



Department of Public Health

National Tuberculosis, Leprosy and Buruli Ulcer Control Programme

Human Rights and Gender Action Plan for Tuberculosis Care and Prevention in Nigeria 2021 – 2025

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Abbreviations

AFB:	Acid Fast Bacilli
AIDS:	Acquired Immune Deficiency Syndrome
CBO:	Community Based Organization
COVID-19:	Novel coronavirus SARS-CoV-2
CPT:	Cotrimoxazole Preventive Therapy
CRG:	Community Rights and Gender
CSO:	Civil Society Organization
DOTS:	Directly Observed Treatment Short Course
DPH:	Directorate of Public Health
DR TB:	Drug Resistant TB
FCT:	Federal Capital Territory
FBO:	Faith Based Organization
FMoH:	Federal Ministry of Health
GBV:	Gender Based Violence
GF:	Global Fund
HBC:	High Burden Country
HIV:	Human Immunodeficiency Virus
IDP:	Internally Displaced Persons
KP:	Key Population
LEA:	Legal Environment Assessment
LGA:	Local Government Area
LGTBLS:	Local Government TB and Leprosy Supervisor
LPA:	Line Probe Assay
MDR-TB:	Multi-Drug Resistant TB
NCD:	Non-Communicable Diseases
NGO:	Non-Governmental Organization
NSP:	National Strategic Plan
NTBLTC:	National Tuberculosis and Leprosy Training Centre
NTBLCP:	National Tuberculosis and Leprosy Control Programme
PHC:	Primary Health Centre
PLHIV:	People Living with HIV
PMDT:	Programmatic Management of Drug Resistant TB
PMV:	Patent Medicine Vendor
PPM:	Public-Private Mix
STBLCP:	State TB and Leprosy Control Programme
STP:	Stop TB Partnership
TB:	Tuberculosis
TB/HIV:	Tuberculosis and HIV
TBL:	TB and Leprosy
WHO:	World Health Organization

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Foreword

Tuberculosis (TB) is a public health problem in Nigeria. The country ranks 6th among the 30 high TB burden countries globally and 1st in Africa. Currently the incidence of TB in the country is 219/100,000. Nigeria is also among the 14 countries with high burden of TB, Multi-Drug Resistant TB (MDR-TB) & TB/HIV co-infection. The burden of MDR-TB in the country is based on Drug Resistant TB prevalence of 2.9% among new TB cases and 14% among retreatment TB cases. In the year 2019, a total of 120,266 TB cases representing only 30% of the estimated TB cases were notified, leaving over 300,000 TB cases undetected in the community. This group continues to transmit the infection.

With the low case notification concerns, the programme has embarked on several strategies and interventions including care for key populations. In the past, one key area which has not received adequate attention is the issue relating to Human rights and Gender barriers to accessing TB services. However, evidence from several assessments around the globe and in-country has shown that TB prevention and control cannot be achieved without addressing these issues. These are also established in pillar 2 of the World Health Organization (WHO) End TB strategy. Yet, there is no document in-country to provide guidance for TB stakeholders on addressing Human rights and Gender barriers to TB services.

Various assessments done in-country have revealed some Human rights and Gender related barriers to TB care and prevention. These include the Legal Environment Assessment (LEA), TB Gender Assessment and Key Population (KP) Prioritization & Rapid Assessment. Findings and recommendations from these assessments have informed the development of this action plan intended to help all TB stakeholders to proactively implement interventions that will address Human rights and Gender related barriers to TB services.

I hereby enjoin all stakeholders to be guided by the principles spelt out in this document as well as proactively implement the activities outlined so as to address Human rights and Gender related barriers to TB care and prevention in Nigeria.

Dr. Osagie E. Ehanire MD, FWACS

Honourable Minister of Health

Federal Ministry of Health

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1. Introduction

Nigeria has an estimated population of over 200 million people in 2020² and TB is a major public health problem. According to the 2019 WHO Global TB report; Nigeria ranks 1st among the 30 TB high burden countries in Africa, 6th globally and classified among the 14 countries with triple burden of TB, MDR-TB and TB/HIV. The reproductive age group (15-44 years) and men are mostly affected ¹. The TB incidence rate is 219/100,000, with an estimated case load of 407,000 annually. The goal of the TB NSP (2021 – 2025) is to ensure universal access to high-quality, patient-centred TB prevention, diagnosis and treatment services for all Nigerians with all forms of TB, regardless of geographic location, income, gender, age, religion, tribe or other affiliations². However, the right to health is not guaranteed for most Nigerians due to poverty, inaccessibility of the health care services, high out of pocket expenditure, unavailability of health insurance, the impact of the current novel coronavirus SARS-CoV-2 otherwise known as COVID-19 pandemic, etc.

The current GF grant (2021-2023) and the National Strategic Plan for TB Control (2021 – 2025) will have interventions that will address TB related Human rights and Gender issues. These interventions will ensure that barriers faced by Nigerians in accessing TB care and prevention services are reduced to the barest minimum. This is in line with the global focus which has shown evidence that TB care and prevention indicators cannot be fully met without addressing related social issues. This also shows the country's efforts in aligning with global best practice to end TB. For instance, the WHO's End TB strategy and the Stop TB Partnership both recognize the vital role of Human rights and Gender in ending TB. The strategy establishes “protection and promotion of human rights, ethics and equity” as one of four essential principles to ending TB globally. **Error! Bookmark not defined.** Likewise, the Stop TB Partnership encourages “people-centred, human rights-and gender-based approach to TB” as part of the paradigm shift in addressing TB through the Global Plan to End TB. Indeed, Stop TB Partnership's Global Plan acknowledges that TB programming will not be successful unless global and national programmes are grounded in human rights³.

However, the level of implementation of TB related Human rights and Gender related issues has been inadequate and uncoordinated. Thus, the need to address this in a broad and coordinated manner cannot be overemphasized and will play a vital role in helping the country to achieve its End TB targets. Therefore, the NTBLCP and partners have provided in this action plan robust

strategies and interventions that will address Human rights and Gender related barriers to TB care and prevention in Nigeria aimed at achieving a TB-free country.

1.1. Country profile

Nigeria shares borders with Benin, Niger, Chad and Cameroon, as well as a coastline on the Gulf of Guinea. It has an area of 923,768 Km² with an estimated population of over 200 million in 2020.² There are three levels of government: Federal, State, and Local Government Area (LGA). There are 36 States and the Federal Capital Territory (FCT) Abuja, with each State broken down into LGAs. There are 774 LGAs in the country. For political purposes the country is organized into 6 geopolitical zones. See figure 1.

Figure 1. Nigeria geo-political zones



Source: Research Gate. https://www.researchgate.net/figure/Map-of-Nigeria-showing-the-36-states-and-Federal-Capital-Territory-FCT-Abuja_fig1_260023562 [accessed 19 Jan, 2020]

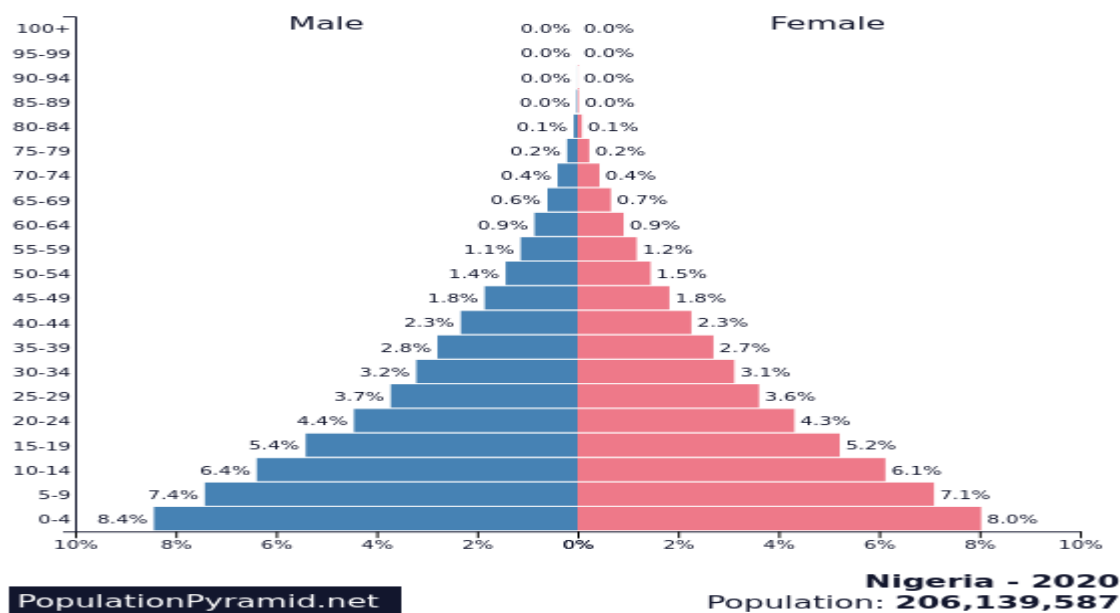
1.2. Demography

The population of Nigeria is estimated to be over 200 million people with an annual growth rate of 2.6 percent⁴. The median age is 18.4, signifying that most Nigerians are very young and growing rapidly, as shown in the population pyramid in Figure 2. However it is estimated to slow down in the coming years.⁴ The split between males and females is almost even with men taking a slight edge in numbers as there are 1.04 males to every 1 female⁸. However, it should be noted that, while women are slightly outnumbered by men, after the age of 65, women outnumber men.

Approximately half of Nigeria’s population live in urban areas where TB is also concentrated, according to the prevalence survey data.⁴ There are 5 major cities with high populations: Lagos, Kano, Ibadan, Benin city and Port Harcourt. Considering the country’s estimated 2020 population and total surface area, its population density will be 212.04 persons per square km⁸

This density, population distribution and predominant age group has implications for the dynamics of TB transmission and for the approaches to TB education, case-finding, and case holding, emphasizing the need for more intensive efforts to diagnose paediatric TB and use of modern communication methods to reach young people at risk for TB with appropriate messages.²

Figure 2. Population pyramid, 2020. (Source : PopulationPyramid.net)



1.3. Health System

The Nigerian health system is diverse with orthodox and traditional methods working alongside each other with little or no collaboration. The health system is made up of public and private health care facilities. The levels of care provided in the facilities are classified into primary, secondary and tertiary. The public health sector is owned and governed by the three tiers of government - the Federal, State and LGAs. The Federal Government manages tertiary health care (Federal University Teaching Hospitals, Federal Medical Centres and Federal Specialists’ Hospitals); the State is responsible for the State university teaching hospitals and general hospitals respectively while the LGAs manage the Primary Health Care (health care centres, health posts and dispensaries).^{Error! Bookmark not defined.} On the other hand, the private sector which could be for-profit

(owned by individuals or consortiums) or not-for-profit (missionary hospitals, Non-Governmental Organizations [NGO] clinics) also provide health care at the three levels described above.^{Error!}
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1.4. Nigeria TB Profile

TB is a major public health problem in Nigeria as it remains a serious health threat to men, women and children. The high disease burden was revealed by the result of the first National prevalence survey which showed a burden of TB far higher than had been predicted, doubling the previous WHO estimates for TB prevalence to 322/100,000 population and tripling the estimates of incidence to 338/100,000.² Thus, Nigeria is ranked 1st in Africa and 6th Globally amongst the 30 High Burden Countries (HBC). The country is also among the 14 countries in the world with the triple high burden of TB, TB/HIV and DR-TB. The working/productive age group of 15-44years is most affected by the disease. However, men are more affected than females¹.

Furthermore, Nigeria is among the eight countries that accounted for two thirds of the global TB cases and among the ten countries that accounted for about 80% of the missing TB cases (gap). Nigeria has the lowest TB treatment coverage (the number of people notified and treated divided by estimated incidence) globally.¹ According to the 2019 Global TB report, the TB treatment coverage for Nigeria is 24% for 2018 leaving a gap of 76% with over 300,000 cases being missed annually⁵. This is compounded by the missing cases among children and those of Drug resistant TB. These missed cases serve as a reservoir for continuous TB transmission in our communities especially among the vulnerable groups, including women and children.

The NTBLCP, which is a Division under the Department of Public Health of the Federal Ministry of Health (FMOH) has made great strides in addressing TB since it began implementing the WHO recommended strategies for TB control in all States and the FCT from 2004 till date. The NTBLCP through the support of partners has boosted diagnostic capacity across the country. As at the end of 2019, 399 Health facilities had GeneXpert MTB/Rif assay equipment, 3220 facilities had Acid-Fast Bacilli (AFB) sputum smear microscopy services while 12 reference laboratories had Line Probe Assay (LPA) and culture services.

A total of 12,606 public and private health facilities are providing treatment services for TB (DOTS centres) while 28 health facilities provide hospital-based management of Drug resistant TB cases. The programme also decentralized DR-TB services in the community in order to

increase access to care and provide services that are patient centred. Currently majority of the DR-TB cases are managed via community DR-TB intervention in all the 36 states plus FCT.

These investments have shown results as there has been a steady increase in TB case notifications from 31,164 in 2002 to 120,266 at the end of 2019 with a Treatment success rate of 87%.⁶ As a country with high TB/HIV burden, NTBLCP is also building the capacity of health workforce on the implementation of TB/HIV collaborative activities. Based on this effort, the percentage of patients receiving TB/HIV care in the TB unit has remained high. In 2019, 97% (116,879) TB patients received HIV testing and counselling out of which 10% (12,521) were found to be co-infected. Of these co-infected patients, 91% (11,372) and 91% (11,404) had access to life-saving Anti-Retroviral Drugs (ARVs) and Co-trimoxazole Preventive Therapy (CPT) respectively. In the area of Programmatic Management of Drug-Resistant TB (PMDT), the country made a tremendous achievement. There has been a steady rise in the number of diagnosed DR-TB cases from 25 in 2010 to 2,384 in 2019 while the number of patients enrolled every year also increased from 23 in 2010 to 1,975 in 2019.

Despite these achievements, the country's progress towards reaching the End TB targets for the control of TB has been fairly slow. Going forward, all case finding interventions must be implemented to scale in order to achieve the End TB targets.

1.5. The National Tuberculosis, Leprosy and Buruli-ulcer Control Programme (NTBLCP)

1.5.1. Organizational Structure

The NTBLCP is a division under the Department of Public Health (DPH) of the Federal Ministry of Health saddled with the responsibility of coordinating TB, Leprosy and Buruli ulcer control activities in the country. NTBLCP is structured along the three tiers of Government i.e. Federal, State and LGA.

The National level (referred to as NTBLCP Central Unit) is responsible for facilitating policy developments regarding TB, Leprosy and Buruli ulcer control. They provide guides on care of the 3 diseases, resource mobilization, programme monitoring, supervision and evaluation, human resource development and technical support to State programmes. The NTBLCP is headed by a National Coordinator who is supported by the various units of the programme.

The programme has a training centre called the National TB and Leprosy Training Centre (NTBLTC) located at Zaria that is responsible for the HR development of the programme, patient

care, research and provides technical support or any other assignment as instructed by the National Coordinator.

At the State level, the programme is under the Department of Disease Control/Public Health of the Ministry of Health; the day to day programme management is carried out by the State Programme Managers supported by the State TBL Supervisors, logistic officers, M&E officers and other support staff. In addition to coordinating TB, Leprosy and Buruli ulcer activities in respective States, these staff supervise, monitor and provide technical assistance at the State and LGA levels.

The LGA is the operational level of the programme based on the principles of Primary Health Care (PHC). At the LGA Level, the TBL prevention and control activities are the responsibility of the Local Government TBL Supervisors (LGTBLS) who support PHC workers in the implementation of TBL activities at health facility level. TBL prevention and control activities are implemented in close collaboration with Civil Society Organizations (CBOs, CBAs, FBOs, NGOs) and key affected persons in the community. Their roles include: assisting the State TB and Leprosy Control Programme (STBLCP) with planning, organizing and conducting training programmes; assisting with diagnosis and management of non-compliant TBL & BU patients; Supervising other health workers providing services; ensuring that National guidelines are adhered to; keeping an up-to-date and accurate record of activities; ensuring that patients' record cards are properly filled and kept by the health unit staff; ensuring that all patient level data are documented electronically; collating, analysing and reporting all data generated at the LGA level quarterly etc.

1.5.2. Goal of NTBLCP

By 2025, to achieve a 50% reduction in TB prevalence rate and 75% reduction in TB mortality (excludes HIV-related TB) rate in Nigeria compared to 2013 figures.

1.5.3. Long-term goal

To reduce significantly the burden, socio-economic impact and transmission of Tuberculosis, Leprosy and Buruli Ulcer in Nigeria.

1.5.4. The general objectives

- i. To reduce the prevalence of Tuberculosis, Leprosy and Buruli Ulcer to a level at which they no longer constitute public health problems in the country
- ii. To prevent and reduce impairments associated with leprosy and Buruli Ulcer
- iii. To provide appropriate rehabilitation for persons affected by leprosy and Buruli Ulcer

1.5.5. New strategic directions

The basic strategies for the treatment and control of TB in Nigeria remains the provision of free

TB services to all persons presumed to have TB or confirmed with active disease. However, the new Strategic directions that would enable a successful and efficient implementation are outlined in the NTBLCP Strategic Plan for the year 2021 to 2025 as seen below:

- Domestic resource mobilization with in-country funding of TB budget
- TB case finding (including key populations)
- Comprehensive engagement of all private care providers
- TB laboratory services
- Community system strengthening (including key populations)
- TB treatment and care (including comorbidities: HIV and non-communicable diseases - NCDs) with high treatment success rate
- TB prevention and infection control
- Childhood TB
- Programmatic management of drug-resistant TB (PMDT)
- Supply chain and logistics
- Strategic information and research

2. Rationale for Human Rights, Key Population and Gender Interventions in TB Control

TB is one of the 10 leading causes of death worldwide from a single infectious agent, ranking above HIV and AIDS.⁷ In 2018, according to WHO Global TB report, there were an estimated 10 (9.0—11.1) million new (incident) TB cases worldwide. Of these cases, 5.7 million were men, 3.2 million were women and 1.1 million were children. People living with HIV (PLHIV) accounted for 9% of the total and 1.2 million TB deaths were recorded in HIV-negative individuals while 251,000 TB deaths were among people living with HIV.⁷

Nigeria is a signatory to several conventions that support access to health as a human right. TB is often regarded as a disease associated with poverty and inequality, which fuels discrimination of those affected. While several studies indicate that everyone is at risk of exposure, the levels are disproportionately higher among Key Populations (KPs). Several factors related to Human rights and Gender hinder the effectiveness, accessibility and sustainability of TB programmes and services in the country.⁸

⁷ Global tuberculosis report 2019 ISBN 978-92-4-156571-4 © World Health Organization 2019.

Women and men are affected by TB differently; epidemiologically, biologically, economically, socially and psychologically. As a National programme, the response to address barriers created by Human rights and Gender related issues, particularly those affecting key populations is essential. TB is the major opportunistic infection among people living with HIV. Therefore, addressing Human rights and Gender issues with TB and HIV are closely related.⁸ TB kills more women globally than any other single infectious disease, and more women die annually of TB than of all causes of maternal mortality combined.⁹

Barriers associated with Human rights and Gender are well acknowledged. As the programme reviews the National Strategic Plan for TB Control (2021- 2025) to guide programme implementation and resource mobilisation, it will take into cognisance, the Human rights, KP and Gender aspects in order to achieve the country's overarching goals of a Nigeria free of TB.

3. Scope of Human Rights and Gender action plan

The Human rights and Gender action plan will span from 2021 to 2025. It is a 5-year framework that will guide the NTBLCP and stakeholders in the implementation of interventions that will address Human rights and Gender related barriers to access TB diagnosis and treatment, putting into consideration key and vulnerable populations. It will provide strategies and facilitate implementation of key activities which will help in achieving the overall goal of ensuring access to care for all. The Human rights and Gender interventions are cross-cutting and are expected to address barriers to accessing standard TB preventive, diagnostic and treatment services.

During implementation, the dynamism of the global approach to TB interventions will be considered. Several innovations arising from reviews and operational research may occur, the action plan will be flexible to accommodate these new approaches to ensure the expected goals are achieved. The NTBLCP and partners will review the implementation plan annually and use the lessons learnt from the interventions to adjust the plan. The assessments on key populations, Human rights and Gender issues as they relate to TB were limited, and therefore may not be representative of the whole country. Thus, the NTBLCP should make a conscious effort to conduct a more representative assessment on key populations, Human rights and Gender as it relates to TB during the implementation of this plan.

4. Goal of Human Rights and Gender action plan

The overall goal is to contribute to improved access to standardized TB Preventive, diagnostic treatment, care and support for all by 2025.

5. Objectives of Human Rights and Gender action plan

The objectives of the Human rights and Gender action plan are to:

- Ensure the existence and implementation of laws, policies, guidelines and systems which facilitate an enabling environment by 2025
- Promote and provide accessible, acceptable and quality TB services by 2025
- Promote Gender specific interventions that will eliminate barriers to standardized TB Preventive, diagnostic and treatment for all
- Implement gender transformative interventions and promote equity in the national TB response in Nigeria by 2025
- Reduce stigma and discrimination towards TB patients and enhance their participation in the interventions.
- Strengthen Monitoring and Evaluation of Community, Rights and Gender (CRG) interventions in Nigeria by 2025

6. Overall Approach of Human Rights and Gender action plan

The NTBLCP is the lead in the development of the Human rights and Gender Action Plan. The process of developing this action plan started from 20th January to 28th February 2020 and involved the engagement of key government staff, TB partners and other multisectoral stakeholders including legal teams and Human rights activists. An analysis of the Human rights and Gender landscape in Nigeria was done and gaps were identified. These gaps were prioritised through the following approaches:

- ✓ Gaps and corresponding recommendations from the Human rights and Gender assessment reports were identified
- ✓ Participants were divided into four groups that worked on the identified gaps and recommendations from the CRG reports while also prioritizing the gaps
- ✓ Groups were supervised during the process while a representative presented for each group which provided opportunity for further comments and inputs from the larger group

This Action Plan is in 6 sections with each section interwoven for easy flow. The first section focuses on introducing the workplan as it relates to Human rights and Gender; the second section is for country TB profile, goals and objectives; while the third section focuses on rationale for the

document, desk review of current assessments as recognized by the programme. The fourth section focuses on how Human rights and Gender related issues create barriers to persons accessing TB services while the fifth and sixth sections represent the costed activity plan framework.

7. Desk Review of Community Rights, Key Populations and Gender Assessment in Nigeria

Several assessments of the NTBLCP performance are being conducted on quarterly and annual basis. While these reviewed TB programme targets, highlight milestones, progress and challenges, they do not address issues related to specific key populations, community rights and gender.

The TB Legal Environment, Gender and KP Prioritisation Assessments conducted between 2017 and 2019 in Nigeria through the support of the Global Fund's Strategic Initiative for finding the missing people with TB provided the opportunity for a review of the TB control efforts from a patient centred perspective.

7.1. Legal Environment Assessment (LEA) in Nigeria

The LEA was conducted in 2017 and validated in 2018. The primary goal of the LEA is to create an enabling legal environment for people with TB, TB survivors, their families and people at risk of the disease in Nigeria to promote better individual health outcomes and improve TB programme performance. To this end, the LEA involved a review and assessment of the laws, policies, guidelines and case law that constitute the legal and policy framework related to TB in Nigeria, to identify approaches that support the fight against TB, those that hinder the effort, and gaps where new law or policy is needed. This review considered the legal framework at the national level and in Lagos State. Given the diverse social, economic, religious and cultural contexts throughout Nigeria, additional findings and recommendations may have been reached if the LEA covered other areas of the country.

The LEA also leveraged qualitative research in the form of in-depth interviews and structured dialogues with a wide range of stakeholders, including people affected by TB, TB program coordinators, CSOs, TB care providers in the public and private sector, researchers, and international organizations. The LEA team also conducted site visits to observe the operations of public and private TB clinics, research facilities, and relevant government ministries. Based on all of these, the LEA provides concrete recommendations to implement a human rights-based, person-centred approach to TB prevention, testing, treatment and care in Nigeria.

7.1.1. Legal Environment Assessment Findings

The LEA Key Findings are as follows:

- **Limited access to DOTS centers and TB services:** DOTS centers are often located too far from communities where people with TB live, especially at the LGAs. People with TB sometimes interrupt their treatment as a result of the cost and inconvenience of transportation to the clinic and time away from their places of work. Public clinics are also often overcrowded and people affected by TB experience long waiting times for services, delays in obtaining test results, and other inconveniences prior to initiating treatment.
- **Lack of privacy and confidentiality:** The lack of privacy and confidentiality is a barrier to TB testing and treatment, and a challenge for adherence. In addition to concerns around confidentiality of medical records, DOTS centers often have signs marking them as TB clinics and facility procedures that reveal people with TB or presumptive TB.
- **Stigmatizing and discriminatory treatment in TB clinics:** People affected by TB are often treated in stigmatizing, disrespectful and discriminatory ways by health care workers, in both public and private clinics. This discourages them from continuing their treatment or even seeking testing in the first place.
- **Employment discrimination against people affected by TB:** Many people, who are otherwise qualified, are permanently dismissed or forced to leave their employment after being diagnosed with TB, including, but not limited to, school teachers, construction workers, and factory workers. Employers, in these cases, do not consider whether a person remains contagious or has been cured.
- **Stigmatization and discrimination of people affected by TB in their communities:** People affected TB experience severe stigma and discrimination in their communities and families, resulting in delayed diagnosis and treatment initiation, lack of treatment adherence and completion, poor individual health outcomes, intense self-stigmatization, and mortality.
- **Lack of legal protections against discrimination of people affected by TB:** Despite widespread discrimination against people affected by TB in employment, health care and other settings, the law does not prohibit discrimination against people affected by TB. However, the national *HIV and AIDS (Anti-Discrimination) Act, 2014* prohibits discrimination against people living with HIV.
- **Lack of Isolation and involuntary isolation policy:** Nigeria does not have a policy on the isolation and involuntary isolation of people with TB, leading to confusion among health care workers regarding what measures are lawful and appropriate in situations

where people with TB are contagious, refuse treatment and are unwilling or unable to take appropriate infection control measures.

- **Problematic legislation:** The Lagos State *Public Health Law, 2015* is overly broad and permits unjustified invasions of privacy and deprivation of liberty of people affected by TB, as well as people living with HIV, thus, hindering the State TB response.
- **Inadequate Advocacy and Community Mobilization:** There is inadequate community mobilization and advocacy (in decision making processes, governance, program design and implementation) around TB. There are few CBOs working on TB and limited representation of people affected by TB in decision making.
- **Low awareness, lack of accurate information, and myths and misconceptions about TB:** Low public awareness and lack of accurate information about TB disease and TB treatment among people affected by TB, health care workers, CSOs and CBOs, law and policy makers, and the public drive the epidemic. This leads to preventable morbidity and mortality. In some cases, religious and traditional beliefs about TB and people affected by the disease contribute to the spread of dangerous myths and misconceptions.
- **Delays in TB diagnosis:** People affected by TB often experience long delays—more than a year in some cases—from the onset of symptoms to diagnosis. Contributing factors include low awareness of TB symptoms among the general public, Patent Medicine Vendors (PMVs) and some health care workers. In addition, inappropriate prescriptions of cough medicines from the PMVs, rather than referrals to DOTS further delays in their treatment journey.
- **TB drug stock-outs:** Though TB drugs are generally available in public clinics, supplies fluctuate; as at 2017, the Lagos State program had experienced long delays—up to two years — in receiving drugs procured at the national level. This is especially true for second-line drugs used for MDR-TB treatment.
- **Out-of-pocket expenses especially for TB services:** People affected by TB often pay out-of-pocket for testing services for their initial diagnosis, including for chest x-rays in public and private clinics and hospitals, and for incidental costs, including for transportation to and from clinics. These out-of-pocket costs create barriers to TB services and challenges for treatment adherence.
- **Lack of consistent, good-quality counselling for people diagnosed with TB:** A lack of consistent, good-quality counseling for people diagnosed with TB contributes to widespread treatment interruptions, as people with TB are not provided information about

the benefits and risks of treatment, including those associated with stopping or interrupting treatment.

- **Over-the-Counter Sale of TB Drugs:** The availability of TB drugs at private chemists and pharmacies in some parts of the country and the lack of quality assurance for drugs purchased in the private market contributes to inappropriate TB treatment and drug resistance.
- **Challenges for Public-Private Mix (PPM) programs:** Some private providers fear that participation in the PPM program will drive other patients away due to pervasive TB-related stigma. PPMs also create financial disincentives for private provider participation, as only TB drugs are provided free, with all other costs associated with TB services, including staff, time and materials costs being borne by the providers. The fragmentation and lack of coordination among parallel case notification systems has also resulted in low notification among private providers.
- **Barriers to TB services and treatment adherence for key and vulnerable populations:** Treatment interruptions and lost to follow-up occur because DOTS centers have inadequate resources for mobile populations, leaving mobile individuals responsible for informing clinics about their departure and destination.

7.2. TB Gender Assessment in Nigeria

The TB Gender Assessment took place between 2018 and 2019 in 4 States namely Lagos, Kano, Benue and Cross River. The objectives were to:

- Examine and understand the gender barriers in the pathway to TB prevention, diagnosis and treatment services
- Explore in details existing gaps and gender norms that prohibit men, women and transgender groups, (where applicable) from seeking care /treatment for TB
- Identify priority interventions to address the identified gaps and opportunities for informing a gender-responsive and gender transformative National TB response
- 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.

The assessment examined the following areas:

- i. Awareness and knowledge of TB
- ii. Perceptions and emotional reactions regarding TB
- iii. Exposure to risk factors for TB

- iv. Barriers and enablers to seeking diagnosis and treatment
- v. Barriers and enablers to adhering to treatment
- vi. Impact of TB on personal life during and after treatment
- vii. Perceptions of ways in which men and women experience, or are impacted by TB differently
- viii. Public perceptions of ways to improve TB awareness, diagnosis, and treatment success and reduce TB-related stigma for all genders

7.2.1. Gender Assessment Findings

Key findings highlighted from the assessment include the following:

Health seeking practices

While both men and women showed similarities in terms of their first port of call when seeking TB services (oftentimes from PMVs), men displayed a higher tendency to delay seeking care at a health facility until it is late. 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.

Barriers limiting access to TB diagnostic and treatment services

Several barriers limit people with TB from accessing the diagnostic and treatment services. These barriers are also context and gender specific.

- **TB related stigma** is a major barrier with gender-specific differences.
- **Poverty** is a key barrier affecting both men and women with TB. However, as a result of cash power differentials, women (particularly the married ones) tended to be poorer and more dependent on the permission/consent of their spouses or the decision maker in the home
- **Socio-cultural norms:** Culturally, men are expected to be strong almost invisible and possess the capacity to endure pain. Given traditional roles 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. Women are expected to be weak, submissive, prone to illness and physically/financially dependent on men for their health. Their homemaker, caregiving role and the desire to protect their children/families from being infected predisposes them to seek care early. Though women may desire to seek care early, lack of resources and the need to obtain permission/consent from their husbands/household heads could delay their health-seeking practices.

- **Adherence to treatment:** While men tend to abandon treatment once they feel better or give excuses related to their work demands, women are more focused on getting cured in order to be able to cater for their children and families.
- **TB related Gender Based Violence (GBV):** Women are often at the receiving end of GBV, but the cases are under-reported, “invisible, yet present due to a culture of “silence”. It is 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.
- **Impact of TB:** 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:** There is increasing recognition at the National and State programme levels of the need for gender-sensitive considerations in designing programmes that are patient centered 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 include the “*Uwar Gida*” Housewives Initiative.

7.3. Tuberculosis Key Population Prioritization & Rapid Assessment

This assessment was conducted between 2018 and 2019; one of the key objectives was to identify those populations and sub-groups who are considered “hidden” with high TB rates, who are yet to be reached by government TB services. Such KPs exist, however, based on country context, the following 10 key populations in order of priorities were identified in Nigeria:

- I. People living with HIV (PLHIV)
- II. Inmates of correctional centres & Detainees
- III. Sex Workers
- IV. Internally Displaced Persons
- V. Urban Poor
- VI. Rural Poor
- VII. Smokers
- VIII. People who Use Drugs
- IX. Children

X. Healthcare Workers

Other KPs identified were Miners, People with Silicosis, Migrants, Nomadic populations, People with Alcohol Dependency, LGBTQI, Indigenous populations, Homeless, People with Mental or Physical disabilities, People with Diabetes, Elderly, correctional centre workers, Refugee camp workers, Community Health/Outreach workers, Hospital visitors, correctional centre visitors, Sex worker clients, family members of people who use drugs, Miners' family members and People at Risk of Zoonotic TB.

In Lagos State, the prioritized KP in no specific order include health-care workers, PLHIV, people living in congested settings, correctional center inmates, drugs users, malnourished people, smokers, and commercial long-distance travelers in air-conditions.

In Kano State, the prioritized KPs were the poor people in urban slums, PLHIV, detainees, children, and drug users, People at risk of Zoonotic TB, and students.

In Benue state, the prioritized KPs were hospital workers, PLHIV, correctional center inmates, people who have severe kidney disease, commercial drivers, rural poor, market women and religious settings;

In Cross River State, the prioritized KPs were PLHIV, relatives of TB patients, urban slum dwellers, drug users, children, casual laborers in quarries.

Different States had different perspectives on who their KPs were with different factors contributing to their vulnerabilities.

8. Human Rights and Gender Barriers in TB Control in Nigeria

Tuberculosis disease is a huge global burden and the control is challenged by many factors related to Human rights and Gender which hinder the effectiveness, accessibility, service provision and sustainability of TB control. Several Human rights and Gender related risks of TB transmission and barriers to available services are outlined below

8.1. Human Rights issues associated with TB:

Human rights are rights inherent to all human beings, whatever the nationality, place of residence, sex, national or ethnic origin, colour, religion, belief, language, or any other status. We are all entitled to enjoy human rights without discrimination. In light of this, a human rights-based TB response supports and enhances traditional approaches to combatting the disease. The approach focuses on social and economic drivers, combatting TB-related stigma and discrimination, protecting privacy and confidentiality, and ensuring good-quality testing and treatment for TB is available and accessible without discrimination. A human rights-based TB response is predicated on an enabling legal and policy environment that promotes the dignity and autonomy of people

affected by TB, leads to better individual and public health outcomes, and supports TB program performance: “Respect for Human Rights Protects Public Health”.

Some human right issues associated with TB:

I. Stigma and Discrimination

The *National Strategic Plan for Tuberculosis Control* acknowledges that “fear of stigma and discrimination” are priority contributing factors to low TB case detection and low treatment success rates in some States and LGAs. The stigma and discrimination associated with TB and discriminatory practices at workplaces, health care centres, families and communities that drive the unfair and inhuman treatment of persons affected by TB, have either kept people away from testing or when detected, away from treatment owing to the stigma associated with TB and the consequent discrimination thereof.

II. Laws and Policies

The National Health Policy 2016 that calls “to revise, update and enact new health legislation” is relevant here. Tension undoubtedly exists between the public good and human rights with regard to isolation and treatment. Laws like the Quarantine Act, 1926 and the other isolationist laws do not conform with human rights, need to be revised

The WHO Ethics Guidance for the Implementation of the End TB Strategy on isolation and involuntary isolation establishes circumstances and justifications for isolation and involuntary isolation and this should be the standard.

When Laws and Policies legislate and fortify anti-human rights practices, and is not people centred, results are often not very helpful. Information and awareness are key here in people understanding the science of TB with regard to infection over and above fear.

III. Information and Awareness

TB information and awareness is a right and includes information from health care workers. Treatment literacy with regard to types of drugs, names, its use and side effects is important. Knowledge of risks and benefits of treatment and non-adherence; nature of TB infection and TB disease; duration of the TB contagion; counselling and information about preventive and infection control measures etc. Awareness’ of all of the above enlightens and empowers patients and the public. Presently this is not the case, and this has exacerbated the situation of case finding and treatment.

IV. Culture and Customs

There are several cultural norms and practices that act as barriers to TB treatment, support, care and control. Some cultural practices in a way affect the behaviour and attitude of the practitioner leading to stigma and discrimination. For example, some cultural languages and how it describes

TB are discriminatory in practice which stands as a barrier. Cultures, traditional, norms and beliefs can also affect how people access care related to orthodox medicine. It can also affect how people relate with people infected with TB in the society. Women and girls are known to experience delays in accessing care because they have to seek permission from the house-hold heads before being able to access health facilities for TB care. In some instances, inability to bear the cost of transportation and availability of alternative care in form of traditional or herbal medicine influences health seeking behaviours in communities in Nigeria. In some communities, men are prioritized over women while male children are also attended to first before females. These are factors that could promote the spread of TB in communities if not appropriately addressed through interventions.

V. Justice Systems

A lot of our judges are not very conversant with the emerging issues in the area of TB, they may not be up to date about what constitutes stigma and how it affects the human rights of people infected with TB. This Human rights and Gender plan seek to address such issues through interventions that align with identified gaps. Inadequate access to justice can serve as a barrier to protecting the rights of people infected by TB from stigma and discrimination.

Another barrier is the delay in justice, for example trials can take so long and many years in the court before cases are decided and concluded. An example is the correctional centre system that has more awaiting trial inmates than those already convicted, thereby creating a congested correctional centre system that exposes inmates to TB infection. Some inmates are recorded to have gone to correctional centre and come out with TB infection.

VI. Underlying poverty and economic inequality

Poverty is a key problem to many persons in Nigeria, it is estimated that 50% of the citizens are said to be living below United States Dollar (USD) 1.90 per person per day (International Poverty Line)²⁰. Although poverty rate in the country differs from community to community and life seems better in Urban area than rural area, the existing number is huge, and majority of these persons live in conditions of overcrowding, inadequate ventilation and poor nutrition thereby making them vulnerable to diseases like TB¹⁶. Women and girls are known to be disproportionately affected. Although TB diagnosis and treatment are free in Nigeria, out of pocket expenditures are relatively high. The report of the catastrophic survey showed that, 71% of the TB patients spend more than 20% of their income in seeking for TB care²⁵. TB patient often lack transportation fare to and from DOTS centres²⁵. This is enough to impede people from seeking TB services in the community. Therefore, efforts should be made to address issues that will reduce the cost of care on patients.

VII. Access to TB care

Access to TB care (diagnosis and treatment) can be hindered by cost, insecurity, availability of TB services, lack of social security including health insurance. The availability of TB diagnosis and treatment also has been a concern, reports of sputum loss in some diagnostic sites and few cases of diagnosed TB cases waiting for treatment due to irregular supply of drugs has been reported in some States. Therefore, there is need for an effective logistic management of TB commodities and medicines at all levels to ensure access to care. Expand TB services to ensure these services are available to those who reach the service point. According to the NTBLCP guidelines, the primary diagnostic tool for TB is the GeneXpert MTB/RIF, however, there are a total of 399 in the country compared to the target of 774 (1 per LGA) as at the end of 2019. Furthermore, the coverage of health facilities with TB services is as low as 5% among private-for-profit hospitals and clinics²⁸ and 19.6% among PHCs in the country²⁹; this limits access to TB diagnostic and treatment services.

VIII. Correctional Centres inmates and detained persons

The poor conditions in correctional centres especially in Nigeria make the centres a vulnerable place of transmission of infectious diseases such as TB. Most of the centres in Nigeria are overcrowded, with poor ventilation, hygiene and nutrition. In Nigeria, there are 244 correctional centres out of which 83 provide TB services giving a TB services coverage of 34%¹⁴. The capacity of most of the Nigerian correctional centres are for about 50,000 inmates. However currently there are about 70,000 inmates in these centres. Out of this figure More than **49,000** inmates are awaiting trial and presumed innocent. What this means is that in addition to being presumptive constitutionally innocent, there is the added health rights violation of exposing them to TB, (although this right may have been compromised until court proves otherwise). This aligns with the concerns of correctional centres. Data suggest that TB is the leading cause of death among inmates in correctional centres globally.

9. Key Populations (KP) most affected by Tuberculosis

The following KPs are most affected by TB in Nigeria:

- ***Children***

Children depending on their caregivers (e.g. parents, guardians) for accessing health care services are at high risk of developing TB. TB diagnosis among children is also difficult due to presentation with non-specific symptoms, inability to produce sputum more especially among <6 and problems in getting samples (e.g. gastric wash) for confirming TB. The impact of TB among children include absenteeism from school thereby depriving them the right for education, stunted growth, high rates of morbidity and mortality.²²

- ***Migrants and Refugees***

Migrants and refugees constitute an important KP for TB. They are at high risk of TB as a result of poor housing conditions characterized by poor ventilation and overcrowded settings. This population is also at risk of malnutrition and poor access to TB services among other factors. Women and children form the majority of migrants and refugees in crises situations. Some migrant population in Nigeria are the Nomads, long distance drivers, fisher men etc. They are located in hard-to-reach areas, slums, swamps, creeks etc. They are at high risk of TB due to poor housing, inadequate nutrition, lack of access to health facilities, information and services. Poor vaccination coverage, consumption of unpasteurized milk and frequent migration also add to this risk.²² Migrants and Refugees may be denied access to TB diagnosis and treatment due to fear of being caught with illegal documents and they lack education and information on TB. Even when they are aware of TB, their native beliefs, culture, dispositions etc deterred them from accessing care²².

- ***Internally Displaced Persons (IDPs)***

There is a rise in crisis globally. Nigeria is facing several crises i.e., from Boko haram, communal clashes, farmer/herdsmen crisis, armed banditry, etc. With all these crises, many communities have been displaced. The IDPs are known to be at high risk of TB due to poor housing, overcrowding, malnutrition and poor access to health services among other factors. According to the International Organization for Migration Displacement Tracking Matrix (2018), women and children constitute 53% of IDPs in North East Nigeria. Lack of resources (human, financial, material etc.) and adequate health care services increase IDPs vulnerability to TB and may lead to limited access to services, information and education. Ensuring appropriate TB treatment and control may be difficult due to changing emergency situations and unstable refugee population.

- ***People working in Poorly Ventilated and crowded Environments***

Poor working conditions can greatly increase TB transmission, such as in health care settings, correctional centres, mines and factories. The TB diagnosis or a negative perception of a history of TB may lead to loss of work, or inability to get work. People ill with TB may face the trade-off of pursuing treatment or maintaining their job. Workplace policies which should be backed by legislation is key in addressing the plight of workers affected by TB. This is lacking in Nigeria

- ***Slum Dwellers***

The slum dwellers are known to have high rates of TB, mainly due to poor housing conditions which predisposes them to overcrowding/poor ventilation, poor access to health services, poor immunization coverage and malnutrition. High TB rates and lack of access to care among slum

dwellers are compounded by poverty, discrimination and poor education. Women and children are disproportionately affected by these risks.

- **People who use drugs**

The TB risk is increased in people who use drugs regardless of HIV status. More recently, there has been an increased drug use especially among youths in many parts of Nigeria. Drug use is often associated with poverty, malnutrition, discrimination, crimes, unemployment, homelessness, poor health seeking behaviour, high risk life style and lack of access to social services.

- **People who use alcohol**

The harmful use of alcohol is a significant risk factor for TB. In rural Nigeria, this is particularly so with locally brewed alcohol such as “Burukutu”, “Pito” “Sepe” “ogogoro” which have been clinically confirmed to be harmful and predisposes to TB infection. Harmful use of alcohol is associated with TB infection and poor treatment outcome.

- **Involuntary Isolation**

Involuntary isolation may be imposed on persons being tested or treated for TB without due process or justification thereby inhibiting rights which has important social and economic impacts.

- **Women**

TB is among the top three causes of death among women aged 25-44³⁰. The 'feminization' of the HIV epidemic has meant an ever-greater burden of TB among women. Maternal TB/HIV is an important risk factor for paediatric TB and maternal and child mortality. TB can cause infertility in women if latent bacilli get reactivated and infect the genital tract. Genital TB is always hard to diagnose because of the absence of specific symptoms. TB-related stigma and discrimination can affect women seeking and accessing health care

10. Strategic Partnerships

Strategic partnerships involving organizations, agencies and programs is important in ensuring that the action plan is implemented and adequately monitored. The following will facilitate such partnerships:

- a. Stakeholders Mapping: All stakeholders identified during the Human Rights and Gender assessment should be mapped
- b. Consensus on activity implementation: Consensus should be built on integrating Human rights and Gender related activities into stakeholders’ annual plans including National Strategic Plan, Global Fund Plan and USAID Country Operational Plans.

- c. Technical Support: Technical support should be provided to the NTBLCP and other stakeholders in the implementation of the Human rights and Gender Action Plan.

12.1. Community Systems Strengthening for CRG Tools

The implementation of this action plan will benefit from community systems strengthening which is encouraged to improve health in communities. CSOs (CBOs, FBOs, and CBAs) are grounded in communities and have the ability to interact with communities, react to community needs and issues, and engage with key and vulnerable groups. They provide direct services to communities and advocate for improved programming and policy environments. This enables them to influence the level of impact of Human rights and Gender relates activities in communities and among key and vulnerable populations.

11. Action Plan for Identified Barriers

S/N	Objective 1. To ensure the existence and implementation of laws, policies, guidelines and systems which facilitate an enabling environment by 2025						
	Programme Area	Activities	Indicators (output/process)	Results/outcome	Cost (Naira)	Time Frame	Responsible Persons
1	Production of a TB Law Reform Proposal on Gender and Human Rights in the Context of TB	Develop a process for the passage of TB specific law and policy encompassing Human rights and Gender in Nigeria. Stakeholders to review Law Reform Proposal Advocate for passage of TB specific law by stakeholders	A process for the passage of TB specific law and policy encompassing Human rights and Gender in Nigeria developed Law Reform Proposal reviewed by stakeholders	Draft of TB Law reform proposal ready to be shared with Legislatures for presentations	3,921,000	Q1, '21	NTBLCP, Stop TB Partnership and other Partners
2	Develop policy briefs, guidelines, and information packages on improving community, gender and rights of TB patients	Conduct workshop with stakeholders to develop policy briefs, guidelines and information packages on improving Human Rights and Gender of TB patients. Advocacy Visit with legislators (Upper and Lower Houses) and Sponsors (in the National assembly)	Workshop with stakeholders to develop policy briefs, guidelines and information packages on improving Human Rights and Gender in TB control conducted Number of advocacy visits conducted	Policy briefs, guidelines and information packages available and in use Human rights of TB patients improved	7,690,000	Q1, 2021 Q1, '21	Consultant, NTBLCP, STOP TB partnership and CSOs

		on improving Human Rights (and Gender) of TB patients Advocacy Meeting with legislators (Upper and Lower Houses) and Sponsors (in the National assembly) on improving Human Rights (and Gender) of TB patients	Number of advocacy meetings conducted	Human rights of TB patients improved			
3	Awareness creation on TB Law Reform Proposal including processes for activation and implementation	Conduct mobilization meeting with legislative assistants and clerks on fast tracking the production and roll out of the Promulgated Laws/policies	Number of Mobilizations meetings held	Prompt and early roll out of Promulgated Laws/policies and activation thereof.		Q4, '21	NTBLCP, Stop TB Partnership, other Partners
4	Support parliamentary debates, press conferences and petitions	Attend and participate in public hearing on passage of draft TB Human rights and Gender law.	Number of debates, press conferences and petitions attended	Law on TB Human rights and Gender passes	7,400,000	Q2 – Q3, '21	NTBLCP, Stop TB Partnership, other Partners
		Produce promulgated Laws	Number of promulgated Laws/policies on TB Human Rights produced	Utilization of Promulgated Laws/policies on TB Human Rights	7,690,000	Q4, '21	NTBLCP, Stop TB Partnership, other Partners
		Create awareness on Laws/policies on TB Human Rights among CBOs, TB community, NGOs, etc.	Number/Types of SBCC (Print and Electronic) Materials Produced	Impacts of the SBCC materials on the TB awareness creation	18,500,000	Q3 – Q4, '20	NTBLCP, Stop TB Partnership, other Partners
Objective 2: Strengthen legal system an rights approach to support TB management in relation to Gender and Human Rights issues in Nigeria							

5	Enhance judiciary and the legal community's awareness on a human rights-based, gender transformative TB response and their role in the response	Map all legal organizations working on human rights, gender and health issues	Number of legal Organizations working on human rights, gender and health issues identified and Mapped	Valid directory of all Legal Organizations working on human right and gender violation in Nigeria	345,000	Q1, '21	NTBLCP
	Monitoring and Documentation of rights violations of TB Patients	Inclusive development and deployment of online TB rights violations of TB patients and annual release of date	Online portal to capture and analyze rights violations developed	Existence of Data of human rights violations of TB patients and Interventions by State and non-state actors based on scientifically produced data			NTBLCP, CBOs, TB patients community
		Conduct sensitization meeting with National judiciary, legal communities and CSOs	Number of Meeting held with judiciary & legal communities	The judiciary and the legal communities are more knowledgeable & involved in TB Human right cause	18,500,000	Q3 – Q4, '21	NTBLCP, Consultants, Stop TB Partnership, other Partners
		Identified and engage relevant bodies to provide legal support services and data on violations for informed interventions.	Number of organizations engaged	legal support services and data on violations for informed interventions available		Q3 – Q4, '21	NTBLCP, Stop TB Partnership
	Conduct sensitization workshop for judicial officers and legal communities at State levels on understanding TB and human rights	Number of sensitization workshops held with judiciary officers and legal communities at state levels	The judiciary and the legal community's, are more knowledgeable, involved in TB Human right cause	18,500,000	Q3 – Q4, '20	NTBLCP, Stop TB Partnership, STBLCP, FIDA, Lawyers Alert and Partners	

Objective 3: To reduce stigma and discrimination towards TB patients and enhance their participation in TB interventions							
6	TB Stigma Assessment	Conduct stigma assessment using the STP TB Stigma Assessment tool– “Implementation Handbook and Data Collection Instruments”	Number of states where stigma index assessment study is conducted	Report of stigma index assessment study	55,500,000	Q2, '21	NTBLCP
7	Stigma reduction and discrimination	<p>Develop gender sensitive interventions to reduce TB stigma and discrimination based on Stigma Assessment findings to be implemented</p> <p>Conduct community sensitization on TB and stigma reduction</p> <p>Engage TB survivors as TB Champions; to demystify TB and serve as Counsellors and Treatment supporters at facility level and in all levels of programming</p> <p>Train journalists and media executives on addressing TB, TB</p>	<p>Number of interventions to reduce stigma and discrimination implemented</p> <p>No of CBOs supported to conduct community sensitization</p> <p>Number of TB survivors engaged</p> <p>Numbers of journalists sensitized</p>	<p>stigma and discrimination reduced in the community</p> <p>Communities sensitized on TB and stigma reduction</p> <p>Myths and Misconceptions around TB addressed using TB champions</p> <p>Journalists use appropriate languages in</p>	88,494,000.00	Q2 – Q4, '21	<p>NTBLCP</p> <p>NTBLCP/ Partners</p>

		stigma and local language terminologies		report about TB and address stigma on reportage			
		Develop SBC materials for stigma reduction and discrimination in TB	Availability of SBC materials on stigma and discrimination	SBC Materials to address stigma and discrimination developed and used			NTBLCP and Partners
8	Development of stigma policy document	Conduct Stigma Policy Development workshop	Availability of Stigma policy, SOPs documents	Stigma policy document developed and used	4,284,000.00	Q2, '22	NTBLCP
		Develop guidelines, training modules and SOPs on implementation of policy on TB stigma and discrimination at health care facility	Availability of guidelines, training modules and SOPs at Health Care facilities	Guidelines, training modules and SOPs developed and used			
9	Develop capacities of Healthcare workers, CSOs to address	Conduct TOT for NTBLCP, partners and National CSOs on understanding KPs, Human rights and Gender issues and addressing	Number of master trainers trained on addressing stigma and	Master trainers on addressing stigma and Discrimination in	34,624,400.00	Q2, '22	NTBLTC and partners

	Stigmatization and Discrimination	TB related stigma and discrimination Conduct stepdown training to build the capacities of Healthcare workers, CSOs to address Stigmatization and Discrimination	Discrimination in TB Number of Stepdown trainings conducted	TB available and used HCWs & CSOs trained on addressing Stigmatization & Discrimination			NTBLCP STBLCP CSO and Partners
Objective 4: Increase Access to quality TB services among Key and Vulnerable Populations by 2025							
10	Active TB case finding among key and vulnerable populations	Conduct KP Size Estimation Survey in Nigeria Conduct workshop for dissemination of findings and prioritization of TB Key and Vulnerable Populations for Interventions Conduct workshop to develop Guidelines for TB Control among Key	KPs survey conducted Workshop for dissemination of findings and prioritization of TB Key and Vulnerable Populations conducted Workshop for developing guidelines	Findings from KP survey available to influence programming Findings from KP size estimation survey disseminated Guidelines for TB Control among Key Populations developed		Q1, '21 Q3, '21 Q4, '21	NTBLCP CSO

		Populations in collaboration with NTBLTC	among KPs conducted				
		Identify and engage CBOs operating in key and vulnerable population areas to implement Active TB case finding	Number of CBOs operating in key and vulnerable population areas	Improved Active TB Case Finding among key and vulnerable populations	19,756,400.00	Q2, '21	NTBLCP CSO and Partners
		Conduct round table meeting with CSOs and NTBLCP to review and integrate gender and human rights issues into their operational plans	Number of CBOs that mainstreamed KP, Human rights and Gender issues in their operational plans	KP, Human rights and Gender issues mainstreamed in their operational plans			NTBLCP NTBLCP and Partners

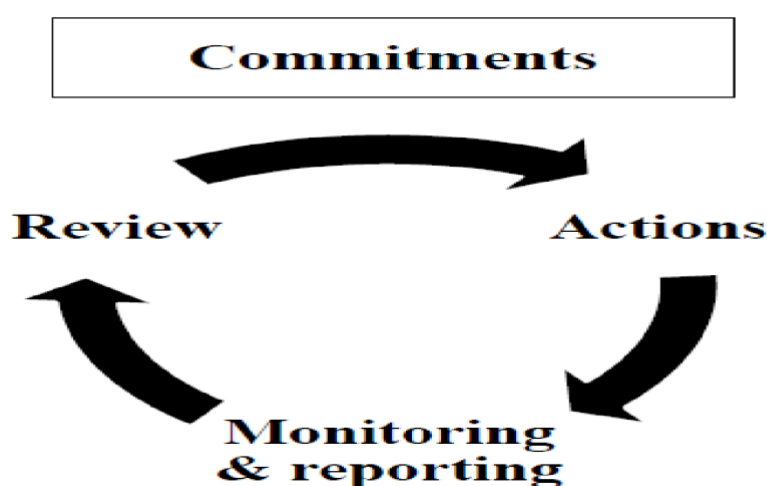
12. National Accountability Mechanism for Human Rights and Gender barriers in TB control

Accountability means being responsible and answerable for commitments made or actions taken. It involves achieving objectives and results in response to mandates and in accordance to the overall interventions and programme Budget. ²¹ It includes fair and accurate reporting on programme performance, stewardship of funds, and all aspects of performance according to the programme guidelines, to its stakeholders in a timely and transparent manner²¹. Accountability framework defines how a specific entity (or entities) will be held accountable for commitments made or actions taken. An accountability framework needs to define who is accountable (for example, individuals, organizations, national governments), what commitments and actions they are accountable for, and how they will be held to account ²¹.

Therefore, accountability framework for this Human rights and Gender in TB control will define who is to be held accountable, what commitments they are accountable for, what actions are to be taken in the context of those commitments. This needs to be clear to all stakeholders (individuals, firms, organizations, governments) in involved in TB control.

Accountability is often seen as government–donor relationship and vis-à-vis, government accountability to its citizens and responsiveness to their expectations on the health service is central. The essential components of an accountability framework (commitments, actions, monitoring and reporting, review) and the key stakeholders involved are shown below

Figure 3: Four Core Components of an accountability Framework



Accountability Mechanism Key Stakeholders

Figure-4: The framework of partners that will be implementing the Action plan

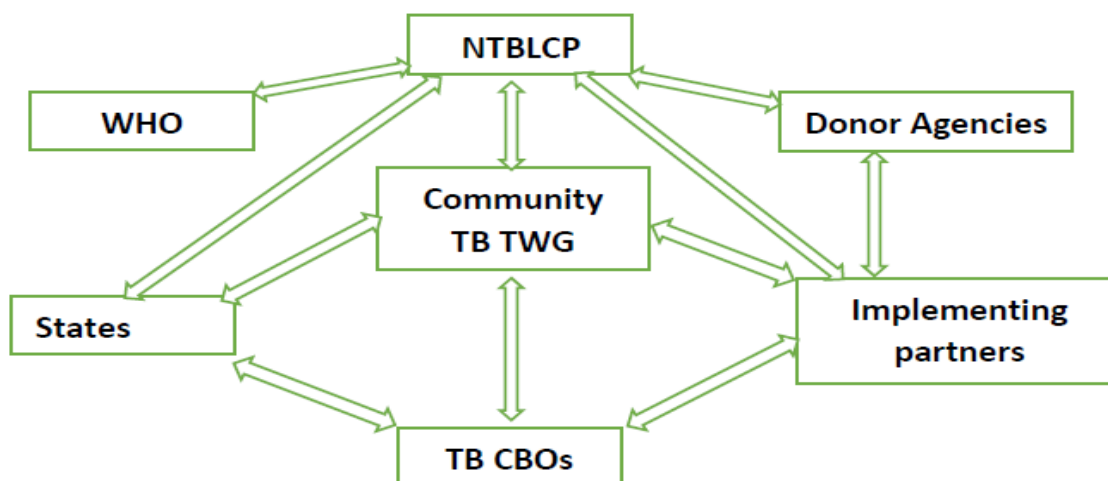


Table 1: Summary of accountability “frameworks” for global health priorities

For what are they accountable? Mode of accountability		How those accountable are held accountable Process of accountability		Who is accountable? Responsible Organization
Commitment	Action	Monitoring and reporting	Review	Responsible
Establish policies that address Human right and gender issues in TB	Develop and engage law makers to pass a bill on Human right and gender issues in TB	Human right and Gender Law for TB	<ul style="list-style-type: none"> • Report • 2021 	NTBLCP WHO International Partners
Reviewed guidelines and RR tools	Review RR and other electronic tools to capture vulnerable populations	Updated guidelines	<ul style="list-style-type: none"> • New tools • 2021 	NTBLCP WHO International Partners
Establish stigma and discrimination issues	Conduct various studies to address the	Study reports	<ul style="list-style-type: none"> • Printed study reports • 2022 	NTBLCP WHO International Partners
Strengthened community engagement	Map CSO working on TB and facilitate coordination activities	Meeting reports	<ul style="list-style-type: none"> • Printed meeting reports • 2020 	NTBLCP WHO International Partners
Develop TB isolation policy.	To provide policy guidelines to implement a rights-based detention such as TB isolation policy.	Developed TB isolation policy	<ul style="list-style-type: none"> • Guideline • 2020 	NTBLCP WHO International Partners

13. Reference`

1. World Health Organization (WHO) Global TB Report 2019
2. NTBLCP National Strategic Plan 2015 To 2020
3. WHO “END TB STRATEGY”
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