health facilities at all levels and ensure the steady supply of requisite protective gear, establish mechanisms for supporting health workers who may come down with TB and collaborate with the Association of Private Medical Practitioners providing TB services to institute similar practices in their respective private health facilities

To Specific States within the North –West, North Central and North East geopolitical zones)

6. Address security challenges / intercommunal clashes at State levels
7. Expand access to and equitable distribution of TB services particularly in crisis prone areas/regions
8. Improve the living and feeding conditions in IDP camps and ensure sustained access to TB diagnostic and treatment services for camp residents
9. Scale up and expand the reach of context specific and evidence based gender sensitive good practices such as the involvement of male/female adherence supporters, the War Gida Housewives Initiative, Outreach programmes for men and flexible DOTS Clinic hours etc.
10. Work with community leaders / traditional rulers and institutions to address socio-cultural norms that serve as barriers to men and women's access of TB diagnostic and treatment services
11. Strengthen, support and incentivise DOTS providers, community health workers and community volunteers with necessary tools and transportation equipment (motorcycles) to enable them deliver essential TB services in hard to reach and crisis prone areas

To Donors and Development partners

12. Support the development of gender transformative TB policies and programmes and implementation guidelines
13. Support the scale up and equitable distribution of GeneXpert machines and other relevant TB diagnostic services across the country
14. Support National and State programmes to ensure timely delivery of drugs/ test kits and other relevant commodities at State and LGA levels as well as resources to support drugs/commodities redistribution
15. Support the implementation of TB related ACSM Interventions that address socio-cultural norms across Federal, State and Local Government levels.
16. Strengthen the capacity of media (particularly local language reporters) and support the convening of regular post training media engagement platforms to debunk context specific myths and misconceptions and promote TB information in a sensitive, non-stigmatising manner
17. Strengthen the capacity of advocates(patients communities, civil society groups, human rights organisations , media to understand and address all forms of TB related Gender Based Violence, and demand access to justice for TB patients whose rights may have been violated using the various existing legal instruments

To Civil Society Organisations and Community groups working on TB

18. Leverage on traditional methods of communication and platforms, mobile outreaches (e.g. Use of the WOW trucks), community dialogues, problem tree, etc. to educate communities about TB related stigma, its manifestations and to develop community-oriented solutions for addressing stigma
19. Develop and encourage the emergence of a corps of TB Champions (both male and female) to share experiences and highlight information about TB being curable
20. Create demand for TB Services through community-based outreaches, house-to-house mobilisation and integration into existing community structures
21. In collaboration with Governments, development partners and implementing agencies, leverage on community structures to expand access to services to people in hard to reach settings and key populations

To Media

22. Promote awareness through multiple channels and reinforce messaging on TB signs, symptoms, TB predisposing factors and gender dynamics, available services and curable nature of TB
23. Develop gender sensitive human interest stories, case studies and local language reports that debunk TB related myths and misconceptions, address societal norms about male/female health seeking practices and educate the audiences about TB services and where they can be accessed

