Gender integration strategy

Eradicate Tuberculosis

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Abbreviations

ADS  Automated Directives System
AIDS  acquired immune deficiency syndrome
ANC  antenatal care
ARASA AIDS Rights Alliance for Southern Africa, Prison Care and Counselling Association
CCM  Country Coordinating Mechanism
CITAM+ Community Initiative for Tuberculosis, HIV/AIDS, and Malaria plus related diseases
CSO  civil society organization
DOT  directly observed treatment
DOTS  directly observed treatment, short course
FGD  focus group discussion
FP  family planning
GRZ  Government of the Republic of Zambia
HIV  human immunodeficiency virus
IMPACT Innovations and Multi-Sectoral Partnerships to Achieve Control of Tuberculosis
IPT  isoniazid preventive therapy
M&E  monitoring and evaluation
MDR-TB  multidrug-resistant tuberculosis
MEASURE Monitoring and Evaluation to Assess and Use Results
MEL  monitoring, evaluation, and learning
MoGCD  Ministry of Gender and Child Development
MoH  Ministry of Health
NTLP  National Tuberculosis and Leprosy Program
NTP  National Tuberculosis Control Program
PEPFAR United States President’s Emergency Plan for AIDS Relief
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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission</td>
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<td>POC</td>
<td>point of contact</td>
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<td>PRISSCA</td>
<td>Prison Care and Counseling Association</td>
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<tr>
<td>SADC</td>
<td>Southern Africa Development Community</td>
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<td>SI</td>
<td>strategic information</td>
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<td>STI</td>
<td>sexually transmitted infection</td>
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<td>TB</td>
<td>tuberculosis</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>Zambart</td>
<td>Zambia AIDS Related Tuberculosis Project</td>
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1. Introduction

In recent years, governments, donors, program implementers, and other stakeholders in global development have renewed efforts to address gender-based inequities. The United States Agency for International Development’s (USAID’s) introduction of the Gender Equality and Women’s Empowerment Policy in 2012, followed by a series of interlinked topic-specific policies and guidelines addressing gender-based violence, anti-trafficking, child marriage, and other issues, signals a development vision that reflects the fundamental role of gender integration in programs across all USAID sectors. USAID defines gender integration as a process that “…involves identifying, and then addressing, gender inequalities during strategy and project design, implementation, and monitoring and evaluation,” and notes that “since the roles and power relations between men and women affect how an activity is implemented, it is essential that project managers address these issues on an ongoing-basis.” (USAID, 2012). The USAID-funded Eradicate Tuberculosis (TB) Project, operating in six provinces in Zambia (Northern, Luapula, Muchinga, Copperbelt, Central, and North-Western), is designed to identify and implement locally appropriate, gender-equitable, and sustainable solutions to meet its two objectives:

1. Increase the number of individuals screened for TB by 50 percent.
2. Increase the TB treatment success rate to 85 percent and beyond in the target provinces, contributing to a global reduction in mortality by 50 percent in target provinces by 2021.

Achieving these two objectives relies in part on addressing gaps in the health-seeking behaviors of both males and females and effectively addressing gender-related barriers that lead to late presentation and poor treatment outcomes. Throughout the design of the gender integration strategy, Eradicate TB takes a gender-aware approach, emphasizing the need for gender-sensitive activities and monitoring and evaluation (M&E) approaches.¹

The gender integration strategy outlined in this document adopts the United States President’s Emergency Plan for AIDS Relief (PEPFAR) definition of gender as “a culturally-defined set of economic, social, and political roles, responsibilities, rights, entitlements obligations, associated with being female and male, as well as the power relations between and among women and men, boys and girls” (PEPFAR, 2013). It also draws on guidance provided to USAID missions and implementing partners through USAID’s operational policy Automated Directives System (ADS) Chapter 205 Integrating Gender Equality and Female Empowerment in USAID’s Program Cycle. USAID ADS 205 guidance emphasizes the importance of gender analysis as a tool to “identify, understand, and explain gaps between males and females that exist in households, communities, and countries” and “identify the relevance of gender norms and power relations in a specific context” (USAID, 2017). The following sections include background on country

¹Guidance provided by USAID through the MEASURE Evaluation Guidelines for Integrating Gender into an M&E Framework and System Assessment identifies gender-aware as “a recognition or examination of a culturally defined set of roles, duties, rights, responsibilities, and accepted behaviors associated with being male and female, and the power relations among women and men, and girls and boys.” Gender-sensitive describes interventions that “explicitly address the culturally defined roles, duties, rights, responsibilities, and accepted behaviors that are associated with being male and female” and “consider the power relations among women and men, boys and girls.” (MEASURE Evaluation, 2016).
context and overarching project approaches, gender analysis process and findings (including constraints and opportunities under each of the five gender domains), a summary of the ways that the Eradicate TB project will address gender issues in each project task and subtask where relevant, sections outlining gender-sensitive approaches envisioned for M&E activities, and gender in project management.

2. Background

TB infections in men and women

Zambia is currently included as one of thirty countries with the highest TB/HIV burdens worldwide, with an estimated 638/100,000 bacteriologically confirmed TB cases according to the country’s National TB Prevalence Survey. Reflecting trends in many other high TB–burden countries, TB infections are more common among adult men than among adult women, with a male-to-female ratio of 2:1. Researchers examining the uneven sex distribution for TB globally believe that both biological and social determinants play a role in the heavier burden among men, ranging from greater alcohol and tobacco use and occupational exposures to delayed health-seeking behaviors (Neyrolles & Quintana-Murci, 2009).

The World Health Organization (WHO) notes that evidence from recent prevalence surveys highlights case detection and reporting gaps that are often greater for adult men compared to women, resulting in what may be an underestimate of the TB burden in males (WHO, 2016). Nevertheless, TB is among the top five causes of death for women of aged 20 to 49 globally (WHO, 2015). Pregnant women are at a particular risk due to immunological changes that increase vulnerability to mycobacterial infection or reactivation (Bates, Ahmed, Kapata et al., 2015). Given Zambia’s higher HIV prevalence among women (16.1 percent) compared to men (12.3 percent) aged 15 to 49 years, Zambia’s Ministry of Health (MoH) considers HIV-positive women to be particularly vulnerable to TB infection (GRZ/MoH, 2017). Zumla, Bates, and Mwaba reported that active TB in HIV-positive women can increase the risk of maternal mortality by 300 percent, although exact estimates are difficult to produce without the necessary data (2014). In Zambia, TB has been identified as the leading cause of non-obstetrical deaths among HIV-positive pregnant women (Kancheya, Luhanga, Harris, et al., 2014).

As in many other countries, estimates for TB infection among pregnant women in Zambia are difficult to obtain. Pregnancy status data are documented in TB registers at the health facility level and reported upward to district and provincial health information systems, but are not specifically highlighted in TB reports at those levels. A study conducted by Kancheya, Luhanga, Harris et al. set in three out-patient antenatal (ANC) clinics in Lusaka found acceptability of TB screening through symptom questionnaires undertaken by peer educators to be very high (100 percent of women invited to participate in the study agreed). However, symptom-based screening of pregnant women, including HIV-positive pregnant women, was not highly sensitive in the identification of TB-positive individuals, echoing results of other studies that have found cough, sputum expectoration, and hemoptysis to be less common during pregnancy (Kancheya, Luhanga, Harris, et al., 2014).
The Eradicate TB project

An explicit emphasis on gender-equitable access to quality-assured TB services for both males and females underpins the project’s technical approach. There are three overarching strategies to achieve this:

1. Create a gender integration strategy to articulate potential gender issues associated with Eradicate TB and outline activities to mitigate their impact on project outcomes.

2. Streamline gender throughout project activities to address the unique needs of males and females with regard to TB services.

3. Implement sound approaches to address three critical gender issues. These include:
   - Training health workers to recognize and address gender-related barriers to diagnosis and treatment.
   - Increasing the understanding of gender norms that affect health behaviors and adherence among miners, their intimate partners, and other social contacts, and refining case finding to address gender barriers.
   - Reducing gender barriers to TB control among prison populations.

Additionally, the Eradicate TB project specifically incorporates gender in its M&E approaches, as further described in Section 5 (Gender-sensitive M&E and performance indicators). The approaches and activities identified above are informed by the gender analysis summarized in Section III below and elaborated in subsequent sections of this document.

3. Gender analysis

The Eradicate TB project has based its gender analysis on guidance provided in USAID ADS 205 (2017). This guidance outlines a process to examine the following issues:

- Differences in the status of women and men and their differential access to assets, resources, opportunities, and services.
- The influence of gender roles and norms on the division of time between paid employment, unpaid work (including subsistence production and care for family members), and volunteer activities.
- The influence of gender roles and norms on leadership roles and decision-making: constraints, opportunities, and entry points for narrowing gender gaps and empowering females.
- Potential differential impacts of development policies and programs on males and females, including unintended or negative consequences.

In designing the gender analysis, the Eradicate TB project has addressed these points through a review of existing materials (i.e., national policies and guidance, research reports, and articles) and discussions with 21 key stakeholders including government partners, program managers, and technical experts, including those whose work focuses on prison populations and mine laborers. As well, the Eradicate TB team conducted four group consultations with TB patients and former TB patients (one male group consultation and one female group consultation) and caregivers of TB patients (one for male caregivers...
and one for female caregivers). All consultations took place in July and August 2017 in Lusaka and/or Copperbelt Province. Appendix 2 presents a complete list of stakeholders consulted for the gender analysis, and Appendix 4 lists references for this strategy. The Eradicate TB project focused the review of materials and stakeholder discussions around the following domains guided by USAID ADS 205:

- Cultural norms, beliefs, and behaviors.
- Gender roles, responsibilities, and time-use.
- Access to and control over assets and resources (including access to information and services).
- Patterns of power and decision-making.
- Laws, policies, regulations, and institutional practices.

The Eradicate TB project focused the gender analysis specifically on the intersection of these domains with reference to TB control, care, and treatment. For stakeholder discussions, the project developed guides for different stakeholder groups, including national government stakeholders, technical experts on gender and TB, technical experts in the mining sector, and technical experts in the prison sector, with questions clustering around the five gender domains. Appendix 4 lists example questions taken from various discussion guides. Observations from the document review complement the synthesis of stakeholder perspectives, which is presented in table format in Appendix 2. This table highlights, for each of the five gender domains, the key gender issues and the impact of each issue on the project’s goal and objectives, more specifically the impact on TB risk and TB transmission, and the impact on TB health-service demand and TB treatment adherence. The following domain summaries further elaborate these key gender issues and articulate the unintended consequences, both positive and negative, that the project may cause with regard to gender. Section 4 (Gender integration in the Eradicate TB project activities) presents the project’s approaches to mitigate gender-related constraints and capitalize on gender-related opportunities.

**Gender-based cultural norms, beliefs, and behaviors**

Both the existing TB literature and stakeholder consultations conducted for the gender analysis identify a wide range of cultural norms and beliefs with clear gender dimensions that directly impact health. Many of the cultural norms, beliefs, and behaviors further described below differ for males and females depending on the different social expectations ascribed to each sex. However, these norms and beliefs contribute to the transmission of TB, hinder the care-seeking needed for effective treatment, and translate into significant challenges to achieving TB control universally, for both men and women.

**Gender dimensions of TB stigma related to HIV**

Courtwright and Turner (2010) describe stigma as “a process that begins when a particular trait or characteristic of an individual or group is identified as being undesirable or disvalued” and a cause of shame, guilt, and self-isolation when internalized by the affected individual. Both males and females with TB suffer significantly from the stigma surrounding the disease due to a diverse set of underlying reasons.
Globally, a leading cause of TB-related stigma is based on its highly contagious nature. In many settings, however, prevailing community beliefs also blame TB-infected individuals for having done something to deserve the illness, and in countries with high HIV prevalence, TB is often considered a marker for HIV, bringing an added level of stigma and shame (Courtwright A, Turner A, 2010). In countries such as Zambia where HIV prevalence is high, TB-infected individuals are strongly affected by stigma due to its association with HIV.

Stakeholders consulted for the gender analysis explained that in the minds of many Zambians, a TB diagnosis makes HIV infection a foregone conclusion, whether or not an individual is actually HIV-positive. In a study by Cremers, Gerrets, Kapata, et al., focus group discussions (FGDs) with TB patients and TB treatment supported in Zambia revealed that a local derogatory term for HIV-positive individuals, “kanayaka,” is also often applied to TB patients (Cremers, Gerrets, Kapata, et al., 2016). Assumed HIV infection is in turn associated with sexual promiscuity. In this way, the stigma of having a contagious illness is compounded by social judgements related to sexual behaviors, even though TB is not a sexually transmitted infection (STI). While these beliefs and assumptions affect both men and women suffering from TB, an additional gender dimension related to the TB-HIV link further impacts women. More specifically, several stakeholders for the gender analysis noted that although TB-infected males are subject to stigmas related to HIV (even if they are not in fact HIV positive), society will see the assumed sexual behaviors of a man with TB to be more culturally acceptable compared to a woman. The social judgement against a woman with TB, assumed also to be HIV-infected, involves a greater sense of immorality, and ultimately the blame for a man’s TB infection often automatically falls to his female partner. Stakeholders reported that a community’s moral judgments against women with TB are typically much stronger than those against men. Blaming and stigma against women with TB is perpetrated by both women and men, and stakeholders further noted that stigma against women with TB is common even in otherwise supportive environments such as church groups. Notably, stakeholders also reported that health care workers and community volunteers who work in TB programs, many of whom are women, are also subject to TB-related stigma in their communities, regardless of whether they have ever suffered from TB or HIV infections themselves.

**Gender aspects of traditional beliefs regarding causes of TB**

Stakeholders for the gender analysis uniformly reported that the majority of Zambians have a good understanding of accurate biomedical explanations for TB transmission. However, a number of erroneous beliefs regarding the causes of TB persist, especially in rural areas. Many of the beliefs involve the role of women, and where prevalent, further compound the stigma experienced by female TB patients. A combination of observations from stakeholders consulted for the gender analysis and the TB stigma literature in Zambia (in particular a study by Cremers, de Laat, Kapata, et al., 2015) provides examples of false beliefs surrounding the causes of TB that implicate women:

- Sleeping with a menstruating woman.
- Sleeping with a woman who has recently aborted.
• A woman adding salt to food while menstruating or after an abortion.

Social costs of TB stigma for women

Stakeholders for the gender analysis reported that TB stigma has decreased over time as improvements in HIV treatments, and the ability of HIV-infected individuals to lead productive lives, have led to some reduction in HIV-related stigma. Nevertheless, both males and females suffer social costs related to a TB diagnosis, and stakeholders explained that the impact of these social costs tends to fall disproportionately on women. More specifically, while women in Zambia traditionally hold the role of caretaker in households and communities and are expected to care for family members who are sick (men, women, and children), men are rarely seen taking on this function. Therefore, if a married woman with TB requires care at home, and there is no other female at home available to help, the woman will be sent away to her relatives for the duration of her illness. This impacts her socially as she is essentially sent away from her husband, may be disconnected from her children, and becomes a “burden” to other relatives. Stakeholders described that in some cases, the husband may blame her for bringing illness into the house and permanently abandon or reject his TB-infected wife. They also indicated that in cultures such as that of Zambia, where marriage holds an essential social value, a woman who rejected by her husband because of TB suffers additional social costs and stigma associated with a broken marriage and/or abandonment. Unmarried women with TB are also affected. Stakeholders explained that men will generally see women with TB as less desirable for marriage, and that since men hold the social power to call off a marriage due to illness, this leaves unmarried TB-infected women with a certain social vulnerability. According to stakeholders, it may be rare for a husband to use physical violence against wife specifically for TB, but in instances of co-infection with HIV, or suspected co-infection, the risk for gender-based violence (GBV) increases significantly.

Male gender norms and behaviors

Stakeholders for the gender analysis identified a number of gender norms specific to men that influence men’s health behaviors related to TB. In terms of risk behaviors related to TB infection, both the TB literature and stakeholders have identified the greater social acceptability of alcohol consumption and tobacco use for men, compared to women, as a contributing factor in their biological vulnerability to TB infection. Most stakeholders indicated that in Zambia it is also becoming more acceptable for women to consume alcohol, but that both smoking and drinking alcohol are behaviors more socially sanctioned for males compared to females. Several stakeholders noted that men, in general, are more reluctant than women to speak with others about their health even when they are ill. This stems in part from prevailing cultural beliefs that men should always be seen a strong, healthy, and not in need of help. While it may eventually be difficult to deny illness or hide a TB diagnosis in the household setting, stakeholders explained that the man’s family is likely to keep his TB diagnosis a guarded secret. Another male gender norm that impacts men with TB involves the fact that both men and women expect men to be the providers and sustainers of the family. Any health-related barrier to a man’s ability to work, and to be the breadwinner for his family, is seen as a
major threat not only to his family’s well-being, but also to his identity as a man. Both of these factors have a direct impact on men’s health-seeking behaviors and treatment adherence as described below. Additionally, however, several stakeholders pointed out that in some cases TB-infected men who suffer from the social stigma or self-stigma related to these threats to male identity may also battle depression, feelings of failure and hopelessness, and other psychosocial stresses. Consequently, these conditions can also interfere with their ability to adhere to TB treatment. This observation was corroborated in consultations with male TB patients and former TB patients undertaken for the gender analysis, in which respondents emphasized hope, and “personal conviction to get back on one’s feet” as important factors for successful treatment adherence.

Stakeholders also explained that men who are suffering from TB or other illnesses are unlikely to seek treatment first at a government health facility where diagnosis and treatment options are most readily available. This is due in part to the perception among many men that public health facilities are the domain of women. More specifically, women are seen to be the main users of public health services where they access family planning services and antenatal care and address child health issues. Society expects women to be in public health clinics for these reasons, and therefore the majority of individuals going to these facilities are women. Stakeholders explained that, again as a matter related to male identity, most men eschew the same public health facilities where they are most likely to get the comprehensive care they need.

**Impact of gender norms and stigma on TB service–use and adherence**

These gendered social dimensions of TB also have a direct impact on the health behaviors of both men and women, directly affecting the likelihood of diagnosis, treatment initiation, treatment adherence, and cure. First, there are clearly strong social disincentives to seek health care if a person fears a TB or TB/HIV diagnosis. Stakeholders indicated that men in particular are most likely to delay or altogether avoid seeking care for the reasons identified above. Women were reported to be more likely to seek care eventually because they are more attuned to health concerns, given their responsibilities as wives and mothers for the health of other household members and greater familiarity with health services. Second, both men and women face strong social incentives to hide a TB diagnosis and avoid disclosure. Many patients take great pains to keep their need for TB treatment a secret due to the ongoing risk of stigmatization and social isolation. This in turn may negatively impact adherence to TB treatment. Stakeholders described instances they either knew of directly, or had heard about, including women hiding their TB medication in mealie meal bags, a man who buried his treatment in the ground and dug it up whenever he needed to take it, and another patient who hid his medications in a sock. More than one stakeholder told of women picking up TB medications on behalf of their husbands due to men’s fear that someone would find out about their TB diagnosis. Finally, as mentioned above, individuals impacted by stigma associated with TB, with its gender dimensions and implications for both men and women, may be more susceptible to depression and other psychosocial stresses that can negatively impact the focus and endurance needed to complete the TB treatment regimen.

Constraints and opportunities for the Eradicate TB project are depicted in Box 1 and Box 2 respectively.
Box 1. Constraints for the Eradicate TB project.

- TB-related stigma due to association with HIV affects both males and females. However, blame, moral judgement, and social costs are more severe for and more heavily impact women due to the association of HIV with promiscuity. This can lead women to postpone or forego health-seeking for TB.

- Conceptualizations of male identity are based in part on physical strength and providing for the family. This may lead to self-denial about illness, hiding of symptoms, reluctance to seek health care, and/or poor treatment adherence.

- Erroneous beliefs about non-biological causes of TB, many biased against women, add to strong TB stigma and lack of understanding about what is needed for disease treatment. Both males and females interpret these non-biological beliefs with the understanding that nonmedical causes require nonmedical solutions, thereby prompting care-seeking from traditional healers and religious leaders.

- Women with TB symptoms are typically afraid of being blamed for spreading TB, may fear losing marital opportunities/marital status, and face high social costs if they are diagnosed with TB and others learn about the diagnosis.

- There is greater social acceptability of alcohol and tobacco use among males compared to females. These are TB risk factors for both men and women.

- Conceptualizations of public clinics and hospitals as “female domain” lead males to shun public health
Gender roles, responsibilities, and time-use

Labor roles of men and women

As in any society, the different roles that Zambian men and women play in families and in society are linked closely to common gender-related cultural norms and beliefs. As described in the preceding subsection, there is in Zambia a strong cultural belief that men must play the role of economic breadwinner and provider for the family. Stakeholders for the gender analysis reported that this is often one of the reasons that males are reluctant to invest time, and in some cases money, in seeking health services for TB. To come home at the end of the day empty-handed, having spent time at the health facility rather than earning income, can become not only a social embarrassment for the man, but also a point of contention within the household since many women also have this expectation. This may be especially true for men in lower socioeconomic classes who are working on an hourly basis.

Worldwide, men in occupations such as mineral and metal mining are especially susceptible to TB infection. Copper mining is a major industry in Zambia, and the labor pool in this sector is overwhelmingly male. The gender-related time-use implications of this situation imply a significant TB vulnerability for males, as they are exposed regularly to dust, chemicals, and other industrial byproducts.
that can damage their lungs and facilitate the entry of TB bacilli if exposed. As further elaborated in the description of institutional practices in the mining industry, male miners have a strong economic incentive to avoid the TB screening that is often required by the mining companies. Being dispelled from a mine due to TB infection, in a physically weak condition and without other employment opportunities, can lead to dire economic consequences for the whole family.

Although the majority of miners working in both industrial and artisanal mining activities are male, women can also be found in this sector, especially in small-scale mining activities. In 2014, women held ten percent of small-scale mining rights in Zambia (Nguluwe, n.d.). Females are most likely to be engaged in small-scale gemstone mining activities and are particularly dominant in stone crushing work. Stone crushing is often done illegally (i.e. without specific rights or licenses) and is unregulated. This leaves females vulnerable from both the economic and health perspectives. Stone crushing activities, often found near larger mineral mines, expose women to significant risks. Typically, they lack of safety equipment such as goggles, masks, and gloves and are exposed to dust inhalation and the development of silicosis, a known risk factor for TB and other respiratory illnesses (Nguluwe, n.d.).

Stakeholders consulted for the gender analysis not only commented on women’s role in stone crushing, but also pointed to poorly ventilated indoor markets as another space typically occupied by females for income-generation that can increase their risk of TB infection. Typical market interactions in close and regular proximity to both buyers and sellers were reported to be another opportunity for TB to spread among females.

**Women’s role as caretakers**

The occupation-related risks described above notwithstanding, women’s role in the Zambian context is most often tied to the domestic sphere, and both the TB literature and stakeholder comments point to the overwhelmingly female role of caretaking for sick family members. The regular direct contact with a TB patient puts women who are caretakers at increased risk of TB infection themselves. Female caretakers consulted for the gender analysis explained that their roles as caretakers for a TB patient in their families came about by default; that is to say, other family members were afraid to take care of the sick individual, and it was left up to the female caretaker to step into the role. Female caretakers categorically said that men do not take on caretaking roles in the family. However, as noted earlier, the Eradicate TB team was also able to consult with a small number of male caregivers, and learned that their roles as caregivers were more likely to come about after discussion within the family during which they had been “appointed” as the primary caregiver for the sick family members. Even male caregivers said their situation was nevertheless uncommon, and noted that usually the support given by males to the TB patient is limited to financial inputs.

Typically, an older female family member cares for female TB patients, although this caretaker may be someone in the woman’s extended family, as female TB patients are often sent away to relatives to be cared for. In either scenario, the burden most often falls to women. Both male and female caretakers said that they have been subject to stigma and social isolation as a result of their role, as others in the
community assume that their close, regular contact with a TB patient means that they are also infected. Stakeholders also pointed out that the women who act as caregivers are at increased risk of TB infection not only because they are caring for an infectious individual, but also because the home environment where the caretaking occurs is often poorly ventilated, especially in rural areas. One stakeholder mentioned that women’s lung health is also jeopardized by the charcoal smoke they inhale while cooking at home on a daily basis.

**Gender dimensions of social spaces and time-use**

Several stakeholders consulted for the gender analysis highlighted the gender-related differences between males and females in their use of social spaces and the implications of these tendencies for TB transmission. More specifically, as one stakeholder described it, males are socialized to be more “adventurous” than women in terms of spending most of their social time outside the home and being socially allowed to be anywhere they like. This implies that men are in contact with more people on a social basis, compared to women, who are expected to be at home most of the time. While many women socialize with other women at home, rather than go out to social venues, especially in rural settings, men are more often seen circulating in bars, in nightclubs, at sporting events, and at other social venues. When drinking in a social setting especially, men may face additional TB risks from sitting close together around a communal drinking source, with different groups coming and going throughout the night. In this way, one male may have social interactions with a number of different groups of other men. The risk of TB exposure increases with the number of social interactions the male experiences in a short time. Although this scenario is more common for men than women, several stakeholders noted that alcohol consumption is becoming more socially acceptable for women as well, and pointed to female-specific social interactions such as kitchen parties, initiation ceremonies, and communal cooking for funeral preparations as social time-use opportunities that may be conducive to TB transmission.

Box 3 and Box 4 below highlight constraints and opportunities for the Eradicate TB project.
**Box 3. Constraints for the Eradicate TB project.**

- The prioritization of men’s income-generating responsibilities results in economic disincentives to health care-seeking when this is seen to have time costs that result in financial loss to men and their families. This implies a decreased demand for screening, testing, and treatment.

- Certain roles and time-use functions associated with TB infection risks have strong gender dimensions. Males dominate the copper mining industry and face economic disincentives to test and be treated for TB. Females often work in stone-crushing and/or markets with poor ventilation, which both carry TB infection risks.

- The majority of home-based caretakers for TB patients are women. In addition to social stigma and the added workload of caring for a sick family member, caregivers suffer financially due to constraints in their time-use and capacities to work also outside the home, while also facing increased expenditures for medical needs, food, and transportation for health care. The financial impact for caregivers can be significant.

- Males and females often occupy different social spaces with implications for TB infection risks, with men in many cases more likely to socialize outside the home, compared to women. This can increase the number of social contacts they encounter, including individuals who have TB and are infectious.

- Women’s mobility is somewhat more constrained to the home than that of men, especially in rural areas, and they may be more likely to socialize in smaller groups, thereby reducing infection risk. However, there are also many times when women come together in larger groups for specific functions, such as kitchen parties, initiation ceremonies, and communal cooking in preparation for funerals.
Patterns of power and decision-making

In the context of the Eradicate TB project, there are three main areas of concern regarding the gender dimensions of power and decision-making as they pertain to increasing demand for services and capacity-strengthening in health service delivery. These include patterns of household decision-making related to health care and the empowerment of women in TB health care-seeking, patterns of power within male prison populations, and gender balance in the staffing of TB-related program planning and services.

Household decision-making and the empowerment of women in TB health-seeking

Stakeholders for the gender analysis frequently mentioned that it is common in Zambian couples for the husband to have decision-making rights within the household, including all resource-related decisions and
all health-related decisions, even regarding the wife’s health care. However, some stakeholders also pointed out that this may depend somewhat on which health services are in question. More specifically, a husband, and society in general, expect women to attend clinics for antenatal care and health services for children. However, if the health need is non-routine, as would be the case for TB services, it is more likely that the woman will feel obliged to first seek permission from her husband. This may be the case whether or not transportation costs will be incurred. Although stakeholders consistently indicated that health care providers are equally likely to screen women and men for TB, even if TB cases are more common among men, one stakeholder also pointed out that the situation may not always be straightforward. In some cases, a woman may feel empowered enough to go to a health facility, but be reluctant to state to the nurse or physician the true reason for seeking services, or fully describe her TB symptoms. This may be because she is unaware of the full range of TB-related symptoms (i.e. lack of knowledge/information about TB), or may be due to the TB stigma related to HIV, or TB stigma more generally, and/or fear of experiencing violence from her husband if it is discovered that she has TB. In this way, even if a woman manages to get to a clinic, she may not be empowered enough to provide the information needed for the health care worker to screen and test for TB. As noted in the literature, if health workers do not have women’s social restrictions in mind when they are interacting with female patients, and do not ask probing questions, the resulting diagnosis and prescription of treatments may be incorrect. Additionally, the need for health worker confidentiality about the TB status of both male and female patients, and the ability of health workers to inspire trust and confidence with the suspected TB patient, is paramount.

Patterns of power within male prison populations

The rates of TB transmission in prisons seen in many countries is also a facet of Zambian prison settings, strongly disadvantaging incarcerated males, and placing their families at risk when released. While the institutional practices within prisons that contribute to TB transmission are described further in the last section of the gender analysis, it is also important to note that most prison populations involve distinct power relations and hierarchies. A report about prison conditions in Zambia describes cell captains as prisoners who have unofficial disciplinary authority over other prisoners (ARASA, PRISCCA, Human Rights Watch, 2010). Male gender norms characterized by strength and power are not checked at the door upon entry into the prison system. Rather, most research globally points to an intensification of these tendencies as male prisoners find themselves in a fight for survival within the prison walls. Research by Egelund, focused in part on masculinities within Zambian prisons, points to the bind faced by many male prisoners who are subject to a prison social code centered on being a man, being tough, and being strong, while this identity is constantly threatened by the social and physical violence that characterizes most prisons (2014).

Stakeholders consulted for the gender analysis indicated that some prisoners are given control over other prisoners, but at the same time, that prisoners tend to look out for each other like a family. Stakeholders also noted that men do suffer self-stigma when suffering from TB, and that the fear of losing respect associated with illness contributes to their not wanting to be identified as sick. Indeed, stakeholders
reported that very few prisoners come forward when ill, and that TB detection requires someone else to notice that they are sick. Research from other settings also points to the reluctance of male prisoners to be identified as sick or weak due to fears that peers and guards will treat them poorly, or that their status within the prison hierarchy will be compromised. These masculinities and power-based realities can provide strong social disincentives to be diagnosed or treated for TB, and may lead some prisoners to hide their symptoms (Waisbord S, 2010). One stakeholder interviewed for the gender analysis observed that prisoners need to know that power within prison does not protect one from disease. Rather, prisoners must be encouraged to have the “personal power” to come forward and get treatment. Programs supporting prisoners have included support structures and groupings of prisoners into trios so that they can remind each other to be watchful for symptoms and adhere to treatment.

**Gender balance in the staffing of TB-related program planning and services**

The gender analysis focused primarily on gathering insights from stakeholders on patterns of power and decision-making within couples and at the community level. However, power and decision-making extend to work places, and in recent years there has been increasing attention on the health sector in gender discrimination in employment and occupation, an issue confronting many countries (Newman, 2014). In 2015, Zambia ranked 124th of 188 countries as measured by the Gender Inequality Index, which includes measures such as the share of parliamentary seats held by women and female labor force participation (45.3 percent) compared to males (76.2 percent) (UNDP, 2016). On August 21, 2017, President Lungu signed the Southern African Development Community (SADC) protocol on gender and development, which requires signatory states to ensure equal access to employment and benefits, among other rights. While this signals high-level support for gender rights and equality in many domains, it is possible that improvements remain to be made toward gender balance in health sector employment. The Eradicate TB project has a focus on human resources (HR) development within the National Tuberculosis Program (NTP) and the opportunity to include gender balance and equity in decision-making processes through the HR assessment, HR strategy and plan development, and strengthened HR tracking and management capabilities.

Box 5 and Box 6 identify constraints and opportunities for the Eradicate TB project.

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**Box 5. Constraints for the Eradicate TB project.**

- Some women are constrained in the TB health care demand due to power relations within the couple. Some women may be empowered enough to seek health services, but not to freely describe their TB symptoms to the health care worker due to fear of stigma and/or a positive test result, which could jeopardize marital status and incur spousal violence.

- The power hierarchies and challenging physical conditions found in male prisons reinforces masculinities that tend to increase prisoners’ reluctance to be identified as sick or weak. This can complicate TB case-finding in prisons since men may be more likely to hide their symptoms than to come forward with TB health needs.

- In many sectors, women are under-represented at the higher levels of staffing hierarchies. This may result in the exclusion of valuable skills and perspectives in health and other sectors.
Access to and control over assets (including access to information and services)

Access to and control over employment, income, and other sources of cash

The Ministry of Gender and Child Development Central Statistical Office has provided a wealth of information regarding the gender dimensions of access to and control over assets, especially in terms of agricultural assets, access to income through employment and other productive activities, and social protection opportunities, as reported in its Gender Status Report 2012–2014. Referencing the Central Statistical Office Labor Force Survey of 2012, there was a relatively balanced picture of individuals who were economically active in the seven days prior to the survey: 48.4 percent of males and 51.6 percent of females. However, the percentage of women in informal employment (94 percent) compared to formal employment (6 percent) in 2012, compared to men (78 percent in informal employment and 22 percent in formal employment) may point to limitations in women’s access to formal employment opportunities, education/skills, and business capital as well as the time constraints faced by women in their reproductive roles (GRZ/MoGCD, n.d.).

The Zambia Demographic and Health Survey 2013–2104 data indicate that women have more limited access to cash from employment compared to men, as 57 percent of married women who had worked in the 12 months prior to the survey had received payment in cash only, compared to 71 percent of married men. In this survey, 68 percent of currently married women who earned cash in the past 12 months reported that they had earned less than their husband did. Women’s decision-making over the use of her own cash income appears to be linked to whom within the couple is earning cash. Overall, 49 percent of currently married women with cash earnings in the past 12 months indicated that decisions about how to
use that cash were made jointly by the couple. Seventy-one percent of women said that decisions about
the woman’s cash income were made jointly when the husband and wife were earning about the same as
each other. High joint decision-making applied to men’s income in couples with similar cash earnings
was observed as well. Women having a leading role in decision-making about their own cash income was
reported by 61 percent of women whose husbands had no cash earnings or did not work in the past 12
months. Decision-making about the husband’s cash income was made either jointly (55 percent) or by the
man alone (37 percent) if the woman had worked in the past 12 months but without getting cash income

A review of the literature on gender barriers to financial access by New Faces New Voices points to
several supply-side barriers to women’s access to formal finance services. Although formal financial
institutions do not typically report sex-disaggregated data, they generally target salaried workers with
regular and relatively high incomes, thereby leaving many Zambians, especially women, out of the
picture. Given the urban bias in the geographic distribution of formal financial institutions, many rural
women (and men) face additional time and expense barriers just to reach services. For these reasons and
others, women’s use of informal financial mechanisms is higher than men’s, according to qualitative
research by New Faces New Voices. Women tend to use “chilimba” (an informal rotating savings group
consisting of two or more individuals) and “kaloba” (informal moneylenders who charge interest on late
payments, can take possession of assets, and sometimes resort to physical aggression) more often than

Given the government’s commitment to reducing poverty and vulnerability, especially among women and
children, many social protection programs are biased toward improving the livelihoods women and
various vulnerable groups. Between 2011 and 2014, there were more female than male beneficiaries of
the government’s Public Welfare Assistance Scheme initiatives overall, although the number of male
beneficiaries (17,598) compared to females (15,879) was higher in 2014. A significantly greater number
of women (89,171) compared to men (56,527) were beneficiaries of the Social Cash Transfer Scheme in
2014 (GRZ/MoGCD, n.d.).

**Access to TB information and services**

Observations on differences in women’s and men’s access to employment, income and other sources of
cash provide a general gender context for what may be the typical household economic situation in which
Eradicate TB project operates. Earlier sections of the gender analysis have provided information about
differences in the ways that women and men access health services. However, it is equally important to
consider the possible differences in access to health information, especially as it relates to TB. As noted
earlier, women in Zambia tend to take on care taking roles and to have greater responsibilities for the
health of family members, in general, compared to men. Research on the gender-based constraints to
health service uptake has reported that focus group participants in Kafue and Nokonde districts perceived
women to be the target audience for most health information campaigns, given their household health-
related roles and responsibilities. They also explained that for this reason, men may lack information and
be less likely to seek care even for serious illnesses (GRZ/MOH, 2014). Most stakeholders for the gender
analysis reported that there is much better knowledge about TB symptoms and causes and the fact that it can be cured among both women and men now than in the past. However, building on the gender dimensions of access to health information reported above, one stakeholder explained that culturally, although women may have better access to health information than their husbands, it is relatively uncommon for women to “educate” husbands on health issues, and that women typically focus the transfer of health information on their children. Conversely, several stakeholders noted that men might actually have better access to TB-related information either because they may have more consistent exposure to TV and radio messages, and/or more meeting places in which to receive TB information, and/or because TB messages focus on the demographic more affected by the illness (i.e. men), in mining communities especially. Female TB patients and former TB patients consulted for the gender analysis explained that before becoming infected with TB themselves, they knew about the mode of TB transmission, but did not have an understanding of their own risks, and did not know that it is curable. Male TB patients and former TB patients reported having different understandings about the causes of TB before learning that they were infected, including alcohol-related causes, witchcraft, and genetic inheritance. Most did not suspect TB when they first developed symptoms and did not think that they personally were at risk.

In theory, access to TB services based on supply-side factors is the same for males and females in the general population. As noted in the description of institutional practices, stakeholders consulted for the gender analysis uniformly indicated that health care workers are not more or less likely to undertake TB screening or perform diagnostic tests for males compared to females. However, each of the other sub-sections of the gender analysis highlight the many ways in which other factors can influence men’s and women’s access to, and use of, TB services from the demand side. These are synthesized in Table 1:

<table>
<thead>
<tr>
<th>Demand-side factors that increase access/use of TB services</th>
<th>Demand-side factors that decrease access/use of TB services</th>
</tr>
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</table>
| Males | • Men's greater access to cash can promote initial access to services in the private sector and/or from traditional healers.  
• In some settings (e.g., mining sectors), males may have better access to TB information than women; men may also have more regular exposure to television and radio messages. | • Despite possible access to TB information through certain media and locations aimed at males, men may be less focused on health and health care-seeking in general, compared to women.  
• Men's experience of stigma related to masculinities emphasizing physical strength can deter health-seeking in general and in prison settings especially.  
• Anticipations of lost time and income due to long waiting times can be economically demotivating factors against seeking care, especially from public sector services.  
• Fear of being fired if found to have TB is especially demotivating to accessing health services, especially in mining communities. |
Females

- Females are expected to look after the health of the family, and may therefore be more attuned to the need to seek help when either they or someone in the family is suffering from TB symptoms.
- Women are accustomed to seeking care, especially from government facilities due to maternal and child health needs, and may have better information about TB as part of the general health education they receive while accessing other health services.
- Many women must ask their husbands for permission to seek health services, regardless of potential financial cost, especially if for reasons not related to maternal and child health.
- Women may fear asking their husbands for permission to seek TB care if it will bring about stigma and blame-laden questions related to TB and HIV.
- Women may be uncomfortable discussing TB symptoms with health care workers if they are concerned about stigma within the health care setting and/or confidentiality.

Note: TB, tuberculosis.

Box 7 and Box 8 summarize constraints and opportunities for the Eradicate TB project with regard to gender-related access to and control over resources.

Box 7. Constraints for the Eradicate TB project.

- There are documented constraints to women’s access to, and control over, financial resources. Since TB services provided through government facilities should be free to the user, this should not directly constitute a constraint to the project. However, particularly in instances where transportation costs may be incurred, women without a direct income are especially reliant on their husband’s permission to seek health care.
- Most caregivers for TB patients are women. Given the limitations many women face with regard to accessing cash, female caregivers are especially vulnerable to the financial burdens associated with lost income opportunities and increased expenses (health costs, transportation to health facilities, food stuffs for the TB patient, etc.) when caring for a TB patient.
- Men and women may both experience limitations in their exposure to TB information, albeit in different ways. This will likely constitute a constraint to the Eradicate TB project unless gender considerations are factored into community-level TB education and communications activities.
The gender analysis identified several laws, policies, and institutional practices, including institutional practices in the health sector, mining industry, and prison settings, that have the potential to either support or undermine gender-equitable access to TB services in Zambia. While relevant public law and policy documents (see Box 6) were made directly available through internet searches or the stakeholders consulted, the institutional practices summarized in this section (e.g., institutional practices in prisons and the mining industry) were for the most part either identified through the research literature or described more indirectly in stakeholder discussions.

Laws, policies, regulations, and institutional practices (including health sector practices)

The gender analysis identified several laws, policies, and institutional practices, including institutional practices in the health sector, mining industry, and prison settings, that have the potential to either support or undermine gender-equitable access to TB services in Zambia. While relevant public law and policy documents (see Box 6) were made directly available through internet searches or the stakeholders consulted, the institutional practices summarized in this section (e.g., institutional practices in prisons and the mining industry) were for the most part either identified through the research literature or described more indirectly in stakeholder discussions.

Box 9. Opportunities for the Eradicate TB project.

- It is beyond the scope of the project to address the wide variety of gender-based constraints, for both men and women, regarding access to and control over economic resources, and since public health services are intended to be cost-free to the user, this particular economic consideration should not impact service demand. However, Afya Mzuri and CITAM+ can guide CSOs in considering the financial needs of the predominantly female caretakers of TB patients in content development of communications and advocacy efforts, emphasizing the need for both wider family and government support. As well, there may be opportunities for community health volunteers and facility-based health care staff to link female caretakers to social protection programs where those exist at the district or provincial level.

- Community communication efforts through Afya Mzuri’s capacity-strengthening of CSOs present opportunities to address varying access to TB information for both women and men. This can take into account the likelihood that males and females may both underappreciate their personal TB risk, the possible constraints in couple communication about health information in general and with regard to TB specifically, and the modes and locations of information access that may differ for men and women.


- Ministry of Health. Addressing Gender-Based Constraints to Health Service Uptake. (2014)

National gender and health policies

Zambia’s Gender Equity and Equality Bill (2015) established a Gender Equity and Equality Commission with broad oversight for all aspects of gender equity, equality, and integration of males and females into society; the stimulation of productive resources and development opportunities for both sexes; and the promotion of women’s empowerment and the elimination of discrimination against women, among other things. It enacts the elimination of discrimination in health care services in particular, by holding the MoH responsible for ensuring that women access health care services on an equal basis with men, including
health-related information and education and family planning rights. Although TB is not specifically mentioned in the bill, equity in access to health-related information and education presumably includes TB information. It provides for a number of other crosscutting gender rights and specifically references the rights and obligations provided for in Zambia’s Anti-Gender Based Violence Act, 2011.

The National Health Strategic Plan 2011–2015 notes that despite Zambia’s commitment to gender mainstreaming across sectors, major disparities between males and females in morbidity, mortality, and nutrition status persist. The plan underscores the importance of gender mainstreaming in health and includes both equity of access and gender sensitivity as key principles guiding health service delivery in Zambia. More specifically, the document calls for gender sensitivity and balancing in the management of the health system and delivery of health services at all levels (GRZ MoH, 2011). Although the national health plan’s key strategies by which to achieve this do not focus on differences in the needs of males and females, gender sensitivity as a guiding principle may promote articulation of more specific approaches through other health policies and guidelines.

Several years ago, national policy directives regarding HIV/AIDS and TB were integrated in the National HIV/AIDS/STI/TB Policy (2002). Notably, the gender perspective section of the document focuses very much on HIV/AIDS, without references to gender and TB specifically. Similarly, the more recent National AIDS Strategic Framework 2017–2021 elaborates greatly on the gender dimensions of HIV/AIDS, including gender disparities in the burden of HIV infections and gender-based violence as a significant factor in the country’s gender inequality. It also mentions the importance of confronting TB within the context of HIV. However, there is relatively little guidance directed toward HIV/TB integration, and the policy does not address gender constraints and opportunities in TB programming. The recently released National Strategic Plan for Tuberculosis Prevention, Care and Control (2017–2021) presents sex-disaggregated data for a number of TB indicators and identifies the importance of tracking the number of health care workers trained on TB with sex disaggregation. As with the National HIV/AIDS/STI/TB Policy and National AIDS Strategic Framework, the plan does not clearly address the gender-related aspects of TB infection, diagnosis, and treatment.

Zambia’s Ministry of Gender and Child Development (MoGCD) has a vision to “coordinate and monitor the implementation of gender and child development policies and programmes in order to ensure gender responsiveness and well-being of a child” (MoGCD, 2014). The National Gender Policy (2014) includes a range of policy objectives, which include facilitating “access to cost effective quality and gender responsive health services for all” (MoCGD, 2014). This is to be achieved by increasing access to quality health services and strengthening measures to address HIV and AIDS. The National Gender Policy also calls on the MoH to design policies and programs that address the different health needs of boys, girls, women, and men; ensure that women and girls have access to expert and professional medical services in rural areas; and ensure adequate health care personnel and health centers as close as possible to the communities they serve. Interestingly, many of these measures and directives focus on increasing access to services in general and for specific disease areas affecting mainly females (i.e. the supply side of service delivery), with perhaps somewhat less emphasis on addressing gender constraints to health service
demand. However, stakeholder discussions indicate interest and support for constructive engagement regarding gender and TB, especially in the area of women’s caregiving roles, and the ways society ascribes gender roles can be used positively for effective TB management.

Both the National Health Strategic Plan 2011–2015 and the MoGCD Strategic Plan 2014–2016 identify challenges in gender mainstreaming. The MoH highlights challenges in establishing effective linkages with other government sectors and departments in general, while the MoGCD points to weaknesses in the Gender Focal Point system in many ministries and inadequate budgeting for gender mainstreaming activities as key constraints. In particular, the MoGCD notes that ministries do not typically devote funds to gender auditing and gender analytical skills capacity-building.

**Mining sector policies and institutional practices**

At the regional level, Zambia and a number of other countries in the SADC have made clearly articulated commitments to combat TB in the mining sector by signing the 2012 SADC Declaration on Tuberculosis in the Mining Sector. These include attention to gender in the process of community-building and recognition that not only miners, but also their families and communities, often have limited access to health services. However, the priority areas identified, such as coordination and collaboration for TB and other diseases in the mining sector, strengthening of the policy and legislative environment, and program M&E, among others, do not point to the different needs of women and men.

In different ways, labor laws, company policies, and institutional practices regarding TB screening and treatment in the mining sector impact health-seeking behavior among the predominantly male population of miners. Zambia’s Workers’ Compensation Act of 1999 allows for prospective miners with TB or a history of TB prior to employment to be denied access to mining employment and the removal and eventual discharge of individuals actively mining if found to have TB (Chanda-Kapata P, Kapata N, Masiye F, et al.). As males are typically the main income earners in their families, this endangers the economic well-being of men as well as their wives and children and can create additional health vulnerabilities. Mining companies often work with private health care providers to ensure regular TB screening and in this way facilitate access to care. However, stakeholders consulted for the gender analysis noted that many men working in mines fear using facilities connected to the mining companies due to the existing policies and instead prefer to use a public health facility if needed since they do not share TB diagnosis information with employers. Stakeholders also mentioned that a new policy addressing worker rights in private mines has been put forward and that cases heard in court sometimes support the labor rights of miners. Nevertheless, the overall policy and legislative environment, and the institutional practices of mining companies, leave the majority of male miners with economic and social incentives to avoid TB screening and diagnosis services.

As noted earlier in the gender analysis, most females working in activities connected to the mining sector are stone crushers in informal employment. While their daily labor increases their risk of silicosis and eventual development of TB, these activities are often undertaken without legal rights and are unregulated. Therefore, institutional support for TB diagnosis and care for stone crushers does not exist,
and there are no requirements that protective equipment be provided or used. This places the women engaged in these activities at an obvious increased risk for TB infection.

**Prison policies and practices**

Both male and female prisoners live in conditions of inadequate sanitation and ventilation, overcrowding, and poor nutrition. While these structural conditions and service characteristics negatively impact TB transmission and outcomes for both sexes, the overwhelmingly male composition of the Zambian prison population translates into disadvantages that affect a significantly larger number of men compared to women. A 2015 study of prison conditions reported that of the overall prison population of 18,102 individuals, 1 percent was female, while the overall occupancy rate (combining males and females) was 277 percent (Topp, Moonga, Luo, et al., 2016). The National Health Strategic Plan 2011–2015 mentions concerns about the spread of TB in prisons and includes the targeting of prisoners with TB prevention and treatment. However, the National Strategic Plan for Tuberculosis Prevention, Care and Control (2017–2021) reports that TB infection control is not systematically implemented, that screening upon intake and release is not available in all prisons, and that systems for follow-up and linkage to care for discharged prisoners are lacking. This situation reflects inadequate linkages between prison health units and the National TB and Leprosy Program (NTLP), the lack of a formal coordinating mechanism between the NTLP and Ministry of Justice Correctional Department, and the lack of a clear framework for TB prevention, care, and control in the country’s prison system (MoH, 2017). These gaps impact the health and well-being of all prisoners, but disproportionately affect more men than women given the overwhelmingly male prison population.

Previous research in Zambia indicates that the percentage of females who are tested for TB may be less than half that of males (Human Rights Watch, 2010). Although the Eradicate TB project did not have the opportunity to speak with female prison officials or female prisoners directly, and although females represent a very small percent of the total prison population, research literature sources point to potential barriers to health services among the female incarcerated population. In-depth interviews with female prisoners, prison officials, and health care workers in female prisons in Zambia for a study by Topp, Moonga, Mudenda, et al. (2016) are especially informative. This study observes that none of the female prisons had an internal health facility catering to women’s health needs and that the limited availability of officers to accompany women to external health services was a commonly cited barrier for female prisoners to access health care, including TB cases. The limitations in available resources, implicit prioritization of male prisoners’ needs, and neglectful and/or intimidation-based relationships within the female prison population power hierarchy, and between prisoners and staff, can converge to limit access to health care including TB diagnosis and treatment for females.

**Health sector institutional practices**

Stakeholders consulted in the gender analysis identified a variety of reasons for which males are less inclined than females to use public health services available for TB diagnosis and treatment. Men’s preference for seeking TB care outside the public health services is based in part on institutional practices,
stemming from concerns about the confidentiality of their health-seeking behaviors and health records, and constraints related to service availability during days and times that can allow for more time-efficient and confidential care-seeking. These institutional factors lead many men to prefer traditional healers, private clinics, and pharmacies outside the public health system that are less likely to maintain detailed documentation about individuals seeking care and more likely to be open outside regular business hours. These observations, particularly as related to perceptions about slow service delivery in public facilities, are echoed in a study published by the MoH in 2014 on addressing the gender-based constraints to health services uptake. Study authors reported male FGD participants’ observations regarding preference for care outside the public health system as based in part on time costs, i.e. the time off from other their primary duties that a visit to a public health facility requires, among other reasons. Males indicated that they would be more likely to use public health services if there were more male health care workers and “men-only” hours. Perceptions about the inefficiencies of public facilities persists among men, even though other FGD participants noted the acceptability of preferential treatment commonly shown by public health service staff to males by allowing them to jump the queue in front of other (female) patients. The MoH report recommends considering the establishment of “male-only” hours, separate waiting rooms for men, and male-oriented health information, in addition to offering services at venues where males are most likely to be found according to work and leisure time use patterns. The report also recommends making health services more “male-friendly” by training health workers to challenge their own attitudes toward men’s health and to reinforce the acceptability of male health-seeking behaviors when interacting with male patients (GRZ, MoH, 2014).

Research from South Africa points to the possibility that health care providers may be less likely to screen symptomatic women for TB, and to offer them sputum tests, based on the possible bias inherent in not viewing women as the “typical” TB patient (Smith, Burger, Claassens et al., 2016). However, stakeholders consulted for the gender analysis in Zambia indicated that there is unlikely to be any gender bias in health care providers’ TB screening practices since any possible TB patient, whether male or female, is said to be screened and tested for TB as necessary. Nevertheless, stakeholders were less sure how regularly pregnant women are screened for TB. Given the increased risk pregnant women face for contracting TB compared to non-pregnant women, especially if also HIV-positive, it is especially important to address their TB screening needs. Among findings from the gap analysis undertaken for Zambia’s National Strategic Plan for Tuberculosis Prevention, Care and Control (2017–2021), it is noted that TB screening is limited in prevention of mother-to-child transmission (PMTCT) sites (GRZ/MoH, 2017). In order to address the high TB risks for pregnant women, the National TB Plan calls for the introduction of systematic screening for TB in antenatal and PMTCT clinics so that each pregnant woman is screened at every visit. As well, HIV-positive women without TB infection are to be provided with isoniazid preventive therapy (IPT). It is anticipated that TB screening of pregnant women will be monitored using the existing registration system for Reproductive, Maternal, Newborn, Child, and Adolescent Health (GRZ/MoH, 2017).
The findings from the gender analysis under the domain of laws, policies, regulations, and institutional practices carry a number of constraints and opportunities for the Eradicate TB project, as summarized in Box 10 and Box 11.

**Box 10. Constraints for the Eradicate TB project.**

- Existing policy frameworks for gender and for TB do not specify the gender dimensions of TB infection risks or constraints to diagnosis and treatment access.

- Existing policies regarding TB status and work opportunities in the mining sector create disincentives for the predominantly male miners to access TB diagnosis and treatment.

- TB and other health risks faced by predominantly female stone crushers and miners in small-scale and artisanal mines are not addressed by existing policies or any institutional practices.

- Both male and female prisoners live in conditions promoting the spread of TB infections. However, males may suffer the majority of TB disease burden given the overwhelmingly male prison population and male prison crowding. Once released, the TB risk for male prisoners’ families becomes elevated, resulting in increased need for targeted TB screening and testing as well as challenges to reducing TB mortality.

- In prisons sharing health-related resources (i.e. transportation and staff), the needs of female prisoners are often over-shadowed by those of the male majority. This may lead to lower TB screening and diagnosis for female prisoners and constraints in accessing care.

- Institutional practices within the public health sector can create disincentives for males with TB to access diagnosis and treatment effectively.

- Regular screening for TB among pregnant women is promoted in policy, but appears inconsistently applied in practice. The institutional coordination between ANC services and TB practitioners may not always be sufficient to ensure proper screening and diagnosis, with resulting disadvantages for pregnant women.
Box 11. Opportunities for the Eradicate TB project.

- Advocacy activities under the project can incorporate efforts to elevate gender issues in TB plans and policies.

- Outreach to existing health coordination fora in which the MoGCD participates, such as the Adolescent Health Technical Working Group, or inclusion in other health information exchange mechanisms may help bridge the gender and TB gap in current MoGCD strategies and activities.

- The Eradicate TB project plans include partnering with the Chamber of Mines and private companies to effect policy change in support of hiring ex-TB patients and active case-finding through OneStop TB Clinic models.

- Eradicate TB has an opportunity to incorporate the TB-related needs of female stone crushers in activities, such as transmission heat maps and community outreach, designed to increase TB and multidrug-resistant tuberculosis (MDR-TB) case detection and treatment support among vulnerable groups.

- Although the Eradicate TB project is not equipped to directly change the structural conditions in prisons that impact male and female incarcerated populations, technical assistance to the National Tuberculosis Control Program (NTP) to increase infection control measures, intensify case-finding, and promote treatment adherence provides an opportunity to address the TB health service constraints faced by women in prisons.

- Additional opportunities to address female prisoners’ access to TB services and support exist in the planned expansion of peer-to-peer and volunteer support programs, and the OneStop TB Clinics within prisons, if these efforts also deliberately target female prisoners in addition to males.

- Eradicate TB provides technical assistance to the NTP to train community volunteers and develop and implement a capacity-building plan for health workers, including support to revise health worker training guidelines. Through these activities, the project has an opportunity to address the different gender-related barriers to TB diagnosis and treatment experienced by males and females stemming from institutional practices.

- The Eradicate TB project has an opportunity to support the NTP in its efforts to translate policy to action regarding TB screening for pregnant women within PMTCT services and the expansion of community volunteer efforts to intensify case-finding in target provinces.

- Although data on the TB status of pregnant women will be documented through the existing registration system for Reproductive, Maternal, Newborn, Child, and Adolescent Health, through NTP M&E capacity strengthening activities, the Eradicate TB also has an opportunity to support data-sharing efforts between MoH divisions so that this information is also available for monitoring and planning within the NTP.

- Based on observations from project activities and monitoring data, Eradicate TB may have the opportunity to suggest research topics on implementing changes in gender-based health service institutional practices that could be included in the NTP’s evolving research agenda and capacity-strengthening.
4. Gender integration in the Eradicate TB project activities

Application of gender analysis findings to the objectives of the Eradicate TB project

The gender analysis presented above has addressed each of the five gender domains in turn and includes a summary of constraints and opportunities for the Eradicate TB project to consider in the planning and implementation of various program activities. Looking more broadly at the project’s dual objectives of increasing the number of individuals screened for TB by 50 percent and increasing the treatment success rate to 85 percent and beyond in the target provinces, it is clear that gender considerations will unquestionably play a role in meeting those objectives. More specifically, TB service demand and delivery, which play a crucial role in the project’s ability to increase TB screening and treatment success, are impacted by gender-related factors across the five domains. The ways in which gender is likely to impact TB transmission, and demand for services and treatment adherence, are presented for each gender domain in Appendix 1.

Gender-related factors that can create significant disincentives for TB service demand and adherence to treatment among males include the following:

- Conceptualizations of male identity are based in part on physical strength and providing for the family. This may lead to self-denial about illness, hiding of symptoms, reluctance to seek health care, and/or poor treatment adherence.
- Stigma related to male health-seeking, including HIV/TB stigma, and conceptualizations of public clinics and hospitals as “female domains” can lead men to avoid TB services or turn first to herbalists, traditional healers, and/or private providers who do not typically have direct access to the necessary diagnostic services and treatment supplies.
- The prioritization of men’s income-generating responsibilities and reluctance to lose time and income in health care-seeking can contribute to forgoing TB care-seeking.
- Concerns about the confidentiality of health records and limitations in service availability during days and times that can allow for time-efficient and confidential care-seeking constrain male service-demand.
- Company policies that restrict miners from working if they are diagnosed with TB are a disincentive for male miners to test at company-supported clinics (and an incentive for going to the private sector or traditional healers and herbalists).
- Power dynamics in male prison populations may lead some men to hide symptoms and forgo treatment.

Gender-related factors that can create significant disincentives for TB service-demand and adherence to treatment among females include the following:

- Blame, moral judgement, and stigma related to the links between HIV and TB (whether the individual is HIV-positive or not) heavily impact women due to the association of HIV with promiscuity, including the risk of violence and/or abandonment by the husband. Erroneous beliefs about non-
biological causes of TB, many biased against women, further add to strong TB stigma. These gender-related stigma concerns can lead women to turn first to religious leaders, herbalists, and traditional healers, some of whom may charge money for ineffective treatments and prolong actual diagnosis and treatment. Adherence can be negatively impacted if a woman is unable to disclose her TB infection to her spouse and other family members.

- Due to the prioritization of women’s role in the domestic sphere generally, and as caretaker for the sick, women may deprioritize their own health needs in the face of time constraints raised by domestic responsibilities.

- Some women are constrained in TB health care demand due to power relations within the couple. Women must typically obtain the husband’s permission to seek health care even if there are no financial constraints or transportation barriers. Some women may be empowered enough to seek health services, but not to freely describe their TB symptoms to the health care worker due to fear of stigma and/or a positive test result which could jeopardize marital status and incur spousal violence.

- In some cases, women may have limited access to TB information if they do not have access to television and radio messages, and spend most of their social time in private spaces (although this may be offset by information received through community volunteers and/or at health care facilities).

- In mining communities, female stone crushers work in small, informal enterprises lacking institutional support for TB diagnosis and care.

- In prisons sharing health-related resources (i.e., transportation and staff) between male and female prison populations, the needs of female prisoners are often overshadowed by those of the male majority. This may lead to lower TB screening and diagnosis for female prisoners, constraints in accessing care, and challenges to adherence.

**Application of gender analysis findings to project tasks, sub-tasks and specific activities**

Gender analysis findings will be integrated into project activities under the relevant sub-tasks for each task as follows.

**Task 1: Pursue high-quality DOTS expansion and enhancement**

**Subtask 1.1: Increase political commitment**

Among other things, subtask 1.1 includes an assessment of the NTP’s HR gaps. The Eradicate TB project will incorporate gender-balance issues in the NTP’s efforts to address staffing capacities and structures with support from Initiatives, Inc., through the HR assessment, HR strategy and plan development, and strengthening of HR tracking and management capabilities.

Subtask 1.1 also includes capacity-building for advocacy and increased TB awareness. This involves working with civil society organizations (CSOs) and groups of former and current TB patients to plan and implement TB advocacy campaigns and TB public awareness campaigns. Through these efforts, the Eradicate TB project will directly engage community members in the design of communications messages and advocacy that can integrate gender-based cultural beliefs, norms, stigma, and behaviors
contributing to the spread of TB in Zambia, and hampering TB service demand, as outlined in the gender analysis. As well, activities will respond to the fact that decisions about where and how to implement the campaigns can lead to differential reach of messages to men and women. For example, women may be available for community health talks about TB in the health facility setting, but those messages will likely not reach male partners. Rather, males may be best targeted through social venues frequented by men, their workplaces, private health care providers, and community meetings involving men. Door-to-door outreach may also increase chances of providing TB health communications to men and women together, especially if time-use differences outlined in the gender analysis are considered.

**Subtask 1.3: Standardize TB treatment, support and care**

Among other efforts, the activities under this subtask include the provision of technical assistance to update the national TB treatment guidelines, the training of community volunteers to support patients receiving TB treatment, and the development and implementation of a capacity-building plan for health workers. At this time, the national TB treatment guidelines have already been recently drafted. However, Eradicate TB project staff have addressed this question with the NTP and confirmed that even though this work is essentially finished, there is still an opportunity to incorporate a targeted amount of information on gender in the forward to the guidelines and perhaps other relevant sections. Details about plans to integrate gender into the national TB training modules are also under discussion with the NTP. It remains a question as to whether this will best be achieved through including gender issues at relevant points within each of the existing training modules or as a stand-alone additional module dedicated to gender. However, the types of topics that can be appropriate to include in these trainings include:

- The importance of communicating with both male and female patients in a supportive and nonjudgmental manner, keeping in mind the gender-based fears, stigma, and self-stigma outlined in the gender analysis.
- The importance of emphasizing the confidentiality of TB services and each patient’s TB test results, bearing in mind that men’s livelihoods may be at risk if their TB status is known by the employer, while women potentially face violence and/or abandonment by their spouse due to the TB/HIV link (whether or not she is HIV positive).
- The importance of fully explaining TB transmission and dispelling common myth-based explanations that further stigmatize women.
- The advantages of helping patients starting treatment to think through the potential barriers to adherence that may be typical for males and females and plans for mitigating those barriers.
- The role of depression and psychosocial stresses in complicating TB treatment adherence, especially for men, and the importance of systematic referrals of TB patients to any peer support groups that may exist.
- The importance of helping female caretakers to connect with any social welfare services or nutritional support for TB patients that may exist in the community to mitigate the financial impact of caretaking activities.
- The role of the health workers and community volunteers in encouraging potential female TB patients to be forthcoming in describing their TB symptoms.
• The importance of finding ways to address the common perception among men that public health facilities are a female domain; this may be context-specific but could include outreach to men with screening services in locations and at hours that reflect their time-use patterns, and/or male-only services at certain times/days, or other ways to streamline services.

• The importance of not overlooking the TB service needs of females when providing TB services in male-dominated settings such as prison populations and mining communities.

• The importance of screening all pregnant women for TB at each antenatal care visit, keeping in mind that certain TB symptoms may be masked by or confused with pregnancy-related changes.

As well, the performance-improvement activities envisioned to ensure that trained staff provide comprehensive TB screening and early diagnosis, such as user groups and peer networks, should include consideration of issues highlighted in the gender analysis.

Subtask 1.4: Support the existing NTP M&E system

Several activities to support the existing NTP M&E system are outlined in the Eradicate TB monitoring, evaluation, and learning (MEL) plan. As highlighted in the MEL plan, the project is seconding an M&E advisor to the NTP to, among other activities, examine the NTP’s capacity to analyze and report sex-disaggregated data, such as treatment success rates, that can point to the gender dimensions of access to and use of services, and to be able to recognize and address potential gender constraints. Observations from assessment of these capacities and subsequent technical assistance from the M&E advisor should result in any needed improvements in this area.

Task 2: Address TB/HIV and MDR-TB and the needs of poor and vulnerable populations

Subtask 2.1: Reduce the burden of TB/HIV co-morbidity

One of the key activities under this subtask involves increasing TB and multidrug-resistant (MDR-TB) case detection among vulnerable groups. Among other things, this will entail supporting stakeholders and representative groups at the district and provincial level to integrate gender-sensitive treatment adherence support and identifying and referring presumptive cases into existing community outreach activities. Gender-sensitive treatment adherence support can take into account issues raised in the gender analysis, including helping TB patients to deal with the pressures of stigma and self-stigma. More specifically, while both men and women face TB stigmas that impact their use of services and adherence to treatment, the types and severity of stigma can differ between men and women. Both male and female patients may require support to deal with the psychosocial stresses of living with a stigmatized illness. This may be especially important for male TB patients who live with cultural norms emphasizing strength, productive capacities, and the role of family provider. As well, for some TB patients, adherence may depend greatly on the level of support they receive from caregivers, most of whom are females, and many of whom require support themselves to be able to undertake caregiving successfully. This includes both encouragement from the community, rather than ridicule and isolation, and financial/material support to buy or produce enough food for the patient to take the medications. These and other issues, such as the
tendency for males especially to discontinue taking treatment once symptoms subside, should be integrated into activities aimed at adherence support.

Each of the three approaches designed to support the NTP in implementing a package of intensified case-finding activities integrate strategies to mitigate gender barriers to TB diagnosis and treatment. The first, TB/HIV household interventions, involves contact tracing and infection control among household members living with newly diagnosed TB patients. Two important gender considerations must be stressed. First, this must be done with sensitivity to the fact women especially face serious social, economic, and even physical safety concerns if this approach is implemented without taking into account whether or not a married female TB patient has already disclosed her TB status to her husband. If not, an unintended consequence of this approach may be abandonment or physical abuse by the husband/partner. The second gender consideration in contact tracing involves the fact that male patients’ home-based caregivers are typically women, usually their wives. They are exposed to TB infection themselves, and typically lack access to the financial resources needed to take care of the TB patient and make up for lost income due to caregiving. The intensified case-finding activities could also be used to identify the most vulnerable female caregivers and refer them to any possible sources of support.

The second approach in the intensified case-finding package includes mobile health services through the OneStop Clinic model. As highlighted in the gender analysis, some of the main barriers to male use of TB services include stigma, perceptions that public facility-based services are the domain of women, and concerns about the time spent, potential lost income, and in some cases fear of employment dismissal. If the OneStop TB Clinics are designed in a discreet manner, this is an opportunity to promote services to males who are reluctant to seek care in public health facilities and/or clinics directly linked to their employers. This can increase demand and assist in the identification of missing TB cases, especially among males.

The third approach involves collaboration with private mining companies to effect policy change in support of hiring ex-TB patients by mines; improving TB services in government facilities servicing mining communities; and active case-finding in mining-affected communities, including by deploying the OneStopTB Clinic. In collaboration with private-sector partners Konkola and First Quantum, the Eradicate TB team will examine the gender dynamics driving high TB transmission in these communities. This will be used to design and implement interventions to ensure that miners’ families—especially intimate partners—have access to high-quality services.

Subtask 2.4: Provide support to increase TB detection and treatment among prisoners

The gender analysis has pointed out a few different ways in which gender intersects with TB detection and treatment among prisoners. First, prison populations are overwhelmingly male, and power dynamics in male prison populations may lead some men to hide symptoms and forgo treatment. Second, in prisons sharing health-related resources (i.e., transportation and staff) between male and female prison populations, the needs of female prisoners are often overshadowed by those of the male majority. This may lead to lower TB screening and diagnosis for female prisoners, constraints in accessing care, and
challenges to adherence. Eradicate TB will conduct an assessment to inform the development and implementation of communication strategies for prisoners, prison and health facility staff, and communities surrounding prisons, targeting deficiencies in the testing and treatment of both male and female prisoners, accounting for knowledge gaps, male gender norms, and stigma.

**Task 3: Engage all categories of care providers**

Both males and females are likely to go to traditional healers or herbalists before seeking care in a public health facility. Women are also likely to seek healing from a religious leader, while men may be more likely to go to a private care provider or pharmacist due to their ability to pay for services with cash, compared to females. For both men and women, there is a postponement of care-seeking in the public health facilities and reduced demand for services overall. Reasons for this, mainly related to stigma and confidentiality concerns, are highlighted in the gender analysis. Several activities under this task, including the development of a quality-of-care framework for private medical practitioners, the training of traditional practitioners to promptly identify and refer TB symptomatic individuals to NTP facilities, and support to pharmacy representatives in curriculum development and cascade training, are relevant to gender integration efforts. For example, the private medical practitioner quality-of-care framework should include the additional TB risks for pregnant women and the need to screen and counsel pregnant women accordingly, while also incorporating many of the points identified for gender integration in revisions to the national TB training curriculum described under subtask 1.3. These points are also relevant for integration into the curriculum development and cascade training planned for private medical practitioners and pharmacists.

**Task 4: Enable and promote operational research**

The current knowledge base regarding gender and TB in Zambia and elsewhere is growing but still limited. There are gaps especially in the documentation of implementation and outcomes related to gendered approaches to service delivery, increasing demand for TB services, and improving testing and treatment uptake trends among both women and men, and within certain vulnerable populations including pregnant women, prisoners, and mineworkers. Zambart will be working with the NTP to establish a set of national TB operations research priorities. As well, they will support the NTP in developing strategic partnerships to fund operations research and can raise the need to incorporate gender and TB into these activities. Examples of operations research topics that could be considered include changes in popular perceptions relative to the causes of TB, the success of project activities in addressing male gender norms that impede timely health-seeking behavior especially among miners and prisoners, and/or studies on the impact of health care–worker training material incorporating gender considerations in health worker services.
5. Gender-sensitive M&E and performance indicators

In 2016, USAID and PEPFAR, through the Monitoring and Evaluation to Assess and Use Results (MEASURE) Evaluation, published new guidelines for integrating gender into an M&E framework and system assessment (MEASURE Evaluation, 2016). The tools were pilot-tested in Zambia under the auspices of the National HIV/AIDS/TB/STI Council and therefore especially well-suited to the needs of the Eradicate TB project. As highlighted early in the document’s background section, gender-sensitive M&E involves thinking through what data are collected, how and by whom they are collected, and how the data are analyzed, interpreted, and used. Several of the 12 components in what is presented as a functional M&E system are relevant to the Eradicate TB project, in particular the following aspects of the 12 components:

- Equal opportunities for M&E professional development and growth benefiting both males and females.
- An inventory of M&E stakeholders including key gender stakeholders.
- Data disaggregation by sex and age, and measurement of other indicators to capture information on gender-related barriers to accessing health prevention and treatment services, gender norms that influence health-seeking and risk behaviors, and other indicators that can show gender differentials.
- The involvement of at least one gender expert in the development of national M&E plans and processes.
- HMIS systems that allow for the collection, interpretation, and use of data that can point to gender differences in health risks and access/use of services by males and females.
- Routine monitoring reports that include information on gender differentials, including data disaggregated by sex or other gender indicators.
- Surveys/assessments to assess the needs of vulnerable populations (in this case including mine laborers and prisoners).
- Data collection practices that provide information relative to change in the five gender domains.
- Gender data to help health providers and managers in their decision-making.

The project’s MEL plan explicitly addresses many of these issues as follows:

- Eradicate TB will work with the NTP to conduct an M&E capacity assessment at the national, provincial, district, and community levels of the system to identify critical gaps. This includes the capacity to analyze and report sex-disaggregated data, such as treatment success rates, for gender dimensions of access and use of services to be able to recognize and address potential gender constraints.
- The strategic information (SI) advisor, together with the in-country project staff gender focal point person, will identify and orient the ETB team on monitoring gender-sensitive activities and tracking the appropriate indicators.
- The Eradicate TB team will undertake a baseline assessment that will incorporate various aspects of the project’s gender integration strategy.
• The SI advisor will orient project partners on USAID’s guidance on integrating gender in the project’s M&E activities. This will be an opportunity for the team to discuss and identify gender-sensitive activities as described in the gender integration strategy and the appropriate indicators.

• The SI advisor, in consultation with the gender specialist, will find opportunities to collect gender-sensitive indicators according to USAID ADS Chapter 205 master indicator list. During the internal M&E workshop, the team will revise some of the outreach activities and community volunteer training reporting tools to track such indicators as:
  o The percentage of participants reporting increased agreement with the concept that males and females should have equal access to social, economic, and political resources and opportunities.
  o The number of persons trained with US government assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public- or private-sector institutions or organizations.

• During the M&E internal workshop and through consultations with the project’s gender focal point person, the SI advisor will implement mechanisms to monitor, analyze, and use data to effectively measure progress made to address the challenges in key populations and gender biases.

• Specific measures are outlined in the M&E plan to address information needs for vulnerable populations and the need for sex-disaggregated data relative to those populations. Examples include addressing and measuring improvements in notification and case management in the mining population and initiating a meeting with the MoH Maternal and Child Health Coordinator to discuss the indicators that are collected for TB in pregnancy and integrating this data into project reporting if possible.

6. Gender in project management

The success of the Eradicate TB team in realizing the project’s gender integration strategy relies on certain key project management activities as follows:

Stakeholder coordination

It is critical that other stakeholders are aware of efforts by Eradicate TB to integrate gender with the aim to increase demand for services and improve testing and treatment outcomes. This starts with seeking input from the NTP on the gender integration strategy. Others in the wider national and provincial stakeholder mechanisms, to whom the project will not directly distribute the gender integration strategy, but who will be informed of its contents and from whom general feedback and information-sharing will be sought, include members of the Zambia Country Coordinating Mechanism (CCM), which meets on a monthly basis.

Staffing and budgeting for gender integration

The Eradicate TB project has a senior management team composed of key staff that is gender-balanced, including two males (Chief of Party and Deputy Chief of Party) and two females (Finance Director and
Strategic Information Advisor). The project will also identify a technical staff member (potentially the vulnerable populations advisor) to take on the role of gender focal person. This individual will be responsible for ensuring that the gender integration strategy stays on track at all levels and making adjustments to it as needed throughout the five-year life of the project. He/she will be supported in this responsibility by PATH’s US-based Gender and Gender-Based Violence Researcher and additional technical staff.

The gender integration strategy calls for three specific activities that were identified in the proposal and that may require specifically budgeted funds. These include:

1. Integration of gender in revisions to the NTP training materials for TB health care workers.
2. An assessment of gender constraints to TB screening and treatment uptake in the mining sector in collaboration with private mining companies Konkola and First Quantum.
3. An assessment to inform the development and implementation of communication strategies for prisoners, prison and health facility staff, and communities surrounding prisons, targeting deficiencies in the testing and treatment of both male and female prisoners, accounting for knowledge gaps, male gender norms, and stigma.

In keeping with the aim of integrating gender into specific project objectives and activities, it is anticipated that other aspects of the gender integration strategy, e.g., gender barriers in communication and advocacy capacity-building, integrating gender into M&E approaches, and training community volunteers, will not incur specific additional expenses beyond what it already budgeted for them. Rather, the gender integration strategy is intended to guide the content and focus of planned and budgeted efforts in ways that ensure the gender dimensions of barriers to service-demand for TB testing and treatment are effectively addressed.

Adaptive management

The Eradicate TB project recognizes that addressing the gender dimensions of TB transmission, diagnosis, and treatment are deeply-rooted and not amenable to quick-fix solutions. Rather, it is likely that iterative processes of planning, implementing, learning, and adapting will be necessary. Therefore, the Eradicate TB project considers the gender integration strategy to be a living document. The strategy will be shared with both the NTP and project implementing partners, in addition to USAID, to generate additional input and ideas. The project’s gender focal point, with support from PATH’s Gender and Gender-Based Violence Researcher and additional technical staff, will review the strategy in preparation for quarterly partner meetings and note areas of particular relevance to project activities that time. He/she will solicit feedback from partners on the gender dimensions of that quarter’s activities using the description of tasks and subtasks above and lead a focused discussion about ways in which the approaches currently envisioned may need to be adjusted. If necessary, subsequent versions of the gender integration strategy will be drafted and shared with USAID, the NTP, and implementing partners, to guide later phases of project implementation and ensure progress toward the Eradicate TB objectives.
Appendix 1. Summary of gender analysis key findings, impact on TB risk/TB transmission, and impact on health-service demand and/or adherence

Gender-based cultural norms, beliefs, and behaviors

<table>
<thead>
<tr>
<th>Norm/belief/behavior</th>
<th>Impact on TB risk/TB transmission</th>
<th>Impact on health-service demand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptualizations of male identity based on physical strength and health may lead to self-denial about illness, hiding of symptoms, and/or reluctance to seek health care.</td>
<td>Postponement of TB diagnosis and treatment initiation can lead to greater severity of disease and a longer period of infectivity. TB transmission from males to males and males to females is increased the longer TB-infected males wait to seek care.</td>
<td>The postponement of health-seeking behaviors by males until symptoms are severe, or forgoing health-seeking entirely, results in decreased health service demand. Adherence among males is observed to be lower than for females, in part due to the relatively swift reduction in symptoms. If a male does not perceive himself as sick or still infected/infectious, very often he will drop treatment.</td>
</tr>
<tr>
<td>TB-related stigma due to association with HIV affects both males and females. However, blame, moral judgement, and social costs are more severe for and more heavily impact women due to the association of HIV with promiscuity. Erroneous beliefs about non-biological causes of TB, many biased against women, add to strong TB stigma and lack of understanding about what is needed for disease treatment. Women with TB symptoms are typically afraid of being blamed for spreading TB, may fear losing marital opportunities/marital status, and face high social costs if they are diagnosed with TB and others learn about the diagnosis.</td>
<td>Postponement of TB diagnosis and treatment initiation among both males and females can lead to greater severity of disease and a longer period of infectivity.</td>
<td>Strong TB-related stigma and self-stigma due to association with HIV leads many individuals suspecting they suffer from TB to avoid situations where confidentiality may be compromised and where they may feel judged. Both males and females are likely to go to traditional healers or herbalists before seeking care in a public health facility. Women are also likely to seek healing from a religious leader, while men may be more likely to go to a private care provider or pharmacist. For both, there is a postponement of care-seeking in the public health facilities and reduced demand for services overall.</td>
</tr>
<tr>
<td>There exists greater social acceptability of alcohol and tobacco use among males compared to females.</td>
<td>TB risk is increased among individuals who smoke and/or drink alcohol regularly.</td>
<td>Smoking and/or drinking alcohol has not been noted as a direct influence on TB health-service demand, but may be part of a constellation of health risk factors associated with poor care-seeking behaviors.</td>
</tr>
</tbody>
</table>
Conceptualizations of public clinics and hospitals as “female domains” lead males to shun public health services.

Postponement of TB diagnosis and treatment initiation can lead to greater severity of disease and a longer period of infectivity.

Males favor private providers and traditional healers over public health facilities, contributing to low male demand for TB treatment in public facilities where TB diagnostics, drugs, systems, and support are most readily available.

Note: HIV, human immunodeficiency virus; TB, tuberculosis.

### Gender roles, responsibilities, and time-use

<table>
<thead>
<tr>
<th>Gender-related roles/responsibilities/time-use</th>
<th>Impact on TB risk/TB transmission</th>
<th>Impact on health-service demand and/or adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritization of men’s income-generating responsibilities by both males and females results in constraints to male health-seeking behaviors.</td>
<td>Postponement of health-seeking behaviors and treatment initiation can lead to greater severity of disease and a longer period of infectivity.</td>
<td>The focus on keeping a job, and not missing time/work/income in order to go to a clinic, contributes to decreased male demand for TB services in general.</td>
</tr>
<tr>
<td></td>
<td>TB transmission can increase in male-dominated, high-risk occupations, e.g., mining.</td>
<td>Males favor private providers and traditional healers perceived as more time-efficient and accessible (and less conspicuous) than public health facilities, leading to delays in treatment initiation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Men’s work responsibilities may override their adherence efforts especially with regard to DOT.</td>
</tr>
<tr>
<td>Due to the prioritization of women’s role in the domestic sphere generally, and as caretaker for the sick, women may deprioritize their own health needs in the face of time constraints raised by domestic responsibilities (i.e., females may be too busy to seek health care until already very sick). Many homes in rural areas, where women are caring for the sick, have very limited ventilation.</td>
<td>Transmission from TB patients (male or female) to female caretakers, and from caretakers to family members, and through social networks, is intensified.</td>
<td>Less attention to female caretakers’ risk and health needs, coupled with stigma and beliefs holding women responsible for TB infection, contributes to low TB health-seeking behaviors by women.</td>
</tr>
<tr>
<td>Males and females occupy different spaces in their use of time for occupational/income-generating purposes. Male-to-male transmission is intensified in occupations dominated by males (e.g., mining), while women may spend time in certain locations.</td>
<td>Males and females in certain occupational/income-generation spaces are at increased risk of transmission/infection.</td>
<td>Male demand for TB services increases if screening is close to workplaces and/or if employer support exists.</td>
</tr>
<tr>
<td></td>
<td>Infection risk for those females not working outside the home may be lower than those in occupations of elevated risk, but this lower</td>
<td>Female demand for TB services in situations of elevated risk due to occupation should be higher than females not working in those spaces,</td>
</tr>
</tbody>
</table>

Due to the prioritization of women’s role in the domestic sphere generally, and as caretaker for the sick, women may deprioritize their own health needs in the face of time constraints raised by domestic responsibilities (i.e., females may be too busy to seek health care until already very sick). Many homes in rural areas, where women are caring for the sick, have very limited ventilation.

Transmission from TB patients (male or female) to female caretakers, and from caretakers to family members, and through social networks, is intensified.

Less attention to female caretakers’ risk and health needs, coupled with stigma and beliefs holding women responsible for TB infection, contributes to low TB health-seeking behaviors by women.
and female-dominated occupations (e.g., poorly ventilated indoor markets, stone-crushing) if employed outside the home. Transmission risk may be offset if living with a TB patient in a poorly ventilated dwelling (common especially in rural areas). but may not be present due to concerns about lost income and/or broader social and stigma concerns.

Males and females occupy different spaces in their use of time for social interactions. Males are observed to be more commonly in specific public spaces for social purposes where transmission may be high. Females tend to be restricted to spending time in private (at home) but also engage in close interactions for specific social functions.

Transmission between males may be intensified at traditional ceremonies and/or games (e.g., Nsolo), spectator sports, men’s clubs, bars, and nightclubs (often crowded).

In general, females may be more likely to socialize in homes and with smaller number of individuals leading to reduced transmission risk. However, this may be partially offset by transmission in female-specific social interactions such as kitchen parties, initiation ceremonies, and funeral preparations (cooking together).

Gender-influenced time-use in social domains may not impact health-seeking behavior by individuals directly, but offers opportunities to design information and screening activities based on social spaces.

Females engaged in commercial sex work in general, and in mining areas especially, are at elevated risk of TB infection. Transmission risk between male clients and female sex workers increases risks for both women and men.

Time-use and social constraints to health-seeking behaviors could be intensified by stigma associated with commercial sex, especially for females. This may result in postponement of health-seeking behaviors by female sex workers until symptoms are severe.

Patterns of power and decision-making

<table>
<thead>
<tr>
<th>Patterns of power and decision-making</th>
<th>Impact on TB risk/TB transmission</th>
<th>Impact on health-service demand and/or adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males have power/authority to decide about health and economic issues in the household; women must typically obtain the husband’s permission to seek health care even if there are no financial constraints or transportation barriers.</td>
<td>Postponement of health-seeking behaviors and treatment initiation by women who are denied husband’s permission to use health services, or who are reluctant to ask, can lead to greater disease severity and a longer period of infectivity.</td>
<td>Constraints to women’s health-seeking behavior may delay or decrease women’s health-service demand, diagnosis, and treatment initiation. Women may hide TB treatment and adherence may be negatively impacted if the husband’s permission is not sought/obtained beforehand.</td>
</tr>
<tr>
<td>Males are more likely to have greater access to cash (either from their own or their wives’ employment/income-generation).</td>
<td>Male preference and ability to seek and pay for care in the private sector can delay TB treatment if adequate referral practices are not in place, leading to greater disease severity and a longer period of infectivity.</td>
<td>Cash availability for males likely contributes to increased demand for TB-related services in the private sector and decreased/delayed public-sector health-seeking demand. TB diagnosis and treatment</td>
</tr>
</tbody>
</table>

Note: DOT, directly observed treatment; TB, tuberculosis.
Social norms condoning divorce, spousal abandonment, and the use of physical, emotional, and/or economic violence against women for various reasons, including TB infection, especially when assumed to be caused by HIV (and associations with unfaithfulness/sexual promiscuity), contribute to women’s fears of disclosure and emphasis on confidentiality.

Hiding TB symptoms and postponing health-seeking behaviors and treatment initiation by women who fear violence, divorce, or spousal abandonment can lead to greater disease severity and a longer period of infectivity.

Social norms strongly disfavoring women may lead females who suspect they suffer from TB to avoid situations they perceive to compromise confidentiality. Some females may go to traditional healers or herbalists before seeking care in a public health facility. Women are also likely to seek healing from a religious leader. This leads to postponement of care-seeking in the public health facilities and reduced demand for services overall, delaying diagnosis and treatment. Women may hide TB treatment, and adherence may be negatively impacted.

Male power dynamics in the prison setting favor the strong over the weak/ill and create social disincentive to seek care.

Hidden cases among male prisoners facilitate the spread of TB infection, especially in crowded conditions.

Although male prisoners are screened at intake, subsequent health-seeking behavior and treatment adherence among male prisoners may be negatively impacted.

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**Note:** HIV, human immunodeficiency virus; TB, tuberculosis.

### Access to and control over assets (including access to information and services)

<table>
<thead>
<tr>
<th>Access to and control over assets (including information and services)</th>
<th>Impact on TB risk/TB transmission</th>
<th>Impact on health-service demand and/or adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some men may have better access to TB information than women due to greater access to TV messages or TB education and screening in the workplace (miners); for cultural reasons, men are less likely to share information with women compared to sharing with other men. In mining-related health services, follow-up with wives and other family members appears to be limited.</td>
<td>Both males and females with inadequate or incorrect knowledge about TB are limited in efforts to prevent transmission to others. Limited follow-up with wives (and other family members) of miners with TB may hinder efforts to reduce transmission.</td>
<td>Inadequate or incorrect knowledge about TB can lead to decreased demand for services among males and females, and compromised TB treatment adherence among TB patients, especially males, who do not understand/believe that treatment must continue after symptoms subside.</td>
</tr>
<tr>
<td>Women are in more regular contact with (public) health services than are men due to maternal and reproductive health needs and caretaking for children.</td>
<td>TB transmission from infected women to others can be reduced if women are reached with TB education, diagnosis, and treatment when seeking other health services.</td>
<td>There may be an increased uptake of TB services and treatment initiation among women if health services make effective use of contact opportunities.</td>
</tr>
<tr>
<td>Male prisoners may be screened for TB at intake and release only, with limited screening and diagnosis during the remaining period of incarceration. Female prisoners may be less likely to be screened than male counterparts.</td>
<td>Limitations in screening may result in missed cases, potentially greater disease severity, and a longer period of infectivity.</td>
<td>Male and female health-service demand within prisons is likely constrained by limited TB screening and diagnosis practices. Adherence may also be impacted if services and supplies within the prison health system are generally inadequate compared to needs.</td>
</tr>
</tbody>
</table>
Laws, policies, regulations, and institutional practices (including health-sector practices)

National gender and health policies

<table>
<thead>
<tr>
<th>Policies and institutional practices (including health-sector practices)</th>
<th>Impact on TB risk/TB transmission</th>
<th>Impact on health-service demand and/or adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>One of the key principles of the National Health Strategic Plan 2011–2015 focuses on gender sensitivity and balancing in the management of the health system and delivery of health services at all levels.</td>
<td>If health-service delivery is designed to recognize and adapt to the TB risks and service needs of males and females, TB transmission among both men and women may be effectively addressed and reduced.</td>
<td>Gender-sensitive health-service delivery can result in increased demand for TB services and improvements in adherence outcomes.</td>
</tr>
<tr>
<td>The gender-related dimensions of TB infection, diagnosis, and treatment are not well-addressed by the national TB policy or national HIV policies and guidelines.</td>
<td>The lack of attention to gender and TB as a specific issue may lead program planners and implementation staff to overlook the impact of gender on the success of TB programs. This in turn may indirectly contribute to high TB transmission in instances where gender inequalities are a driving force in regard to infections.</td>
<td>Gender-blind TB service design may inadvertently limit health-service demand among both males and females.</td>
</tr>
<tr>
<td>Gender mainstreaming in line ministries has been found to be inadequate in terms of budgeting and the assignment of gender focal points with the support needed to focus on gender-related issues within various sectors.</td>
<td>Support to address gender in health and other ministries has the potential to address gender-based constraints to TB diagnosis and treatment, thereby reducing TB risk and TB transmission among both males and females.</td>
<td>Improvements in addressing the gender-based constraints to health service delivery have the potential to increase service demand among both males and females.</td>
</tr>
<tr>
<td>Various measures and directives in the National Gender Policy focus on increasing access to services in general and for specific disease areas affecting mainly females (i.e., the supply side of service delivery), with somewhat less emphasis on addressing gender constraints to health-service demand. Stakeholder discussions indicate interest and support for constructive engagement regarding gender and TB.</td>
<td>If health-service delivery is designed to recognize and adapt to the TB risks and service needs of males and females, TB transmission among both men and women may be effectively addressed and reduced.</td>
<td>TB-service demand can most effectively increase if adequate efforts are made in both TB service supply and delivery.</td>
</tr>
</tbody>
</table>

*Note: HIV, human immunodeficiency virus; TB, tuberculosis.*
### Mining-sector policies and institutional practices

<table>
<thead>
<tr>
<th>Policies and institutional practices (including health-sector practices)</th>
<th>Impact on TB risk/TB transmission</th>
<th>Impact on health-service demand and/or adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company policies that promote/require the screening of miners can support access to TB diagnosis and care for men in mining communities.</td>
<td>If miners receive prompt diagnosis and treatment, disease severity may decrease and the period of infectivity may become shorter.</td>
<td>These policies can increase demand for TB services if miners do not fear losing employment when diagnosed with TB.</td>
</tr>
<tr>
<td>Company policies that restrict miners from working if they are diagnosed with TB are a disincentive for male miners to test at company-supported clinics (and an incentive for going to the private sector or traditional healers and herbalists).</td>
<td>Postponement of accurate TB diagnosis and treatment initiation can lead to greater severity of disease and a longer period of infectivity.</td>
<td>These policies can increase miners’ demand for care in the private sector and from traditional healers and herbalists. These policies can potentially increase demand for TB services in public health facilities as well, although factors in other gender domains may reinforce demand in the private sector and from traditional healers and herbalists.</td>
</tr>
<tr>
<td>Female stone crushers work in small, informal enterprises lacking institutional support to TB diagnosis and care for women in this work; protective equipment is also not typically provided.</td>
<td>Unprotected females engaged in stone-crushing are at increased risk of TB infection due to the impact on lung health. Postponement of accurate TB diagnosis and treatment initiation can lead to greater severity of disease and a longer period of infectivity.</td>
<td>The lack of institutional support for this at-risk group, coupled with TB-related stigma and the need to earn income, can inhibit female stone crushers’ demand for health services.</td>
</tr>
</tbody>
</table>

*Note: TB, tuberculosis.*

### Other sector employment policies and practices

<table>
<thead>
<tr>
<th>Policies and institutional practices (including health-sector practices)</th>
<th>Impact on TB risk/TB transmission</th>
<th>Impact on health-service demand and/or adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the workplace, women may face fewer employer constraints to time off for health issues compared to men (whether for herself or to care for a sick family member).</td>
<td>TB transmission from infected women to others can be reduced if women are reached with TB education, diagnosis, and treatment. TB risk for female caretakers is higher than for other females or males.</td>
<td>Employer flexibility in time off may promote women’s health-seeking behavior for TB and/or help increase TB adherence and care for patients who receive care at home from female family-based caregivers.</td>
</tr>
</tbody>
</table>

*Note: TB, tuberculosis.*
Prison policies and practices

<table>
<thead>
<tr>
<th>Policies and institutional practices (including health-sector practices)</th>
<th>Impact on TB risk/TB transmission</th>
<th>Impact on health-service demand and/or adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both male and female prisoners live in conditions of inadequate sanitation and ventilation, overcrowding, and poor nutrition. However, this may be more severe for males given the overwhelmingly male prison population and male-prison crowding.</td>
<td>Structural conditions within prisons increase prisoners’ risk for TB and encourage high TB transmission especially among male prisoners. Once released, the TB risk for male prisoners’ families becomes elevated.</td>
<td>Existing prison conditions should increase demand for services, especially among men, while improvements would ideally enhance TB control and eventually diminish demand for services.</td>
</tr>
<tr>
<td>In prisons sharing health-related resources (i.e., transportation and staff), the needs of female prisoners are often overshadowed by those of the male majority. This may lead to lower TB screening and diagnosis for female prisoners and constraints in accessing care.</td>
<td>Structural conditions within prisons also increases female prisoner TB risks, while constraints to health care access can contribute to greater severity of disease and a longer period of infectivity.</td>
<td>In female prisons suffering health service–availability constraints, women may feel demotivated to request care. Adherence may also suffer among women who do receive treatment but who encounter difficulties with the regimen and need health-service support.</td>
</tr>
</tbody>
</table>

*Note: TB, tuberculosis.*
### Health sector institutional practices

<table>
<thead>
<tr>
<th>Policies and institutional practices (including health-sector practices)</th>
<th>Impact on TB risk/TB transmission</th>
<th>Impact on health-service demand and/or adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many men favor private practitioners, pharmacists, and traditional healers over public health facilities in part because they are less institutionalized than public health services. Private practitioners, pharmacists, and traditional healers are open outside regular hours, which allows employed men better access, and men can be more “secretive” about seeking care in order to avoid stigma. Traditional healers tend not to use explicit records as is done in public health services.</td>
<td>Private practitioners, pharmacists, and traditional healers are limited in their ability to address TB. Postponement of accurate TB diagnosis and treatment initiation can lead to greater severity of disease and a longer period of infectivity.</td>
<td>Men’s demand for health services outside of formal facilities tends to be higher than their demand for public health facilities due in part to institutional practices.</td>
</tr>
<tr>
<td>Regular screening for TB among pregnant women is promoted by policy but appears inconsistently applied in practice. The institutional coordination between ANC services and TB practitioners may not always be sufficient to ensure proper screening and diagnosis, with resulting disadvantages for pregnant women.</td>
<td>The risk of TB infection for pregnant women, especially if HIV-positive, is higher than that of non-pregnant women.</td>
<td>Demand for TB services among pregnant women will increase if institutional support to ensure regular screening and treatment is in place.</td>
</tr>
</tbody>
</table>

*Note: ANC, antenatal care; HIV, human immunodeficiency virus; TB, tuberculosis.*
### Appendix 2. Eradicate TB gender analysis list of interviewees

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Nathan Kapata</td>
<td>Head of Emergency Preparedness and Response</td>
<td>Zambia National Public Health Institute</td>
</tr>
<tr>
<td>Simon Kapilima</td>
<td>Acting Director, Gender Rights &amp; Protection</td>
<td>Ministry of Gender and Child Development</td>
</tr>
<tr>
<td>Namatama Chinyama</td>
<td>Asst. Director, Gender Rights &amp; Protection</td>
<td>Ministry of Gender and Child Development</td>
</tr>
<tr>
<td>Dr. George Mutambo</td>
<td>President and General Practitioner</td>
<td>General Practitioners Association</td>
</tr>
<tr>
<td>Dr. Amina Massod Husain</td>
<td>Member and General Practitioner</td>
<td>Gender Practitioners Association</td>
</tr>
<tr>
<td>Friday Nkhoma</td>
<td>Program Officer, Advocacy and Human Rights</td>
<td>Churches Health Association of Zambia</td>
</tr>
<tr>
<td>Malelo Ilukena</td>
<td>Technical Advisor, Psychosocial &amp; Clinical Services</td>
<td>World Vision</td>
</tr>
<tr>
<td>Mutale Bowa</td>
<td>Executive Director</td>
<td>Afya Mzuri</td>
</tr>
<tr>
<td>Aggrey Chibuye</td>
<td>Behavior Change Specialist</td>
<td>Afya Mzuri</td>
</tr>
<tr>
<td>Charity Haabenzu</td>
<td>Chief Executive Officer</td>
<td>Zambia TB and Leprosy Trust</td>
</tr>
<tr>
<td>Caren Chizuni</td>
<td>Chief Safe Mother Officer, Gender POC</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Ellen Mubanga</td>
<td>Public Private Sector Coordinator, Gender POC</td>
<td>National HIV/AIDS/STI/TB Council</td>
</tr>
<tr>
<td>Grace Hameja</td>
<td>Principal TB Officer</td>
<td>National TB and Leprosy Control Program</td>
</tr>
<tr>
<td>Dr. Kamar Tayan</td>
<td>Chief Medical Officer</td>
<td>Mary Begg Community Clinic Solwezi</td>
</tr>
<tr>
<td>Michael Chimbipa</td>
<td>Gender Focal Point</td>
<td>Provincial Health Office Northwestern</td>
</tr>
<tr>
<td>Mwendabai Mwendabai</td>
<td>Chief Inspector, Community Service Department</td>
<td>Solwezi Police</td>
</tr>
<tr>
<td>Peter Macniellage</td>
<td>Administrative Officer</td>
<td>Provincial Health Office Copperbelt</td>
</tr>
<tr>
<td>Masitano Chilenbo</td>
<td>TB/HIV Liason</td>
<td>Provincial Health Office Copperbelt</td>
</tr>
<tr>
<td>Nelly Nambule</td>
<td>Human Resources</td>
<td>Provincial Health Office Copperbelt</td>
</tr>
<tr>
<td>Linda Malukutu Simbeye</td>
<td>Program Officer</td>
<td>Afya Mzuri</td>
</tr>
<tr>
<td>Dr. Connard Mwansa</td>
<td>Director</td>
<td>Occupational Health and Safety Institute</td>
</tr>
<tr>
<td>Enock Mandiopera</td>
<td>Program Coordinator</td>
<td>Development Aid from People to People</td>
</tr>
<tr>
<td>Imasiku Sitali</td>
<td>Project Coordinator</td>
<td>Development Aid from People to People</td>
</tr>
<tr>
<td>Bethreen Musonda</td>
<td>District Health Management Team HIV/TB/FP</td>
<td>Kabwe District Health Office</td>
</tr>
<tr>
<td>Victor Musukuma</td>
<td>District Health Management Team HIV/TB/FP</td>
<td>Kabwe District Health Office</td>
</tr>
<tr>
<td>Bupe Chewe</td>
<td>Lab Technologist</td>
<td>Kabwe Medium Correctional Health Facility</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Organization</td>
</tr>
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</tr>
<tr>
<td>Henry Mutabale</td>
<td>Regional Health Coordinator</td>
<td>Zambia Correctional Service</td>
</tr>
<tr>
<td>Lontia Chinkubala</td>
<td>Chief of Party, ZamFam</td>
<td>Development Aid from People to People</td>
</tr>
<tr>
<td>Chris Chikatula</td>
<td>CCM Administrator</td>
<td>CCM Zambia Secretariat</td>
</tr>
<tr>
<td>Virgina Bond</td>
<td>Director</td>
<td>Zambart</td>
</tr>
</tbody>
</table>

*Note: AIDS, acquired immune deficiency syndrome; CCM, Country Coordinating Mechanism; FP, family planning; HIV, human immunodeficiency virus; POC, point of contact; STI, sexually transmitted infection; TB, tuberculosis; Zambart, Zambia AIDS Related Tuberculosis.*
Appendix 3. Topics explored in stakeholder discussions for the gender analysis

- What are the social dimensions of TB infection risks, transmission patterns, and levels of infection that differ for males and females at different stages in life (childhood, adolescence/young adulthood, and adulthood)?
- What gender-related social norms in Zambia influence difference between males and females in TB health-seeking behaviors?
- What types of stigma and/or discrimination do men and women with TB commonly experience from partners, families, social contacts, employers, health care providers, and others, and do these differ for prison populations, mining laborers, and other vulnerable populations?
- What are the behavioral differences between males and females that may influence personal TB risk and/or rates of transmission?
- What are the roles and responsibilities of men and women at the family and community levels that may impact their risk of TB infection and/or access to diagnosis and care?
- What are the household-level gender dimensions of decision-making about health-services use that may influence the way that males and females decide to consult a health care provider when they have TB-related symptoms?
- How common is it for women to experience violence by their partner or others due to disclosure or suspicion about TB infection?
- Are there differences between men and women in their understanding of TB transmission, risks for infection, cure options, and when/where to seek care?
- In what ways do men and women face barriers to or opportunities for accessing TB testing services, diagnosis, and treatment?
- Do males and females tend to have different treatment outcomes based on adherence issues?
- Do health workers screen for and treat TB differently for males and females?
- Are there TB-screening practices in place for pregnant women?
- Are there specific policies or programmatic approaches for addressing barriers to TB diagnosis and treatment that males and females may experience differently?
- Are there any initiatives that promote the empowerment of women (or men) for better TB outcomes?
- What TB-related data are collected at the facility, provincial, and national levels that are sex and age-disaggregated?
- What are the key gaps in our current knowledge/understanding about gender and TB, and in what ways do these affect the ability of programs and investments to reduce TB infections?
- What successes and challenges have programs experienced in increasing women’s and men’s access to TB diagnosis and treatment, and how can programs seeking to significantly reduce TB infections implement activities so that there is equitable access by males and females to quality-assured TB services based on their unique needs?
Appendix 4. References included in the gender analysis


Nguluwe UW. Women and Mining in Zambia. Unpublished data, N.D. Available at https://www.academia.edu/28783889/WOMEN_AND_MINING_IN_ZAMBIA.


