ሲአርጂ

CRG

ASSESSMENT REPORT OF ETHIOPIA

COMMUNITIES, RIGHTS AND GENDER

ሪፖርት 2023

REPORT 2023

የጤና ሚኒስቴር፣ ኢትዮጵያ
MINISTRY OF HEALTH, ETHIOPIA

VOLUNTEER HEALTH SERVICES

SUPPORTED BY

Stop TB Partnership

hosted by

UNOPS

" ... People-centered care should be
is unique, and it is important to re
means not only providing medical t
tients and their families. Let us buil
diverse needs of TB affected co

TABLE OF CONTENTS

Acronyms
Acknowledgement
Key Messages
Executive Summary
Framework & Methodologies

CHAPTER 1: CRG BARRIERS FINDINGS & RECOMMENDATIONS

CHAPTER 2: TB KEY AND VULNERABLE POPULATIONS IN ETHIOPIA

- Internally displaced people (IDPs)
- People living with HIV/AIDS
- Urban Slums
- Health Care workers
- Malnutrition
- Drug Users/Khat Chewers
- Mega Projects
- Diabetic Patients
- Congregate settings
- Smoking and alcohol abuse
- Migrants, refugees and returnees
- Miners
- Pastoralists
- Homeless
- KVPs Prioritization

CHAPTER 3: GENDER BARRIERS

- TB Gender Perspectives in Ethiopi
- Accessibility, Availability, Acceptability, Quality of Services, Vulnerability and Impact to infection
- Legal and Policy Framework Impacting on TB and Gender equality
- Health laws, plans, policies, guidelines, and structures Impacting on TB and Gender equality
- Discussion on the Gender Perspective of TB Epidemic

CHAPTER 4: LEGAL BARRIERS

- Laws, Regulations, And Policies Impacting on Gender Equality, Harmful Gender Norms And Gender-Based Violence
- The Relevant Legal Framework
- International, Regional, And National Laws And Standards
- Domestic Legal and Policy Framework
- The FDRE Constitution
- The right to Health
- Rights of Labour
- Right to legal remedy
- Labour laws
- Laws Regarding Persons Held In Custody And Convicted
- The Right to Health Framework68
- Nondiscrimination and equal treatment
- Health-related freedoms
- Gender perspective
- Remedies and accountability
- Participation
- Legal and Policy Frameworks For Selected Key Populations
- Healthcare workers
- People Who Use Drugs
- Mineworkers
- People with Diabetes
- Internally Displaced People (IDPS) and Refugees

Chapter Five: Case Studies

Chapter Six: Strategic Interventions to address CRG Barriers

References

at the heart of our efforts. Each individual's experience with TB
ecognize and address their specific needs. People-centered care
reatment but also offering support, empathy, and respect to pa-
d a healthcare system that listens, engages, and responds to the
ommunities, fostering a sense of trust and collaboration."

Acronyms

AAAQ	Availability, accessibility, acceptability, and quality
CCSI	Country and Community Support for Impact
CBHI	Community Based Health Insurance
CESCR	Committee on Economic Social and Cultural Rights
CRC	Convention on the Rights of the Child
CRG	Community, Rights and Gender
CSOs	Civil Society Organizations
DACA	Drug Administration and Control Authority
DM	Diabetes Mellitus
DOTs	Directly Observed Theraphy
EDHS	Ethiopian Demographic Health Survey
EFMHACA	Ethiopian Food, Medicines and Health Care Administration and Control Authority
ESCR	Economic Social and Cultural Rights
HEWs	Health Extension Workers
FGD	Focus Group Discussion
HCWs	Healthcare Workers
HIV	Human Immunodeficiency Virus
HSDP	Health Sector Development Plans
HSTP	Health Sector Transformation Plan
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICRPD	International Convention on the Rights of Persons with Disabilities
IDF	International Diabetes Federation
IDP	Internally Displaced People
IHR	International Health Regulations
ILO	International Labour Organization
IOM	International Organization for Migration
KSA	Kingdom of Saudi Arabia
KVPs	Key and Vulnerable Populations
MDR-TB	Multidrug-Resistant TB
MOH	Ministry of Health
MOWA	MINISTRY OF WOMEN'S AFFAIRS
NAPHS	National Action Plan for Health Security
NCRRS	National Comprehensive Refugee Response Strategy
NDCMP	National Drug Control Master Plan
NGOs	Non-governmental organization
NQS	National Quality Strategy
NSP	National Strategic Plan
NTP	National TB Programme
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OOP	Out of Pocket Expenditures
OHS	Occupational Health safety
PWUD	Drug Addict/Persons Who Use Drugs
RHB	Regional Health Bureaus
SGBV	Sexual and gender-based violence
TB	Tuberculosis
TBL	TB and Leprosy
UDHR	Universal Declaration of Human Rights
UNHCR	United Nations High Commissioner for Refugees
UNHLM	United Nations High Level Meeting on TB
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VHS	Voluntary Health Services
WFP	World food Program
WHO	World Health Organization

ACKNOWLEDGEMENT

Special Thanks to:

አናመሰግናለን!

Taye Letta.MoH
Dr. Lucica Ditiu, Stop TB
Viiorel Soltan, Stop TB
Austin Obiefuna, ACT
James Malar, Stop TB
Ricarda Steel, Stop TB
Inara Namazova, Stop TB
Dr. Challa Negeri, WHO
Dr. Andaragachew Kumssa, MoH
Ruth Nebiru, MOJ
Dr. Beniam Feleke, CDC
Beiment Fekede, VHS
Kasa Kebie, VHS
Demelash Assefa, KNCV
Demekech Gadissa, KNCV
Amanuel Jenbiru, VHS
Solomon Bonger, Mask
Esayas Assefa, ETA
Tilaye Gudina, MOH
Abdulai Abubakar Sesay
Dr. Hebron Fekadu, ETA
Rebika Tegenu

©Layout & Graphic Design:
Pharmainfo Trading PLC

We would like to express my deepest gratitude and appreciation to all those who have contributed to the successful completion of communities' rights and gender assessment in Ethiopia. This aimed to evaluate and generate data and strategic information of gender and human rights-related barriers, to transform and promote better policy action, with a special focus to implement comprehensive, multi-sectorial action plan to address inequitable access to quality TB services among at risk populations

First and foremost, VHS is indebted to Stop TB Partnership, Country and Community Support for Impact (CCS4i Team) and James Malar for their invaluable guidance, technical support throughout this journey. Their expertise and insightful suggestions have immensely contributed to shaping this assessment and ensuring its quality. I am grateful for the time and effort they dedicated to review and provide constructive feedback that significantly enhanced the clarity and rigor of this study.

We would also like to extend my heartfelt appreciation to TB key and vulnerable communities in Ethiopia, namely the NTP teams and experts who generously shared their experiences and insights. Without their willingness to open up and entrust me with their stories, this study would not have been possible. Their invaluable contributions have provided a rich and robust foundation for analyzing the interplay between community rights and gender in various contexts.

Moreover, we wish to acknowledge the financial support provided by Stop TB Partnership in carrying out this assessment. Their support was instrumental in facilitating data collection activities, enabling access to necessary resources, and enhancing the overall quality of the review. I am grateful for their belief in the importance of assessment and understanding the complex dynamics surrounding communities' rights and gender.

Lastly, I would like to express my sincere thanks to consultants of CRG assessment, my colleagues and Mentors who have offered their assistance, feedback, and moral support at different stages of this research. Their input and encouragement were invaluable in overcoming challenges and advancing the quality of our CRG assessment.

Once again, I extend my deepest appreciation to all those who have contributed to the realization of this CRG report. I hope that the findings and insights generated from this study can serve as a stepping stone towards promoting social justice, equality, and the empowerment of marginalized communities.

Thank you for your continued dedication and commitment to the fight against TB. Together, we can make a difference.

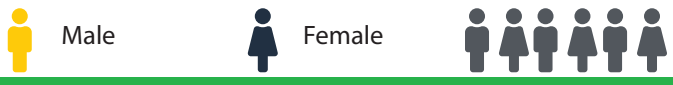


IMAGE : Lorem Ipsum Sit Amet

Male Female Family

"We simply cannot continue to stand on the sidelines and watch while people around the world fall ill and die from a preventable and treatable disease,"

To All Our Friends in Ethiopia,

I could not be happier to share some reflections regarding the finalized Ethiopia TB CRG Assessment. Its completion speaks high to the hard work and commitment of the National TB Program in Ethiopia, the passion of TB affected community and civil society partners in country- including Voluntary Health Services (VHS) - and the strong partnerships from stakeholders in country.

The Global Plan to End TB 2023-2030 provides a road map for ending TB by 2030 and several interventions are listed to support countries to implement this roadmap. TB communities, rights and gender features in an unprecedented manner. The Global Plan clearly calls on countries to complete a TB CRG Assessment, to develop a national TB CRG Costed Action Plan, to integrate it into the broader TB National Strategic Plan and then to ensure it is fully implemented. This is consistent with the United Nations High Level Meeting on TB (UNHLM) Political Declaration commitments, the End TB Strategy, the Global Fund Strategy and, ultimately, with the UN Sustainable Development Goals. Ethiopia is on track to achieve this, moving closer to achieving national commitments made during the UNHLM on TB. Congratulations!

The increased focus and presence on TB CRG reflects the awareness that to end TB we must promote and protect the human rights of people affected by TB. Central to achieving this, we must identify, monitor, mitigate and overcome the human rights and gender related barriers that inhibit people from accessing the TB services they need. Given there are so many missing people with TB, this enhanced focus on TB CRG is timely. Ethiopia joins over 20 other countries that Stop TB Partnership has supported to complete TB CRG Assessments. Those assessments have all found that despite our efforts, barriers in accessibility, availability, acceptability, and quality of TB services remain. That stigma, discrimination, privacy, and confidentiality continue to be barriers that require attention. The nuances of gender related barriers must be further addressed. That participation of people affected by TB must be further strengthened. And, that we need to have renewed focus on the vulnerabilities and barriers experienced by TB key and vulnerable populations in our countries to ensure they too can access the TB services they need.

Stop TB stands ready to support the National TB Program and TB affected communities to turn this assessment into Actions towards the next steps to finalize a costed TB CRG Action Plan and scale up of TB Community Led Monitoring to address the identified barriers. Working closely with Global Fund, USAID and through Challenge Facility for Civil Society, we hope to see significant progress in this important area of the TB response.

2023 will be the year of the second United Nations High Level Meeting on TB. Stop TB look forward to the continued leadership of Nepal in supporting an ambitious Political Declaration. Yes! Together we can End TB.

Dr Lucica Ditiu
Executive Director
Stop TB Partnership

MESSAGE FROM NTP MANAGER

Dear TB communities

In the past decades, Ethiopia has registered progress. The TB incidence has declined at an annual rate of 8-9%, from 268 per 100,000 in 2010 to 151 per 100,000 in 2018. Similarly, the burden of Leprosy has declined from 0.7 to <0.2 per 10,000 population. Ethiopia has indeed achieved the global Leprosy elimination targets.

As we strive to combat the global burden of tuberculosis (TB), it is crucial that we recognize the diverse needs of the communities we serve. In pursuit of our goal for a world free of TB, I would like to emphasize the importance of integrating community rights and gender research into our National TB program.

We acknowledge that TB affects communities from all walks of life, irrespective of their gender, age, socioeconomic status, or cultural background. By acknowledging the intrinsic rights of the communities impacted by TB, we can better address the underlying social determinants that perpetuate the disease's prevalence and hinder effective outreach efforts. It is our responsibility as the National TB program to ensure the empowerment and inclusion of marginalized groups, promoting equitable access to services and resources.

Integrating gender perspectives within our research framework is essential in understanding the unique challenges faced by different genders regarding TB prevention, diagnosis, treatment, and care. By addressing gender norms, inequalities, and societal expectations, we can develop interventions that empower both men and women to seek timely diagnosis and adhere to treatment. Furthermore, we must pay particular attention to vulnerable populations such as transgender individuals, sex workers, and prisoners, ensuring they receive appropriate care without discrimination.

Incorporating community rights into our approaches will enable us to engage directly with affected communities, fostering partnerships based on trust, empathy, and mutual respect. We must create platforms for community participation in decision-making processes, taking into account their perspectives, knowledge, and experiences. This collaborative approach will help tailor our interventions to the specific needs of different communities, increasing their effectiveness and sustainable impact.

As National TB program manager, we have a duty to advocate for policies that safeguard the rights of those affected by TB. This includes ensuring confidentiality, respecting autonomy, and protecting individuals from stigmatization and discrimination. By advocating for gender equality and community empowerment, we can contribute to addressing the social and structural barriers that impede progress in TB control efforts.

I call upon all ending TB key stakeholders to prioritize community rights and gender research within our National TB programs. Let us work together to develop research strategies that generate actionable evidence, drive policy change, and strengthen our response to TB. By adopting a human rights-based, gender-responsive approach, we can make significant strides in achieving our goal of ending the TB epidemic and building healthier, inclusive societies for all.

Taye Letta
National TB Program Manager

Messaage from VHS

Dear Colleagues

I am thrilled to share with you the incredible achievements we have made in empowering our affected communities and upholding rights, while also advancing gender equity and promoting people-centered care for tuberculosis (TB). Together, we have worked tirelessly to ensure that everyone affected by TB has a voice, receives the care they deserve, and enjoys equitable access to resources and opportunities. Through our collective efforts, we have successfully completed national level CRG assessment where TB affected communities living with TB are empowered to actively participate in operational research as well as in decision-making processes that directly impact our lives.

Because, empowering our communities is the key to achieving better health outcomes for all. By working together, sharing knowledge, and raising awareness about TB, we can create a supportive environment where individuals can access the care they need. Empowering our communities means equipping them with information, resources, and skills to become active participants in their own health. Let us foster an environment where everyone feels encouraged and empowered to seek treatment, adhere to medication, and engage in preventive practices.

Upholding our rights is essential in the fight against TB. Every person has the right to access quality healthcare, regardless of their socio-economic status, gender, or any other factors. It is crucial that we advocate for these rights and hold accountable those responsible for ensuring equitable access to TB care. Let us work together to eliminate discrimination, stigma, and any barriers that prevent individuals from receiving the appropriate care and support they deserve.

Advancing gender equity is another crucial aspect of comprehensive TB care. Even though TB incidence is higher among men than women, women carry the sum load of catastrophic cost and their needs must be given due attention. Gender-based violence, social norms, and cultural practices often hinder women's access to healthcare and can exacerbate the spread of TB. By promoting gender equity, we ensure that women have equal access to diagnosis, treatment, and care services. We must also involve women in decision-making processes concerning TB policies and programs at both community and national levels.

More Importantly, People-centered care should be at the heart of our efforts. Each individual's experience with TB is unique, and it is important to recognize and address their specific needs. People-centered care means not only providing medical treatment but also offering support, empathy, and respect to patients and their families. Let us build a healthcare system that listens, engages, and responds to the diverse needs of the community, fostering a sense of trust and collaboration.

In conclusion, empowering TB affected communities, upholding rights, advancing gender equity, and promoting people-centered care are vital for effective TB prevention, control, and treatment. Together, let us work towards building a community where everyone has equal opportunities to live a healthy life, free from the burden of TB. Your commitment and active participation in this journey are crucial, and I believe that together we can make a lasting impact.

Endalkachew Fekadu
VHS, Executive Director

Executive Summary

Tuberculosis remains a major Killer; it is among top five infectious killers in Ethiopia. Unfortunately, Key and vulnerable population groups in low-income countries are primarily affected and missed. Tuberculosis (TB) incidence in these populations can even reach 10 times higher than the national average. In addition, Ethiopia accounts for 3% of the annually 3 million missed people with TB. In 2018, estimated 31% (52,000) of incident TB cases were missed. Majority of missed cases are believed to concentrate among key, vulnerable and underserved communities. Addressing the missed cases does not only have an epidemiological implication but also raises a human right and equity issues.

Key and Vulnerable populations disproportionally affected by TB, the end of TB will not be achieved unless we find and treat all TB cases and address the clinical as well as economic and social determinants of TB. Legal, structural and social barriers increase people vulnerability to TB, which also reduce their access to TB services and impact TB affected people ability to realize their right to health. To end TB by 2030, it is important to ensure social justice by removing these barriers which prevent universal access to quality TB prevention, diagnosis, treatment, care and support. There is a disparate need to analyze the national TB and social determinants of health, health access to healthcare services, sanitation, and housing. Ethiopia is a country with a high prevalence of poverty and facing a multitude of concurrent threats including conflict, drought and floods insecurity, more than 22.6 million people are foods insecure. Continued conflict, mass movement of IDPs across regions within the country, communal violence among pastoral communities, and a fifth consecutive drought largely impacted humanitarian and development interventions (WFP, 2022).

The Ethiopian government has putted tremendous efforts and policies aimed at improving access to healthcare services for vulnerable populations especially for affected due to inadequate access to healthcare services and poverty. To address geographic, gender and Socio-economic disparities, equity-oriented, people-centered approach to expanding access to health seeks to protect disadvantaged populations from financial impoverishment health equity national policy framework in placed (MOH, 2021). More importantly, the Health Sector Transformation Plan (HSTP II) has outlined interventions which emphasize health equity, to reduce regional disparities, inequitable distribution of health outcomes and health services among KVPs. Understanding who is being missed, and why, requires disaggregated data, focusing attention on the root causes of exclusion, the social construction of gender, and the development of interventions that benefit impoverished populations. In Ethiopia, Tuberculosis (TB) is an ongoing challenge with a high rate of prevalence and mortality. TB Key and Vulnerable Populations (KVPs) include populations that are disproportionately affected by the illness, such as women, children, IDPs, prison inmates, people living in slums or overcrowded housing, remote-living people and individuals with HIV/AIDS. As per the World Health Organization's recommended approach for effective TB care and control, community rights and gender must be taken into account when addressing the issue of KVPs in Ethiopia. It is a key intervention for the ending TB and UNHLM achievement of tuberculosis (TB) care goals. Recognizing this, opportunities must be provided to ensure patients from TB key and vulnerable populations have access to patient-centered care. Patient-centered care involves taking an individual's competitive social, physical and psychological challenges into account, providing individualized support for each person affected by the disease and ensuring all care is delivered with respect and dignity.

TB Key and vulnerable populations are facing a range of barriers when they seek healthcare. They still continue to experience stigma, discrimination, and exclusion, while pervasive gender norms and stereotypes endure, with harmful repercussions on health and wellbeing as well as access to health services. In 2018, WHO revitalized UDHR commitment to a rights-based approach to health and made a call for leadership on equity, gender, and human rights to ensure equitable access. Community rights and gender in tuberculosis (TB) are important aspects of TB prevention and control due to their impact on the healthcare system, health workforce, and patient access to care. Community rights ensure that communities have a voice in determining their healthcare needs. Gender equality is critical for providing access to care for both women and men, since access to proper care can be unequally distributed among TB KVPs. Collectively, this UDHR commitment creates a foundation for empowering individuals and meets the needs of marginalized and excluded groups.

One way that community rights help with TB prevention and control is by improving local awareness about the disease. By educating members of the community about TB-related topics such as risk factors, signs and symptoms, diagnosis, treatment options, drug resistance patterns, etc., individuals can better recognize when they need to seek medical care instead of delaying a visit to the doctor or going untreated altogether. This education can also reduce stigma around the disease so people

Deribew et al., "Tuberculosis Burden in Ethiopia from 1990 to 2016." | "WHO, Global Tuberculosis Report 2022.", Shamebo et al., "Prevalence of Pulmonary Tuberculosis in Homeless Individuals in the Addis Ababa City, Ethiopia.", "GUIDELINES FOR MANAGEMENT OF TB, DR-TB AND LEPROSY IN ETHIOPIA." | NTP, "Ethiopian TBL-NSP July 2021 – June 2026."| "Stop TB Partnership, THE GLOBAL PLAN TO END TB 2023-2030." Ali et al., "Prevalence of Pulmonary Tuberculosis among Prison Inmates in Ethiopia, a Cross-Sectional Study."

do not fear seeking help when needed out of embarrassment or shame related to having TB.

Gender is another factor that needs to be accounted for when addressing TB cases among women. In 2021, globally 3.4 million women contracted TB (WHO, 2020). Although cultural norms have contributed to reluctance among some women to seek medical help due to fear of being shamed or judged negatively by those around her; it's important they're advocated for and given resources equally as those provided to men so they can access comprehensive health care without any form of neither discrimination nor stigma attached. The unequal power dynamics between men and women must also be addressed considering that male partners may restrict her access or ability seek quality services with regards to TB treatment despite this decision often interfering with her own health decisions at times influenced by customs versus genuine concerns about her health.

Gender inequality affects the treatment of TB due to unequal distribution of resources between men and women as well as physiological differences that exist between genders which must be taken into consideration when treating TB infections. Women may often lack knowledge about available treatment options because they lack access to sufficient healthcare services or providers who specialize in TB management due national policies which often overlook gender specific needs when developing strategies for disease control measures. In cases where diagnostic tests are used for confirming tuberculosis aren't culturally acceptable for certain genders then obtaining timely diagnoses may be delayed causing further complications and even death if left unnoticed or untreated long enough.

Empowering affected communities through their involvement in decision-making processes surrounding tuberculosis prevention and control will ensure equitable access to information and services regardless of gender identity. Building upon this recognition is essential when looking at how resources should be allocated throughout different regions outside of bureaucracy alone because it takes into account social factors such as gender roles or traditional cultural norms that might shape beliefs about health care-seeking behavior within various communities too which all shape how much progress is made overall in efforts towards addressing infectious diseases like tuberculosis. Ultimately, it is integral that everyone has equal opportunities when it comes removing barriers against optimal health practices along with access to quality treatments if we expect trajectories towards drastically improved outcomes among affected population due more preventative measures being taken within wider populations too while subsequently decreasing rates of transmission. Despite our national efforts to prevent new cases and treat people diagnosed with active TB, the rate seems will not significantly decline until inequities between Key and Vulnerable Populations (KVPs) are addressed through targeted interventions that focus on equitable access to resources including health care services. Addressing social determinants by reducing out of pocket expenditures, stigma and discrimination, psycho-social issues, nutritional and gender bottlenecks efficient community empowerment measures can alleviate the access disparity among key and vulnerable populations. It is essential that comprehensive CRG strategies need to be implemented to ensure equity, access along with gender and human rights responsive programs targeting affected communities in Ethiopia.

"General Assembly Resolution 72/268: Scope, Modalities, Format and Organization of the High-Level Meeting on the Fight against Tuberculosis." | Gostin et al., "70 Years of Human Rights in Global Health." | United Nations, "Illustrated Edition of the Universal Declaration of Human Rights (UDHR)." | MINISTRY OF WOMEN'S AFFAIRS (MOWA), "National Action Plan for Gender Equality (NAP-GE) 2006-2010." | Ministry of Health, "Health Sector Gender Mainstreaming Manual." The Global Fund, "Information Note Tuberculosis Allocation Period 2023-2025." |

Objectives

1

To evaluate and generate data and strategic information of gender and human rights-related barriers, to transform and promote better policy action.

2

To outline, measure and evaluate TB Gender sensitive TB programing

3

To Commence CRG analysis to implement comprehensive, multi-sectorial action plan to address inequitable access to quality TB services among at risk populations.

4

To develop advocacy strategies and costed CRG action plan to reinforce political commitment, to better respond to these barriers and needs.

FRAMEWORK & METHODOLOGIES

Stop TB partnership CRG assessment framework has been used to provide a systematic way of analyzing, understanding and recording what is happening to TB affected communities within context gender and legal environment. From such methodical evaluation of what are the interrelated issues, clear professional findings are shared through technical assistance of Stop TB partnership, Country and Community Support for Impact team. These assessments included seven thematic areas of TB CRG assessment tools to evaluate accessibility, availability, acceptability, and quality of services, legal barriers within legislation, systems and policy framework. Community engagement and participation of KVPs in TB prevention, treatment and care interventions also included. So as to generate gender-transformative programming, we Commence legal and gender analysis of TB services to implement comprehensive, multi-sectorial action plan to address inequitable access to quality TB services among at risk populations. Importantly, to reinforce political commitment, to better respond to these barriers, advocacy strategies and costed action plan developed. The systematic legal and gender data inputs and evidence generated can be used for the ongoing TB NSP development as well as GF Grant Cycle 7 submissions.

METHODOLOGIES

DESK REVIEW

It involves analyzing existing TB and CRG related datasets that were gathered with some different purpose other than addressing the current research inquiry at hand. In this method, we went through great amounts of archived data (policy documents, national guidelines, SOP, NSP review reports and published literature). In order to ensure reliable interpretation, sources carefully assessed for their accuracy and potential bias before being passed onto further investigation.

FOCUS GROUP DISCUSSIONS

It was conducted in interactive manner with a group of TB patients and trained moderator, allowing for more complex and nuanced insights. During these FGDs, the moderator asked open-ended questions related to CRH themes and encourage participants to engage in a dialogue among

INFORMANT INTERVIEW

Informant interviews were done to collect detailed information on issues that would otherwise be difficult to obtain directly from desk review. Informants often include members of TB key and vulnerable population, such as individuals living with HIV, miners, health care providers, IDPs, malnourished, diabetic patients, women who are experiencing access barriers and people who have direct knowledge of TB CRG being studied.

CONSULTATIVE WORKSHOP

It was more open format of discussion, allowing participants to freely express their views and concerns on the subjects discussed without feeling inhibited or constrained by specific questions. This approach also encourages ideas from stakeholders who may not have formed opinion on CRG prior to attending the workshop

Male Female

TIMELINE & PROCEDURES

INCEPTION AND ADAPTATION

- Concept note development
- High level commitment secured
- Core group established
- Initial desk review conducted
- Budget developed
- Assessment plan developed
- Implementing team contracts and TORs finalized
- Multistakeholder working group nominated

FIELD WORK

- Data collection planning and set up complete
- Train data collectors and interviewers
- Conduct interviews and collect data
- Track data collection plan

ANALYSIS AND REPORT WRITING

- TRANSCRIBE AND ANALYZE DATA
- DRAFT FINDINGS AND RECOMMENDATIONS
- MULTI-STAKEHOLDER FINDINGS VALIDATION MEETING
- MEETING REPORT WITH PRIORITIZED RECOMMENDATIONS DEVELOPED

ACTION PLANNING AND DISSEMINATION

- Finalize assessment report
- Develop draft costed action plan
- Core group reviews final report and action plan
- Policy and media briefs developed
- Multistakeholder action validation meeting organized
- Report edited and finalized

CHAPTER 1

CRG BARRIERS FINDINGS & RECOMMENDATIONS

WE CAN END TB.

CRG BARRIERS FINDINGS

The CRG assessment report provides a detailed review of legal, human rights and gender related barriers in Ethiopia, the purpose of this report is to inform policy makers and key stakeholders about the CRG perspective of Ethiopian TB response, identify areas of improvement or potential bottlenecks, and make recommendations for future enhancements. The findings are based on a thorough review of the program's documentation, FGDs with affected communities and stakeholders' interviews, and analysis of program data.

After conducting the review, certain findings and conclusions have been reached regarding the legal, human rights and gender dynamics of TB. These may include an overview of the program's accomplishments, success rates, cost-effectiveness, impact on vulnerable populations, or any challenges faced by the program implementation that limit its effectiveness.

72%

The 2019 EMDHS results show that 28% of households are enrolled in the community-based health

insurance scheme. Rural households (32%) are more likely to be enrolled than urban households (19%). At

the population level, 3 out of 10 (28%) Ethiopians are enrolled, while 72% are not.

COMMUNITY-BASED HEALTH INSURANCE

HUMAN RIGHT PERSPECTIVE & KVPS

The human right to health is one of the most fundamental and universal rights, recognized by international human rights law. However, policy frameworks and implementation have often failed to adequately address the needs of key and vulnerable populations, which can have significant impacts on health outcomes. Key and vulnerable populations typically refer to groups of people who are at increased risk of poor health outcomes due to various factors such as social, economic, or cultural marginalization, stigmatization, or discrimination.

Male Female

CRG FINDINGS

12%+

CBHI coverage varies by region. It is highest in Amhara (12% among women and 13% among men) and is nonexistent in Somali and Benishangul-Gumuz.

HIGH GOVERNMENT COMMITMENT

During our review and oversight, we have seen extraordinary commitment from the government to reach the vulnerable population. It was a crucial aspect of the CRG assessment process, especially in times of crises such as natural disasters, pandemics, or economic instability. This is because the most marginalized and disadvantaged individuals and communities are usually the hardest hit and require humanitarian aid, healthcare services, or social protection systems to survive and thrive. NTP that is highly committed to reaching the vulnerable population recognizes the need for inclusive and equitable policies, programs, and services that leaves no one behind. They have made remarkable progress in reaching vulnerable populations and providing them with the support they require. However, there is still much work to be done, and it is vital that governments continue to prioritize vulnerable populations and work towards achieving greater equality and social justice for all.

INCLUSIVITY OF COMMUNITY HEALTH INSURANCE

Community Health insurance is an essential financial tool in accessing healthcare services for a vast population in the Ethiopia. However, certain vulnerable and key populations are left out of the health insurance loop due to various factors hindering access to coverage. These populations include undocumented immigrants, homeless persons, low-income earners, and rural citizens. Undocumented immigrants are among those who cannot access health insurance as they do not qualify for federally funded health programs due to their immigration status. Despite the state offering community health centers that offer primary health care services to undocumented individuals, many still lack access to comprehensive packages dealing with chronic diseases and other specialized care. Furthermore, language barriers and fear of stigma may cause non-direct seeking of medical treatment, further limiting their access to basic care.

THE NEED TO HAVE CRG FOCAL POINT AT NTP

Not having CRG focal point at the national level can result in many avoidable and costly setbacks in KVPs activities. Ensuring tailored service and addressing access barriers requires a coordinated and organized approach with clear leadership, strong partnerships, and efficient use of resources, all of which can be achieved through a designated CRG focal point. Such an individual or team will allow for effective coordination of activities, reliable monitoring and evaluation of interventions, and consistent programming and policy development, without a designated person or team to oversee and coordinate CRG activities, there is a high likelihood of duplication of efforts and ineffective use of resources. This can lead to inefficiencies in the TB response, which ultimately undermines efforts to end TB. Lack of coordination and leadership at the national level can lead to fragmentation and inconsistency in CRG implementation, damaging stakeholder trust in the overall TB response. It is vital, therefore, to have a leader or teams that can ensure all stakeholders are working together towards common goals, utilizing evidence-based approaches, and promoting transparency and accountability.

AVAILABILITY OF KVPS DATA

Limited availability of data on vulnerable populations' present significant challenges for policymakers, NTP, and other stakeholders, to create tailored system and address their unique needs. Because of this, it is difficult to measure progress and evaluate the impact of interventions, often resulting in poorly informed decision-making. It is, therefore, critical to have a national-level KVPs population data to monitor epidemic trends, assess the effectiveness of prevention and treatment interventions, and track key indicators such as new infections and treatment coverage among the most vulnerable and marginalized. There is a growing need for more comprehensive and disaggregated data on a variety of factors such as age, gender, geography, socioeconomic status and access to healthcare.

CONSIDERABLE OUT OF POCKET EXPENDITURES

TB patients often bear the costs of both direct and indirect medical expenses associated with the disease. Direct costs include medical consultations, hospitalization, lab tests, and medication, while indirect costs include time off work due to illness, transportation to and from the hospital, and travel expenses to access healthcare services . These additional costs add up and place enormous pressure on patients, many of whom choose to abandon treatment altogether due to financial constraints. The financial burden of TB is often intensified by the fact that those affected are usually from the most vulnerable populations, who live in poverty and are already struggling to make ends meet. For many of these people, the cost of TB treatment may be more than their annual income, leading to severe financial strain and even bankruptcy. Moreover, the duration of TB treatment can last up to 6-9 months, making it challenging for patients to stay employed and support their families. Furthermore, TB's financial impact is not limited to patients alone, as it can also place a significant financial burden on women. Even though TB incidence is higher among men than women, women carry the sum load of catastrophic cost. In TB affected households, where men are a bread winner, women are the care giver and took the responsibility of feeding her family, which presents unique complexities and increases economic costs substantially. As a result, failing to address catastrophic cost for TB, could lead to long-term economic and social consequences, perpetuating the vicious cycle of poverty and ill-health.

THE NEED FOR GENDER SPECIFIC INTERVENTIONS

Gender-sensitive interventions are essential in addressing the issues and concerns of both men and women, promoting equal opportunities and inclusiveness that enable women to realize their full potential. Efficient health programs and approaches to reach women are essential to improve women's health outcomes worldwide. Unfortunately, in many parts of the world, including developing countries or remote locations, there is often a lack of resources and infrastructure required to deliver quality health services, particularly to women. Three main reasons for inefficiency are:

1. Lack of Access: Women who live in rural areas or marginalized communities may not have access to healthcare facilities. This is mostly due to poverty, cultural stigma, or geographical remoteness, which increases the cost and difficulty of seeking care. 2. Insufficient Education: Women with low levels of education may not understand how to maintain good health or the benefits of preventive healthcare. A lack of understanding can lead to poor health outcomes as well as misconceptions, such as believing that contraceptives cause infertility.

3. Gender Discrimination: Gender discrimination in many societies prevents women from receiving equal treatment and access to healthcare. This can worsen healthcare inequalities and result in women delaying or not seeking health services.

CONFLICT AND NATURAL DISASTER AFFECT KVPS SERVICE ACCESS

Ethiopian has been through deadliest conflict and droughts. Conflict and natural disasters can have a profound impact on the provision of health services. In regions experiencing conflict, healthcare professionals are frequently targeted for violence, leading to significant reductions in the number of functional health facilities, trained professionals and rampant looting. As a result, there is often a shortage of medical personnel, equipment, and supplies, leading to overcrowded facilities and inadequate care. Moreover, the destruction of infrastructure such as roads and bridges, loss of electricity, and damage to hospitals and clinics makes it difficult for patients to access health care. Natural disasters may exacerbate these problems by causing additional damage to already compromised infrastructure. As a result, key and vulnerable populations may not be able to access care when they need it, leading to worsened health outcomes and higher rates of morbidity and mortality.

In addition to these direct impacts, conflict and natural disasters can also affect health service provision indirectly. For example, the disruption of supply chains caused by conflict can lead to shortages of essential medications and medical supplies, while staff may be unable to safely travel to work. Similarly, natural disasters may disrupt supply chains and hinder access to these necessities. This can make it difficult to provide timely treatment, which can lead to increased morbidity and mortality rates. It exacerbates existing health disparities within a population. Poorer communities are often disproportionately affected by these events, leading to greater barriers to accessing care and poorer health outcomes. Additionally, these groups are more likely to be affected by the indirect effects of conflict and natural disasters, such as economic instability. As a result, they may be more likely to experience illness, injury, and other negative health outcomes.

SYSTEMATIC AND COMPREHENSIVE INTERVENTION TO REACH ALL KVPS

Although there are few activities, to reach key and vulnerable populations, there is a need to design systematic and sustainable interventions focus on specific areas of need, such as access to healthcare, health education, and public health messaging. Lack of effective health program and approach to reach vulnerable populations is a persistent problem in many parts of Ethiopia. The issue often arises from inadequate funding, issues with transportation, and lack of infrastructure. Limited access to healthcare services has significant consequences for vulnerable populations, including increased risk of illness and death, as well as reduced life expectancy. Another contributing factor is the lack of efficient health program is the lack of coordination between various stakeholders involved in healthcare delivery. This includes hospital administrators, healthcare professionals, and local government officials. Without proper communication and collaboration, it becomes increasingly difficult to develop and implement effective healthcare programs that are tailored to the needs of vulnerable populations.

Male Female

CRG FINDINGS

COMMUNITY FEEDBACK MECHANISM TO MONITOR HEALTH SERVICES

In many cases, communities lack feedback mechanisms that they can use to monitor health services. This can be a significant problem as it prevents community members from having a direct say in how services are provided and can make it difficult for service providers to understand what the community really needs. The impact of this lack of community lead monitoring on health service delivery can have negative consequences. In some instances, service providers may prioritize the provision of services that are not a priority for the community, or they may not close untimely and not allocate resources efficiently since they don't know the actual needs of the community. Similarly, in extreme cases, communities may feel disempowered, leading to further marginalization.

ENGAGEMENT OF TB AFFECTED COMMUNITIES AND KVPS

The engagement of Key Vulnerable Populations (KVPs) is critical to the success of community health interventions. KVPs are a group of individuals who experience social stigma or discrimination due to their identities, behaviors, or circumstances. They typically have limited access to healthcare services and are at higher risk for communicable disease. When KVPs are engaged in community health programs, they bring unique perspectives and experiences that inform the implementation and delivery of interventions. By involving KVPs in planning and decision-making processes, interventions can be tailored to meet their specific needs and preferences. This can increase the effectiveness of interventions and improve outcomes for this population. Another benefit of engaging KVPs is that it promotes ownership and sustainability of health interventions. When KVPs are involved in the design of interventions, they become invested in the success of those interventions. This can lead to increased adherence to treatment regimens and better long-term outcomes. Additionally, when KVPs become advocates for interventions within their communities, they can help to reduce stigma and increase uptake of services. There are gaps and challenges associated with engagement of TB affected communities in Ethiopia, however. Many KVPs face significant barriers to accessing healthcare, including fear of discrimination from healthcare providers and lack of access to affordable care. Additionally, KVPs may be harder to reach due to their marginalized status and may be less likely to trust traditional healthcare systems. Addressing these barriers and building trust with KVPs is essential to effective engagement. Meaningful engagement of TB affected communities is crucial for the success of TB programs. Engaging KVPs brings unique perspectives and preferences to the table, improves outcomes for this population, promotes ownership and sustainability of interventions, and reduces stigma around marginalized identities and behaviors. However, engaging KVPs presents several challenges that must be addressed through trust-building and addressing systemic barriers to healthcare access.

HEALTH EXTENSION WORKERS (HEWS) ARE OVERSTRAINED TO ADDRESS THE NEEDS KVPS

Health extension workers (HEWs) play an essential role in providing primary healthcare services to underserved populations. They are individuals who are trained to deliver basic healthcare services, promote healthy lifestyles, and provide preventative measures in communities. HEWs are considered the backbone of healthcare systems in many low-income countries, where there is a shortage of healthcare professionals. However, due to the overburden of HEWs, they face several challenges in reaching key populations.

One of the major challenges that HEWs face is the workload. The burden of community health work is typically high, and HEWs often have to cover large geographical areas/large number of households as well as 18 packages. They are also required to work long hours, which can be physically and mentally exhausting. This workload can make it difficult for them to provide the necessary care to key populations, as they may not have the time or energy to visit everyone who needs their help.

Another challenge that HEWs face is the lack of resources to perform their duties effectively. In many regions, HEWs are not provided with adequate training and equipment. They are also not paid adequately and often have to work with limited resources. This lack of resources makes it difficult for them to reach key populations, as they may not have the necessary access to specific KVPS including pastoralists and miners. Additionally, HEWs may face social and cultural barriers that prevent them from accessing certain populations. For example, in some communities, men may not be comfortable to receive care from women HEWs.

CRG FINDINGS

STIGMA AND DISCRIMINATION

In many of our FGDs, TB stigma and discrimination clearly emphasized, it refers to the negative attitudes, beliefs, and behaviors towards people suffering from a particular illness or disease. Such attitudes could have serious, long-lasting effects on the mental and physical health of affected individuals, their families, and their communities. Stigmatization and discrimination can cause social isolation, loss of employment opportunities, and negative mental health outcomes, among other consequences. Tuberculosis (TB) stigma and discrimination are significant barriers to achieve ending TB goals . TB is often associated with shame, blame, and fear in many societies, making it difficult for those affected to access health services, resources, and support. People with TB are often ostracized, shunned by their communities, and viewed as inferior or dangerous, perpetuating the cycle of stigma and discrimination. The social and economic impacts of stigma and discrimination make it more difficult to identify and treat cases of TB, resulting in increased morbidity and mortality rates in Ethiopia . Several factors contribute to TB stigma and discrimination, including lack of awareness and education about TB, cultural beliefs and practices, poverty and social inequality, and inadequate healthcare systems.

COMPETING PRIORITIES AND AGENDA

Since Ethiopia is overwhelmed by different political, social, economic and natural issues, there are always multiple priorities and agendas competing for attention. This can be seen in both inside and outside settings, where disease prevention directorate and line ministries have different priorities that they are working towards. For example, within NTP, the team may prioritize on large number of aDST, supply management, diagnostics issues and day to day program management, while the outside line ministries may prioritize conflicts, droughts, socio economic changes the country is facing. In these situations, it is important to identify the key drivers behind each agenda and find ways to balance them and continuous advocacy through communication and collaboration. By openly discussing each stakeholder's priorities and agendas, it is possible to find common ground and work towards a shared vision. This approach requires a willingness to listen to other perspectives and compromise where necessary, but it can lead to more effective decision-making and a more commitment to end TB.

COMPETING PRIORITIES AND AGENDA

the country is facing. In these situations, it is important to identify the key drivers behind each agenda and find ways to balance them and continuous advocacy through communication and collaboration. By openly discussing each stakeholder's priorities and agendas, it is possible to find common ground and work towards a shared vision. This approach requires a willingness to listen to other perspectives and compromise where necessary, but it can lead to more effective decision-making and a more commitment to end TB.

CERTIFIED FROM

Rore pererspe cone nullaceratem rendiam fugiaspit venim doloribus enetur sum latur, as alit vel iur,

COLLABORATION AND PARTNERSHIP

The key benefit of efficient collaboration is the ability to share resources and coordinate efforts across different sectors and organizations. This includes sharing data and best practices, conducting joint research and development, and collaborating on TB messaging and education campaigns. By working together, stakeholders can avoid duplication of efforts and ensure that resources are allocated in the most efficient and effective manner. Another important factor is the role of partnership in mobilizing resources and strengthening health systems. In many cases, effective TB prevention and control requires significant investment in infrastructure, technology, and human resources. Collaboration between government ministries, CSOs, affected communities, academia, and private sectors can help to increase funding and resources for these initiatives, as well as build long-term capacity to respond to future outbreaks and epidemics. Overall, collaboration and partnership are essential for achieving successful TB prevention and control, especially in the midst of complex and rapidly evolving public health challenges. By working together, stakeholders can create a more coordinated, strategic response that prioritizes the health and well-being of key affected communities. Yet there is poor collaboration is a lack of communication and coordination among different stakeholders. When parties fail to communicate effectively, it leads to a lack of trust and poor decision-making. In some cases, poor communication and coordination can cause delays in immediate responses that can ultimately contribute to delay to end TB.

LIMITED KNOWLEDGE AMONG KVPS

Literacy limitation is a crucial issue when it comes to preventing and controlling TB. Illiteracy can be a major barrier to receiving the necessary information and understanding the importance of taking preventive measures. People who lack adequate literacy skills cannot read, understand, or critically analyze health-related information, which reduces their ability to make informed decisions regarding their health. One of the significant implications of literacy limitations in disease prevention is inadequate knowledge and awareness of TB transmission and prevention. Individuals with low literacy may not understand the importance of mask, testing for TB, nutritious food, and opening doors and windows, which are vital in preventing the spread of TB, including other airborne diseases. On the other hand, people have delayed care seeking behaviors and more likely to seek medical care when they are already very sick, making it harder to contain the spread of TB. Generally, Limited knowledge and practice can significantly hinder disease prevention, control, and management efforts worldwide. Access to information, mis-understandings about illness prevention, difficulty accessing healthcare services, and lack of healthcare knowledge can all have severe consequences on an individual's ability to manage their health effectively. Therefore, increased efforts must be made to improve literacy levels and provide access to critical health information to all people in need.

Male Female

ASSESSMENT FINDINGS

SOME KVPS LEFT BEHIND

During conflicts and natural disaster, key and vulnerable populations are experiencing significant challenges related to health access. With these emergences, health care services to these populations have been disrupted, causing significant problems such as a lack of access to anti TB drugs and follow-up. Internally displace individuals and Saudi Returnees are facing issues like food insecurity, overcrowded housing, and limited access to healthcare services. For instance, Key and vulnerable populations of Manjo tribe left behind from the general populations, and excluded from critical social and economic opportunities, leading to disparities in well-being and healthcare access. These groups are often marginalized and face unequal treatment due to their race, ethnicity, religion, gender, socioeconomic status, or geographic location. In addition, vulnerable populations with limited access to resources, such as healthcare, education, income, and housing, including homeless individuals, refugees and migrants, low-income families, and people with disabilities are left behind. These groups often lack economic stability and are more susceptible to health disparities.

ENHANCE MULTISTAKEHOLDER ENGAGEMENT

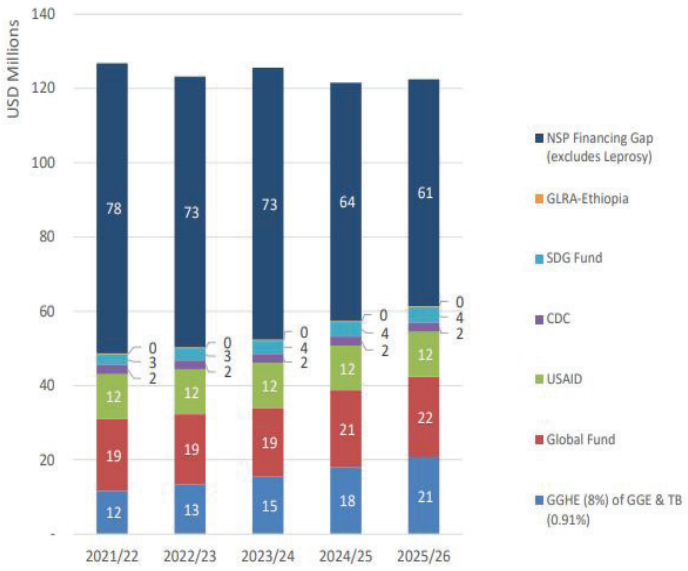
The newly developed MAF document in Ethiopia clearly articulated multi-stakeholder engagement is the key to end TB by 2030; it involves multiple actors with diverse backgrounds, opinions, and interests in TB prevention and control initiatives. More inclusive decision-making and active engagement of CSOs, media, policy makers, religious leaders, academia, professional associations and others can lead to better outcomes. Limited engagement of these key players can also result in missed opportunities for building social capital. Involving a carefully selected and diverse range of stakeholders as equal-sharing contributors helps create solutions that address common goals that contribute to ending TB goals and optimize our effort to reach key affected communities. Inadequate engagement limits innovation and direct input, critical factors to ensure accountability, also enhance transparency in decision-making. Open communication channels and consultations with all key stakeholders, helps build trust and effective collaboration. More importantly, the need to ensure meaningful engagement of KVPs is crucial, if not, it create obstacles in the implementation TB control measures. When key populations are not sufficiently involved, implementation challenges may arise due to inadequate buy-in and support from affected groups. This may lead to activities being ignores, delayed, or ultimately fail to deliver expected results. Also creates an environment characterized by mistrust among them and can negatively affect the implementation.

FUND NEEDED

"As previously stated, the total anticipated financial need for implementing the national TBL-NSP strategies and plans requires an investment of US$ 619,576,000 over five years, with an annual average of US$ 123,915,000." TB DRM ROADMAP FOR ETHIOPIA

$ 619,576,000 USD

Sources: Modeling of GGHE (8 percent) based on HTSP-II projections and assuming that TB accounts for 0.91 percent of GGHE; Financial commitment and expenditure report by TB implementing partners for Global TB Report.



53%-66% - UNFUNDED

FUNDING GAP AND FINANCIAL SHORTAGES

There is a significant funding gap and financial shortage when it comes to TB prevention and treatment. Even in Global fund funding allocation, TB doesn't have adequate financial resources for treatment and care; this has major implications for public health. The ability to detect, prevent, and control TB depends on the availability of proper resources, such as funds, personnel, and infrastructure. In Ethiopia, resources are often inadequate or insufficient, making it difficult to promote effective public health measures. This results in increased suffering, mortality, and economic burden, which reinforces poverty and economic underdevelopment. And can lead to a lack of progress in understanding the disease and developing effective treatments or vaccines. Additionally, healthcare systems may be underfunded, leading to a lack of access to prevention methods or care for those already affected. There are several reasons for this funding gap, including a lack of political will, limited resources, competing priorities, and inequality in the distribution of resources. However, efforts are being made to address this issue through increased advocacy and investment in research and development. Moreover, the lack of resources for TB prevention and control can exacerbate the impact of epidemics and challenge our effort to end TB by 2030.

KEY RECOMMENDATIONS

32%

According to the latest NHA study findings (NHA 2017), the per capita health expenditure in Ethiopia is 33.2 USD. From the total health expenditure, 32% is covered by the government, 31% is from out of pocket expenditure and 35% is from development partners.

DESERVING SERVICE

It is important to recognize that addressing the health needs of key and vulnerable populations also requires an approach that recognizes socio-economic factors and structural inequalities. This means promoting policies that address root causes such as poverty, discrimination, social isolation or marginalization. For example, policies that support equitable access to housing, education, or employment can positively impact population health by addressing key social determinants.

This can be achieved through engaging key and vulnerable populations in the policy formulation process, incorporating their perspectives, and tailoring policies to meet their specific needs. Human rights-based policies for key and vulnerable populations can help address systemic inequalities and promote social justice.

Ensuring that policy frameworks and implementation of healthcare systems adopt a human right perspective when considering key and vulnerable populations is essential to achieving equitable health outcomes. These policies must address systemic factors such as discrimination, marginalization, and structural inequality, and promote access to affordable and appropriate healthcare services for everyone. By prioritizing the needs of marginalized communities, we can build healthier and more inclusive societies that benefit us all. Policies that affect key and vulnerable populations should be grounded in a human rights perspective to ensure that their rights are protected and respected. Such policies should promote equality,

Establishing a community lead monitoring or concrete feedback mechanism to monitor health services is critical for improving public health outcomes. A feedback mechanism ensures inclusivity, accountability, and transparency in healthcare service delivery. As such, policymakers and health organizations must work with community leaders and organizations to establish a reliable feedback mechanism to ensure that health services meet the needs of all members of the community.

The overburden of community health work is a significant challenge that HEWs face in reaching key populations. In addressing this issue, governments and healthcare systems should provide CHWs with the necessary resources, support their training and development, and address social and cultural barriers that prevent them from accessing certain populations. Additionally, more investment is needed in healthcare systems to increase the number of healthcare professionals and ensure that they are better equipped to handle the needs of underserved populations.

Efficient and effective health program requires innovative tools and approach that involves collaboration between key populations, healthcare providers, and community stakeholders. Implementing innovative approaches like OneImpact, AI supported digital x-ray and many other digital techs, which can help us to bridge the gap in health access for vulnerable populations, providing hope for a healthier future.

TB program is heavenly underfunded, leading to a lack of access to prevention methods or care for those already affected. There are several reasons for this funding gap, including a lack of political will, limited resources, competing priorities, and inequality in the distribution of resources. More strategic efforts and activities desperately needed to address this issue.

31%+

The health budget in Ethiopia is low ($33.2 per capita) and 31% of overall health financing is out of pocket payments (OOP).

Addressing the catastrophic healthcare costs is through preventive healthcare measures is the key. This involves promoting health education and awareness, providing vaccinations and immunizations, conducting regular health screenings, and encouraging healthy lifestyles. By reducing the risk of illness and disease, preventive healthcare can reduce the need for costly medical treatments and procedures, especially in private sectors which in turn can lower overall healthcare costs. Additionally, early diagnosis and intervention for TB and conditions can also reduce the risk of complications and the need for emergency care.

Male Female

Managing competing priorities and agendas is a complex process that requires careful attention and strategic thinking. While there is no single approach that will work in every situation, effective communication, collaboration, and a focus on outcomes can help balance the diverse needs of different groups and achieve success as a unified team.

95%

SUCCESSFUL TB TREATMENT COMPLETION RATE

By the end of 2012 EFY, 78.7 % of People living with HIV (PLHIVs) know their status, 90% of PLHIVs who know their status were on ART and 95% of PLHIVs on ART had suppressed viral load. Regarding Tuberculosis, detection rate was 69% and 95% of TB patients successfully completed their treatment

Efforts to reduce TB stigma and discrimination oblige multifaceted interventions, involving the community, government, and healthcare providers. To address TB stigma and discrimination, governments must develop policies that protect the rights and dignity of people affected by TB, promote community engagement and education, and create a supportive environment for TB patients to access care and treatment. Healthcare providers can play a crucial role by providing compassionate and non-stigmatizing care, respecting the privacy of patients, and understanding the patient's perspective on the social impact of TB.

Addressing gender and human related barriers is indispensable to reach key and vulnerable populations who are often left behind with limited access to healthcare services. Key and vulnerable populations who are socially marginalized due to their socio economic status, gender identity or ethnicity needs targeted interventions are essential to reduce health disparities and promote health equity.

Since they have strong relationships, engage community-based organizations (CBOs) meaningfully. These CBOs can provide education and resources to help these groups understand the importance of the intervention and how it can benefit them. This approach is particularly effective for interventions that require behavior change, as CBOs can work with individuals and communities to overcome cultural or social barriers to adopt new behaviors.

KVPs specific intervention is a cost-effective, particularly when compared to broad-based health interventions which target larger populations. By focusing resources on specific areas of need, limited interventions can reduce waste and duplication, while ensuring that resources are allocated where they will have the greatest impact. Additionally, limited interventions can be more flexible and adaptable than traditional health programs, which may be slow to respond to changing health needs.

Promote community engagement and empowerment by involving community members in the planning and implementation process. This approach can help to build trust between health providers and key and vulnerable populations, while empowering individuals to take control of their health and well-being. By working collaboratively with these communities, limited interventions can create sustainable health solutions that address the unique needs of each population, while supporting health equity and social justice.

It is important to recognize that addressing the health needs of key and vulnerable populations also requires an approach that recognizes socio-economic factors and structural inequalities. This means promoting policies that address root causes such as poverty, discrimination, social isolation or marginalization. For example, policies that support equitable access to housing, education, or employment can positively impact population health by addressing key social determinants.

Engaging trusted and influential leaders in key and vulnerable populations can be an effective way to reach people who might not otherwise participate. These leaders might be political, religious or cultural figures with a large following or respect in their communities, and can be instrumental in encouraging participation or providing critical information about the intervention. By leveraging the credibility and influence of key community figures, interventions can reach a wider audience and be more effective in achieving their goals.

Continuous use mass media and informational campaigns to disseminate critical information to key and vulnerable populations. This could take the form of radio broadcasts or public-service announcements on television or social media. These kinds of interventions are particularly effective for health-related issues like TB prevention, where the need for a behavior change may not be as great, but where accurate information can still make a significant difference in outcomes.

CHAPTER TWO

TB KEY AND VULNERABLE POPULATIONS IN ETHIOPIA

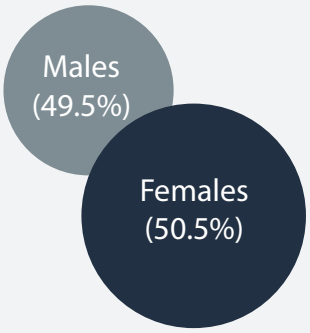
In the context of TB, it is helpful to understand why key and vulnerable populations (KVPs) are at risk of TB. We consider KVPs under three distinct groups

1. People who have increased exposure to TB bacilli (due to where they live or work – overcrowding, poor ventilation) like healthcare workers, household contacts of TB patients, workplace or educational facilities contacts, people living in urban slums and shared living facilities such as orphanages, slums, retirement homes, etc. are at risk of increased exposure to TB bacilli for a range of reasons including poor living and sanitary conditions, poor ventilation, overcrowding, malnourishment etc. Overcrowding in healthcare facilities, congregate settings especially prison and mining increases exposure to the TB bacilli and risk of developing TB.

2. People who have limited access to health services (due to gender, geography, limited mobility, limited financial capacity, legal status, stigma) like elderly and the mentally or physically disabled with limited mobility and support, remote population due to occupation like fishermen, miners, etc., the homeless, migrants, refugees, internally displaced, ethnic minorities and indigenous people who suffer stigma and discrimination. Also included are incarcerated people who may have limited access to health services.

3. People at increased risk of TB because of biological and behavioral factors that compromise immune function like people living with HIV, people with diabetes, people suffering from silicosis and lung disorders, those on long term therapeutic steroids, those on immune suppressant treatment and people who are malnourished are vulnerable to TB because their compromised immune system are less able to fight infections. Certain lifestyle activities like smoking and harmful use of alcohol and drugs increase their risk of TB infection.

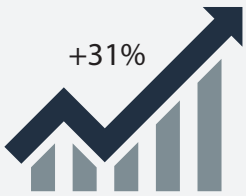
Internally Displaced Persons (IDPs) — Nationwide



As of April 2022, a total of 2.75 million IDPs have been identified.

Total IDPs, 2022

2.7 ~ 4.2 m



2021 | 2.06 m

INTERNALLY DISPLACE PEOPLE (IDPS)

According to data from United Nations Office for the Coordination of Humanitarian Affairs (OCHA, 2022), over 20.1 million people are food insecure in various regions, including 2.73 million internally displaced people (IDPs) and 1.88 million returnees in Ethiopia, the majority of who were displaced due to the recent years of conflict, drought and economic instability. The recent conflict left 3.5 million internally displaced; whereas an additional 700,000 people were displaced due to climatic shocks and loss of livelihoods. Additionally, Ethiopia is hosting more than 844,000 refugees from Eritrea, Somalia and South Sudan. Ethnic and political tensions continued to drive mass displacement, and by the end of the year, the number of Ethiopian refugees fleeing to neighboring countries reached over 874,000 in 2022 (WFP report, 2022). Conflict, political unrest and environmental disasters have created a crisis in Ethiopia: hundreds of thousands of people have been internally displaced, many seeking refuge from their own homes. The gravity of the situation is dire - without access to basic human necessities such as food and water, these vulnerable populations are left with little to no support. The limited resources that are available often times become scarce when placed under strain due to competition or emergencies. With access to limited health care, organized education systems and economic opportunities, these displaced populations experience immense suffering that has left them vulnerable to a range of health related issues including TB.

The lack of access to basic human needs leaves this displacement population exposed to extremely high levels of food insecurity, which in turn makes them more susceptible to various physical and mental health problems including; malnutrition, illness, psychosocial issues and poverty. Furthermore, internally displaced persons (IDPs) are often denied their basic rights such as freedom of movement or access to aid services – leaving them even more vulnerable during times of crisis and insecurity. Together with climate-induced conflict resulting in natural disasters like floods/droughts and extreme weather patterns, IDPs lose much more than just their homes but also means such as land for cultivation – leading oftentimes families into severe poverty by losing significant income sources from subsistence farming or pastoralism. It's essential for the government of Ethiopia to recognize the risks posed by internal displacement

Male Female

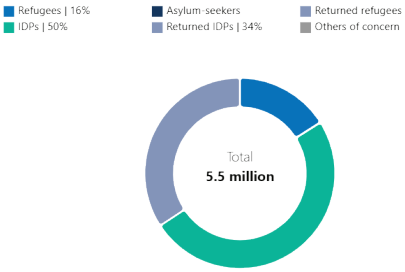
for development goals and take a holistic approach in addressing these challenges at hand so those affected feel secure enough to return home voluntarily when it is safe for them to do so. To develop a preparedness framework and assess the risk associated with displacement– specific attention must be paid towards identification initiatives related largely on mobilizing accurate data sets since key players such as local government agencies.

Through harnessing collaborative engagement of all key stakeholders, it could serve as an opportunity for coordinated contributions from civilian which could fund key activities towards restoring initiatives focusing mainly on poverty prevention & social inclusion legal frameworks introducing where necessary new & improved policies that offer greater protection mandate. Given that prolonged displacement can wreak havoc upon vulnerable populations—it's important then to try foster dynamic inter-agency disciplines through collaborative practices offering tangible reparations to improve health care access thereby addressing socio economic barriers.

IDPs

(68%) are displaced due to inter-communal conflicts, 19% are due to drought and 6% are displaced due to seasonal floods.

Male	Femele
96%	4%



Source: UNHCR Refugee Data Finder for years until 2022, UNHCR planning figures (COMPASS) otherwise.

PRISONERS

There are approximately between 100,000 and 120,000 inmates in Ethiopia, with approximately 4,800 (4%) female inmates (UNODC- office for Drugs and Crime). With a TB prevalence of 458 per 100,000 of prisoners, TB remains to be highly prevalent in Ethiopian prisons as a result of overcrowding of the prisons, poor ventilation, and inadequate healthcare services within the prisons. According to the United Nations, as of 2021, the adult incarceration rate in Ethiopia was 110 per 100,000 populations which represent approximately 130,680 prisoners living under dismal prison conditions, addressing the needs of vulnerable groups in prisons is critical, because several gaps were identified in addressing the unique needs of special categories of prisoners, including women with children and inmates with physical and mental disability. The special condition of children should be given a strong focus starting with separation of these detained children from adult inmates. More efforts should be made to address special needs, ensuring equal access to education, training and health services provided in the facilities.

The federal prison administration has introduced some measures to reduce the risk of transmitting TB amongst prisoners. These measures include providing pre-training programs on preventive measures such as ventilating rooms and providing increased access to early diagnosis. However, these interventions are not sufficient to reduce the alarming TB infection rate in Ethiopia's prisons. More concerted efforts from both the government and key TB stakeholders need to be made in order for effective prevention and control of TB amongst Ethiopia's prisoners' population. To start with, there needs to be adequate resources allocated for interventions such as providing improved medical facilities with better diagnostics tools at all levels across prison establishments. Likewise, establishing comprehensive treatment plans that cater specifically for prisoners with multidrug resistant (MDR) or any type of TB requires additional investment and support by donors. Moreover, addressing other underlying factors associated with higher incidence rates of TB within prisons will encourage reduction of transmission amongst inmates such as an improvement in overall housing conditions within prison establishments along with encouraging healthier lifestyle choices by providing educational workshops on nutrition, hygiene and substance use disorder amongst prison populations.

If all necessary steps are implemented and ensure collaboration effectively, it is possible that the level of vulnerability towards contracting TB within Ethiopian prisons can be substantially reduced over time, providing assurance that detainees have safe living environments free from disease transmission risks as much as possible depending upon available resources.

OVER 20.1 MILLION PEOPLE ARE FOOD INSECURE IN VARIOUS REGIONS

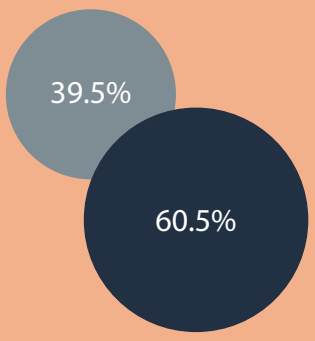
PEOPLE LIVING WITH HIV/AIDS

TB is a leading cause of death among PLHIV in Ethiopia. According to Joint UNAIDS report (2022), there are estimated 610,000 people living with HIV/AID, estimated prevalence rate of 0.9 %. Ethiopia has recorded promising decline in prevalence of HIV over the past decade, yet considerable variation among regions reported, for instance, in Gambella region HIV prevalence can reach 5.7%, 3.52% and 2.67% for Addis Ababa and Diredewa, respectively. The variation in spatial distribution associated with healthcare access, demographic and climatic factors. About 12,000 TB cases (8.4%) in Ethiopia are estimated to be attributable to HIV. The percentage of people living with HIV who report experiences stigma and discrimination in the general community and health care settings in 2021 was reported to be 24.1% and 29.6% indicating that there is significant number of PLHIV who may not be motivated to seek health care services such as for TB diagnosis and treatment. This growing figure is cause for significant concern, as it reflects a disturbing trend of human immunodeficiency virus (HIV) infection and transmission throughout the population. One of the most pressing concerns regarding HIV/AIDS in Ethiopia is the heightened risk faced by people living with HIV (PLHIV). These individuals remain particularly vulnerable to further infections, as well as social exclusion, due to their compromised defense systems, stigma of those living with HIV and other related TB factors.

Tragically, tuberculosis (TB) still remains one of the most serious health risks that threaten people who are vulnerable and affected by AIDS throughout Sub-Saharan Africa. Prolonged exposure to TB bacilli and concurrent antiretroviral treatment tend to weaken immune systems leading to extreme vulnerability and certain fatalities in PLHIV populations. In Ethiopia where poverty is prevalent, adequate access to healthcare is often scarce or not attainable at all, this threat increases exponentially due to limited preventative measures that populations can rely on for protection from threat of TB infection or relapse after initial diagnosis. Additionally many sociocultural issues contribute significantly to PLHIV populations TB vulnerability, including Stigma and marginalization within society which impacts access to care services resulting in low knowledge about preventive practices.

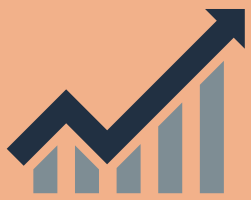
The Ethiopian government has begun taking steps towards better health management through continued implementation of national strategies such as strengthening essential infrastructure networks responsible for delivering basic healthcare services, increased funding provided by international countries such as The Global Fund whose specific remit includes helping Ethiopians gain access to ARV. As a result there has been tremendous progress by concerning authorities striving towards improving the quality of healthcare for all citizens especially PLHIVs. We are starting to see decreased morbidity from TB among PLHVIs with more recent signs indicating reduced co-infection rates too demonstrated though current public health measures including using heath information systems spread across major hospitals collecting vital data on causality and admissions which confirms diagnosis accuracy coupled with anti-TB drugs available across Ethiopian clinics meaning universal access regardless of income status. That said, it's important that programs are tailored specifically toward monitoring needs of now high- risk groups such as PLHIVs who may still be at risk because they fall through gaps left in between nationwide coverage or worse stigmatized while accessing care facilities meaning the infection cannot consistently monitored when long term follow up care is needed exacerbating any issues presenting themselves along the way. Therefore continued research aimed specifically at exploring effects surrounding time frames from multi-factor studies must continue so we can better understand.

PLHIV PREVALNCE



610,000 people living with HIV/AID

bout 12,000 TB cases (8.4%) in Ethiopia are estimated to be attributable to HIV.



URBAN SLUMS

As close to 22 million people in Ethiopia are urban dwellers, due to overcrowding, poor sanitation, and inadequate housing conditions, people in Ethiopian urban slums have been shown to have increased prevalence of TB. According to UN Habitat (2021), 64% of urban Ethiopian populations are living in slums. With a rapid urbanization rate (4.7% per year), urban slum dwellers at risk of TB would equate to approximately 14 million, Of particular note would be the homeless poor in urban shelters that make up over 50,000. In addition, urban dwellers have highest number of smokers and alcohol users, HIV prevalence, malnutrition and prevalence of Diabetes Mellitus (DM) compared with rural dwellers. According to 2022, WHO global TB report, the highest proportion of TB burden is in the age group of 15-34 (youth) combined- the age group that is currently migrating to urban areas of Ethiopia especially the capital city living in informal settlements that are prone to TB transmission and with potentially poorer health seeking behavior.

Unsafe and overcrowded living conditions, coupled with poor sanitation, provide a ripe environment for transmission of TB. People living in slums face poor nutritional status, poor access to healthcare, and high levels of undiagnosed HIV co-infection which furthers their risk of contracting TB infection and reduces their capacity to fight off the disease. The prevalence of TB among urban slum populations is much higher than that in urban non-slum areas due to the combination of these various factors. Another issue that contributes to the vulnerability of these populations is inadequate healthcare delivery systems in Ethiopia's slums which often prevent access to diagnosis and proper treatment for TB. Because reaching medical facilities may require long walks or costly transportation, there can be substantial delays between onset of symptoms and diagnosis resulting in progression from latent infection to active disease. Furthermore, those seeking medical assistance for TB may face stigma from community members due lack understanding about the disease. This stigma can lead individuals to avoid seeking treatment leading them have prolonged untreated TB infections or even reignite or stop treatment altogether as they feel embarrassed or ashamed.

In addition, endemic poverty in many urban slums results in food insecurity, under nutrition and hunger which may promote reactivation of latent TB infection into clinical infectious cases contributing to ongoing cycle of transmission within these communities— this phenomenon has been seen numerous times throughout the global context where reduced socio-economic status increases susceptibility. Moreover persistent exposure to airborne droplets expelled by an infected individual's cough furthers an individual's risk of becoming infected adding an additional challenge within households where people already exist with pre-existing vulnerability characteristics

Male Female

including age and under nutrition as well as structured inequalities associated poverty such a as discrimination, gender norms & inequities in access resources. In order to adequately address the issue of vulnerable population's exposure & TB susceptibility it is essential that we move forward with enhancing existing efforts through collaborating with local NGO's &community members themselves aimed at generating better avenues for improved care for such populations both in terms expanding financial support through public health insurance schemes and traditional fundraising methods but also providing access educational sessions focused around creating greater awareness on acknowledging risks &promoting healthy behaviors such disseminating information on preventive measures like contact tracing . It will require both integrated models utilizing multiple sectors and strategies targeting upstream & downstream circumstances influencing high risk individuals band social norms determining high-risk behavior if real progress is ultimately want achieved towards curtailing harmful impacts on limited resources impacting Ethiopians affected by tuberculosis.

The total health workforce in the base year (2016) was 219,542 out of which 150,534 (68%) were health professionals of various categories working in the health facilities and management structures.

Based on the projection estimate, the number of health professionals of various categories will progressively increase from 248,538 of 2020 and 374,368 by 2025.

HCW 2025

There will be a total of 139,652 management/administrative and support staff by 2025. The proportion of health professionals will remain between 68-73% of the total health workforce.

HEALTH CARE WORKERS

In the year 2020, in public health facilities there are more than 273,601 health professionals, among which 181,872 (66.5%) are health professionals and the remaining 91,723 (33.5%) are administrative/supportive staff. Healthcare workers are at a higher risk of TB infection due to their frequent exposure to TB patients in healthcare settings. It is estimated that there are approximately 1330 cases of TB among health care workers (contributing to 15% of cases) in Amhara region. The high prevalence of TB among healthcare workers is due in part to factors such as inadequate infection prevention and control measures. The attributable risk for TB disease in HCWs, compared to the risk in the general population, ranged from 25 to 5,361 per 100,000 per year.

The threat of tuberculosis (TB) to the health care workers in Ethiopia is a serious concern. TB is a contagious and potentially deadly bacterial infection that adversely affects both individual health and public health systems. Health care workers in Ethiopia are particularly vulnerable to TB due to their frequent contact with patients, lack of adequate protective equipment, limited resources and inadequate infection control measures. As such, these pose a significant risk to African healthcare systems as well as the health of health care workers in these areas.

First and foremost, increased contact with TB infected patients places healthcare providers at a heightened risk for TB exposure. Health care workers are six times more likely than the general population to become infected with TB due to their continuous interaction with sick people in hospitals or other medical settings. Furthermore, many African countries lack the necessary resources necessary for providing proper protective equipment such as gloves or respirators to individuals working with potential TB patients. Other countries only have limited access to such protective gear based on location or cost which can put healthcare workers even further at risk for contracting the disease. Without adequate protective measures like these, even routine procedures like taking vital signs can expose individual's directly vulnerable surface areas of the body those are open channels between patient and provider.

Additionally, it has been found that poor access to proper infection control practices leads to inadequate prevention and treatment of Tuberculosis among health care workers in Africa. In some cases, better education and training on procedures could drastically reduce rates of infection if implemented properly but this must be done at both regional and national levels in order for it to be effective since different parts of the continent have different medical needs. Furthermore, it is also essential that leaders take into account any social determinants that can exacerbate TB transmission within closed worker populations; lack of housing access or overcrowded conditions could increase chances for transmission by subjecting an individual close quarters with other infected individuals over extended periods of time.

Finally, addressing this issue requires increased investment from governments across the continent given how much all stakeholders stand to gain from curbing rates of infection among African healthcare populations-- industry wide advancements would not only ensure better safety for frontline responders but would ultimately contribute towards an improved overall standard of healthcare across borders by optimizing resource allocation towards preventative treatments available throughout communities beyond hospitalized facilities too . By putting more emphasis on preventive rather than reactive approaches we avoid long term costs associated with un timely aid both financially economically--all while simultaneously making vital progress towards sustained improvement in public heath efforts going forward throughout various parts if the continent..

Therefore although tuberculosis poses a major threat to personal and public health in Ethiopia--it's vital we don't overlook importance infectious disease amongst healthcare facilities --instituting better protection instruments—in addition to better training programs , financial /resource aid will equip those direct contact.

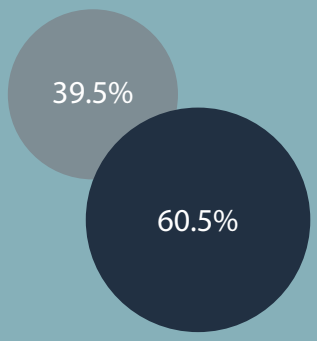
14.08 MILLION URBAN SLUM DWELLERS

MALNUTRITION

According to the latest data from the Food and Agriculture Organization (FAO), the prevalence of undernourishment were approximately 18%. Undernourishment is particularly prevalent among children in the country- according to UNICEF, in 2021, approximately 31% of children under 5 years of age (equivalent to 7.1 million children) suffered from undernourishment. In 2021, undernourishment is reported to have contributed to more than a quarter (37,000 cases) of estimated TB cases for the year (WHO, 2022). Malnutrition is closely associated with TB. In Ethiopia, prevalence of under nutrition among TB patients was ranged from 28.5% to 71.35%. This correlation has the devastating impact on individual health; it has significant social, economic and environmental consequences. The burden of TB is exacerbated by the presence of malnutrition which affects individuals' immune systems, increases their risk of acquiring TB and can make treatment for the disease more challenging. Malnutrition weakens TB patients' bodies making them more susceptible to severe cases of tuberculosis. WFP reported, approximately only 1.2 of the 6.5 million women and children moderately malnourished were assisted northern Ethiopia in 2022. TB spread is also accelerated among people living in overcrowded living conditions with limited access to good hygiene practices. Malnutrition exacerbates this problem by weakening people's immune systems, making them more likely to be infected when exposed to somebody with active TB disease. Studies have reported that dietary modifications lead to better outcomes for people at risk of infection or those who already have contracted TB. For example researchers found that a regular intake of vitamins reduced inflammation while vitamin C has been demonstrated to enhance biologic function and reduce relapse rates. Moreover, protein-rich diets have been associated with improved quality of life since they reduce symptom severity and prevent extreme weight loss caused by prolonged sicknesses such as tuberculosis.

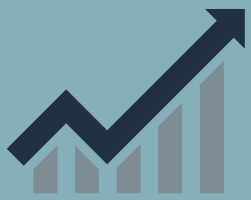
Malnutrition prevention strategies must be implemented alongside supportive care programs because preventing and controlling malnutrition among TB patients supports full recovery from the disease, reducing long-term morbidity, mortality, drug resistance levels and transmission rates into communities. Providing nutrition supplementation during treatment leads not only to an increased likelihood of full treatment completion but also to reduced disease recurrence due to better overall health status post-treatment . Although many interventions exist there needs to be greater emphasis placed on tailored nutritional protocols that incorporate both body composition assessment, enabling interventions where necessary, as well as access to food rich in macro-nutrients through community based programs such additional food aid opportunities or school lunch schemes. These interventions should focus not only on providing physical resources but also on addressing behavior change communication designed specifically towards poverty affected Tb patients about adequate diets for successful outcomes during treatment for TB cases in Ethiopia. As much emphasis should thus be placed on dietary determinants (micronutrients) as well (macro nutrients). Interventions upstream such as agricultural policies that increase availability and affordability of nutrient dense foods must be emphasized too to ensure individuals from across social classes are receiving adequate nutrition required for boosting their immunity against Tb related infections. In summary proper nutrition knowledge plays an essential role when tackling the chronic link between Africa's fighting against Tb alongside malnutrition inequality.

MALNUTRITION



22% of women aged 15–49 years are undernourished.

Only 1.2 of the 6.5 million women and children moderately malnourished were assisted northern Ethiopia in 2022.



MEGA PROJECTS

In Ethiopia, large-scale undertakings are becoming increasingly commonplace due to the need for economic and social progress in the continent. Such projects making a tremendous contribution to Ethiopia's progress require thousands of personnel to execute the projects, many of whom are exposed to TB and other serious health risks. For example, people who are employed as night watchmen or construction workers on mega projects in Ethiopia are among those particularly vulnerable to exposure from tuberculosis (TB). The main reason that many construction workers and similar personnel performing night shifts have higher risk of contracting TB is primarily due to their prolonged periods of hazardous work conditions. Working for long hours in poorly ventilated work sites with inadequate protection against dust, smoke and fumes put these employees in high-risk situations. Furthermore, there is often no provision made by employers with regards to health and safety while they are working at night on these projects, all of which puts them even more prone to having contracted TB. From a medical perspective, it should be noted that early diagnosis can help greatly in optimizing treatment outcomes when it comes to a variety of infectious diseases including TB. The problem that lies however, are that much too often those who have been exposed such workers may not recognize signs or symptoms promptly enough for effective treatment and prevention. This is one of the greatest challenges facing personnel working on mega projects in Africa; being able to detect symptoms early enough for better assurance for infection control. Therefore various steps need to be taken by organizations running such megaprojects across Ethiopian order to protect their own personnel from contraction TB and related illnesses. they must ensure they give proper access their workforce has access adequate equipment suitable attire since lack thereof tend leads increased vulnerability and susceptibility infections like tuberculosis.

Provision regular screening programs should also be done distributed regular basis those working those jobs so that can monitored properly alert any sign track changes close watch out unlikely case infections occur. It is critical company provide protective respiratory masks known as N95/approved equivalent used wide range setting shield infectious particles well adequately ventilate where necessary prevent exposure dust smoke pollutants. In short, companies operating megaprojects in Ethiopia must actively promote health initiatives within their projects especially when it comes to TB exposure prevention efforts prevent occurrence dangerous illnesses associated with prolonged exposure hazards. It up individual contractors businesses create environments conducive wellbeing safe comfortable work environment optimum outcome success risking staff security comfort.

Male Female Family

DRUG USERS/KHAT

Drug user vulnerability to HIV and other communicable diseases, including tuberculosis (TB), is a significant concern in Ethiopia. In particular, the inherent risks associated with Shisha, Khat and others often leads to a high prevalence of diseases like TB that are easily spread through contact. Furthermore, Ethiopia throughout the regions have an inadequate number of friendly public health services available for drug users, leaving them more vulnerable to preventable diseases such as TB. The pooled prevalence of current and lifetime khat range from 14.3%- 39.2%. Twelve percent of women and 27% of men have ever chewed Khat. Among Khat chewers, two in three chewed for 6 or more days in the last 30 days. The prevalence of TB among Khat Chewers is about 31%.

In addition to associated malnutrition threats to communicable disease, a lack of awareness around safe practices puts individuals and their peers at high risk for HIV/AIDS and TB infection. Drugs such as khat or marijuana may be used as a form of recreation; however, this can lead to impaired judgment and decision making when engaging in unprotected sex activities or having multiple sex partners across different locations or social networks.

Moreover, the stigma attached to khat and Shisha use can impede access to basic healthcare services including immunization and anti-retroviral drugs that could help normalize immune system functioning - decreasing chances of contracting TB or other diseases associated with compromised immunity. Unfortunately, drug users are generally impoverished, which means they often cannot afford preventative healthcare measures like regular tests for HIV status or quarantine for recovered patients. This further increases their risk of infection and mortality from treating infected illnesses like TB without access to quality care.

The insecurity that comes from poverty also affects where people sleep at night due to limits on accessing adequate housing. If a Khat chewers is living in overcrowded conditions inside dormitories without proper sanitation, healthy food options or access to clean water (as is often the case) then their chance for getting infected by airborne pathogens like TB significantly increases due to overcrowding and improper ventilation systems inside these buildings. It is especially concerning considering Ethiopia tend not have well-mapped data on exactly how many people actually inhabit these chewing within densely populated urban centers or rural areas - let alone individual rates of infection related directly with these shared household spaces making them even more vulnerable than if they had sufficient personal living quarters when tackling an illness such as TB that spread through mucous membrane transmissions such as sneezing and coughing. Thus, it is evident that Khat chewers are particularly vulnerable when it comes to contracting TB due to limited resources on preventive care measures alongside economic instability leading people into dangerous living arrangements compromising their safety against otherwise preventable ailments

38.6 per cent of children under five years are stunted. 21 per cent of children under five years are underweight. 7 per cent of children under five years suffer from wasting. 22 per cent of women aged 15–49 years are undernourished.

KHAT CONSUMPTION

Generally increases with age and peaks at age 30-34 among both women (15%) and men (34%).

DIABETIC PATIENTS

In 2021, according to the International Diabetes Federation (IDF), an estimated 1.6 million adults had diabetes in Ethiopia. and the rate is increasing rapidly in recent years due in a number of associated factors.

Diabetes is a common condition affecting people all over the world, but it can have especially dire consequences for diabetic patients in Africa. Poor and limited access to healthcare, combined with a lack of awareness, can lead to serious problems for those individuals struggling with diabetes in this region. This creates an especially vulnerable population of diabetic patients in Ethiopia who face several risks to their health due to TB. TB is most often contracted when an individual is exposed to another person who carries the disease. Unfortunately, this risk is significantly heightened in areas where access to healthcare and resources are limited because individuals are more likely to lack preventative treatment as well as healthy living practices such as nutrition and exercise that may combat the spread of TB. For diabetics, TB infection can cause metabolic changes that damage their bodies even further resulting in worsened health outcomes and joint complications that can be extremely difficult to treat or cure.

In Ethiopia particularly, diabetes has been linked to increased rates of TB among the general population, while another study has also demonstrated a link between high blood sugar level levels among diabetics and progression of TB after diagnosis. Additionally, poverty-stricken households often succumb more readily to communicable diseases such as TB due to overcrowded housing conditions that facilitate transmission from one person to another directly through contact or indirectly via contaminated air or water sources.

Diabetic patients in Ethiopia suffer an increased vulnerability compared to other regions due largely in part because of socioeconomic factors associated with poverty and limited access to medical services combined with limited awareness about how best manage their condition both before expecting signs and symptoms associated with TB infections arise. Without adequate knowledge and care strategies implemented beforehand, those living with diabetes may be more prone towards serious health complications posed by developments related tuberculosis infections which puts them at greater risk so it important continue seeking out sustainable solutions so these populations don't fall further behind regarding their overall health outcomes.

1.6 MILLION ADULTS HAD DIABETES IN ETHIOPIA

4.14% TB prevalence Rate

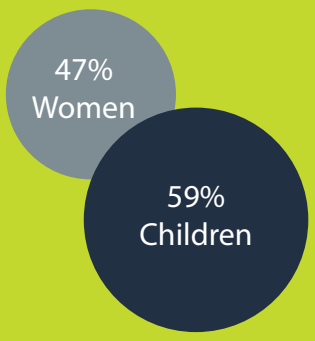
MIGRANTS, REFUGEES AND RETURNEES

Ethiopia hosts approximately 878,000 refugees and migrants from neighboring countries who are at a higher risk of developing TB due to poverty, malnutrition, and limited access to healthcare (UNHCR 2022). In addition, in the last five years Kingdom of Saudi Arabia (KSA) has returned nearly 519,000 Ethiopians back home (IOM, Press Release, 2022). In 2022 only, around 175,000 people were forcibly returned from Saudi Arabia to Ethiopia (93,500), Yemen (65,700) and Somalia (15,000). Migrants repatriated to Ethiopia were registered by IOM upon arrival at Bole Airport in Addis Ababa (82% men, 13% women, 3% girls and 3% boys). Migrants wishing to return to their homes in the conflict affected regions of Amhara, Tigray and Afar (59,400) faced particular challenges; many returnees were stranded in shelters in Addis Ababa, unable to return home, reunify with family or otherwise support themselves. Given the sudden and unprepared nature of this forced repatriation and with little or no fallback position, the seamless reintegration of these returnees has been painfully slow and largely unaddressed. Most of them returned empty-handed and have faced different economic and psychosocial challenges (ILO, 2022). According 261 000 cases reported in 2022 alone, returnees has one of the highest prevalence rates of TB in Ethiopia, approximately 1702 per 100,000 people infected this year with an estimated 1.2 million undetected cases of TB infection existing within the population (WHO). This alarming statistic illustrates how easily contagious and prevalent TB is amongst returnees and those coming into contact with it, placing migrants and refugees in great danger if they do not have access to sufficient resources preventing its spread.

Migrants and refugees in Ethiopia are particularly vulnerable to tuberculosis (TB), due to many factors, including poor living or sanitary conditions as well as inadequate access to healthcare services within refugee camps, migrants and refugees in Ethiopia have higher restrictions on their ability to seek treatment or prevent the spread of this deadly disease. Another reason why migrants and refugees are especially vulnerable to TB is because they often live in overcrowded camps with substandard levels of sanitation or other conditions that can facilitate transmission and inadequate care-seeking behavior such as limited access to healthcare services or higher cost barriers associated with seeking treatment. Without proper screening processes at refugee camps regarding current infections, those migrating usually carry latent infections which could lead to much more dangerous consequences if left undiagnosed leading again due stigmas against going leaving their community for undisclosed health problems. Therefore not only do migrant/refugees not receive proper treatment but are more likely discarded opinions avoiding diagnosis all together allowing figures like the death toll anticipated by WHO keep climbing possibly putting others life's' at risk too.

The Government of Ethiopia striving toward strengthening repatriation and rehabilitation programs and ensuring the orderly return of its citizens abroad. The involvement of key partners in the planning and operationalization of this goal is essential, emphasized an official of the Consular Affairs Directorate General at the Ministry of Foreign Affairs of Ethiopia.

Migrants, refugees and returnees



Ethiopia hosted over 823,000 refugees.

TB Prevalence Rates 1702 per 100,000

1.2m

Undetected TB cases, globally

CONGREGATE SETTINGS

In Ethiopia, TB is a major public health problem, especially in crowded settings. Most transmission of TB in Ethiopia occurs within households or densely populated communities where sanitation and overcrowding are likely to be major issues. Studies conducted at various schools and health facilities throughout Ethiopia have shown varying prevalence levels depending on the location and settings. The prevalence of smear positive pulmonary tuberculosis in holy water sites was found to be 7.4 fold higher than the prevalence in the general population in Ethiopia. The rates range from very low (<5%) up to 44%, however commonly reported prevalence values range between 10 and 20%. To reduce the spread of tuberculosis in Ethiopia's crowded settings both a strong healthcare system with adequate resources as well as public health initiatives focusing on preventive measures. In many setups across the region, poor sanitation and inadequate ventilations provide ideal conditions for the spread of TB. The overcrowding associated with large gatherings in religious settings (holy water sites) increases the likelihood of contracting TB, which is an airborne disease. Furthermore, many of these facilities are often located in areas with inadequate medical infrastructure, leaving them vulnerable to outbreaks and further infection. Congregated settings including public transport gatherings, prisons and detention centers, refugee camps, homes for the poor and homeless and urban settings for the poor dwellers are usually overcrowded and poorly ventilated that favors t/he increased transmission of tuberculosis. Crowded people are particularly vulnerable to the spread of TB due to the close proximity of many individuals in confined space. When someone infected with TB coughs or sneezes, their germs can travel up to six feet, quickly infecting those around them if no preventative measures such as masks or social distancing are used. People living in crowded areas often lack adequate ventilation, allowing airborne bacteria from infected individuals to spread more easily in confined indoor spaces. Another factor that contributes to the vulnerability of crowded people is their often limited access to health care services, due to factors such as poverty, distance from primary health care facilities and a lack of knowledge about preventive care; this leads them to receive treatments late or not at all. With a weak immune system due to poor nutrition and living conditions, these individuals do not receive appropriate treatment when they should which can cause their condition to deteriorate quickly. It is important for citizens of Ethiopia, especially those who live in densely populated regions, to be aware of the risks associated with TB so they can take proper precautions and seek medical attention immediately when any symptoms arise. For example, they need to understand that covering their mouth while coughing or sneezing can help protect themselves and others from being infected as well as ensure good hygiene standards around food preparation amongst other areas of household life. Moreover, making sure that everyone has access to quality healthcare services by providing free care in rural locations can help reduce both human suffering and poverty related diseases like TB amongst crowded populations in Ethiopia.

Male Female Family

SMOKING AND ALCOHOL ABUSE

Smoking and alcohol consumption are major health risks in Africa. It is estimated that more than 25 percent of the adult population in Ethiopia is either a smoker or consumer of alcohol. According to World Health Organization (WHO) estimates, 79,000 deaths occur annually due to tobacco consumption and about 17 million premature deaths occur due to consumption of alcohol worldwide. And an estimated 20% of adult TB cases are attributable to smoking.

Approximately 3% of adults in Ethiopia smoke tobacco products (WHO report on the global tobacco epidemic, 2021). According to the latest available data from WHO, smoking rates are higher among men than women, with 13.9% of men smoking compared to 1.1% of women. The higher prevalence of smoking is among people aged 25-34 years, with 12.4% of this age group being smokers. TB notification is also among the highest in similar age group and sex (men) indicating that tobacco smoking may be one of the contributing factors for disproportionately higher TB in men of this particular age group. Of the estimated 143,000 incident TB cases in Ethiopia in 2021, approximately 3,100 cases (2.2%) are attributable to smoking while 8,200 cases (5.7%) are attributable to harmful use of alcohol.

Tobacco consumption and drinking of alcohol have been linked with serious diseases such as lung cancer, cardiovascular diseases, diabetes and chronic obstructive pulmonary disease. Ethiopia has some of the highest prevalence of these non-communicable diseases in the world. The tobacco industry has been aggressive in marketing its products across Africa, resulting into an increase in smoking among both adults and youths in the country. There is a higher prevalence rates for cardiovascular risk factors among smokers compared to non-smokers which makes them prone to cardiovascular diseases at an early age. Alcohol also has negative impacts on human health including liver cirrhosis, birth defects, dementia and certain cancers as well as other mental health disorders. Studies have found that binge drinking is commonly done by young people leading to increased risky sexual behaviors among them which put them at a higher risk for contracting HIV/AIDS.

It is evident that smoking and alcohol use significantly contribute to morbidity and mortality rate in Ethiopia which could be curbed through prevention initiatives by governments, health organizations, private sector companies, civil society groups etc . These institutions should focus on implementing effective interventions that help people quit smoking like mass media campaigns targeting specific audiences who still smoke , increase taxes on cigarettes , provide hot line services , school based programs providing information about dangers of smoking . Similarly platforms such as Education on risks associated with hazardous use of alcohol through community outreaches, taxing alcoholic beverages can be implemented. Enforcing laws on sale purchase and advertisement can definitely help reduce vulnerability related behaviors caused by addictive substances which will lead to better health outcomes for people living in Africa.

"Ethiopia hosts over 823,000 refugees and asylum seekers predominantly from South Sudan, Somalia and Eritrea. The majority lives in 24 refugee camps established across five regional states. Over 70,000 others also reside in the capital Addis Ababa as urban refugees. 47% of the refugees are women and girls, while 59% are children. Ethiopia also has 4.2 million internally displaced persons (IDPs) and over 1.5 million IDP returnees, largely resulting from the ongoing conflict in northern Ethiopia and localized conflicts and tensions in different parts of the country."
UNHCR

ALCOHOOL

Six percent of women and 9% of men consumed alcoholic drinks almost every day in the last 30 days.

MINERS

As the country's mining sector is largely informal and unregulated, there is limited data available on the number of people working in the sector. The estimated number of people involved in gold mining (legal and illegal) is estimated at 1.24 million. TB prevalence among miners in Sub Saharan Africa is estimated at 3,000–7,000 per 100,000, which is about 10 to 50-times higher than in the general population. Miners in Ethiopia are vulnerable to Tuberculosis due to a variety of factors. The first factor is that the miners often work in unventilated, dusty conditions, creating an environment where airborne bacteria and viruses can spread easily. This is particularly true of underground mines, where dust levels can reach alarming heights and ventilation systems are not always adequate or maintainable. In addition, miners often work long hours without respite, meaning they have weaker immune systems and are less able to resist infection than people with outside employment.

Another factor is poverty, miners generally live in substandard housing that provide little protection from the elements, giving them colds and other health problems which predispose them to TB. Furthermore, insufficient education about how such diseases spread means simple preventive strategies like hand washing and sanitary waste disposal for disposing of sputum are not put into practice as much as one could hope for. Poverty also leads to malnutrition which further compromises their resistance to infection by TB bacteria.

A third factor is inadequate healthcare provisions for miners, particularly those operating illegally in artisanal mining practices. Such miners may struggle even more with access to medical services and becoming aware of tuberculosis symptoms before the condition becomes severe enough to mean hospitalization or death in some cases. Finally, overcrowded living conditions can lead to further spread of TB, caused either by transmission between people or through inadequate sanitation due to overcrowding making it difficult for persons living there to keep things clean, once again promoting opportunities for transmission of the disease.

1.24 MILLION ESTIMATED MINERS

PASTORALISTS

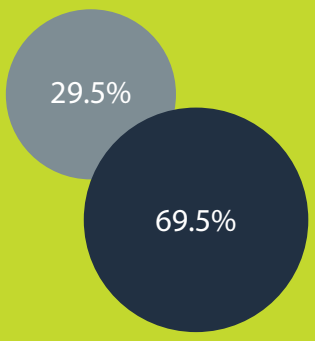
Pastoral areas in Ethiopia cover two thirds of the land mass of the country and support 12-15% (or 12- 15 million people) of the country's human population and 2-3 million households are pastoralists and agro-pastoralists, herding their livestock in the arid and semi-arid lowlands. The first population-based nationwide survey in 2010-2011 recorded a point prevalence rate of 316 (163-468) per 100,000 populations, with pastoral areas has a prevalence much higher than the national average. Pastoralist communities in Ethiopia often have limited access to health care services which makes it difficult to diagnose and treat TB in these areas. Pastoralist communities face numerous challenges when it comes to accessing healthcare. These challenges are often associated with their unique way of life and geographical location. There are a number of barriers that affect TB healthcare access for pastoralist communities. Firstly, the mobility of pastoralist communities poses a significant obstacle to accessing healthcare. These communities frequently move with their livestock in search of grazing lands and water sources. This mobility makes it difficult for healthcare providers to deliver consistent and regular services to these populations. The lack of fixed healthcare facilities in remote areas exacerbates this issue, as pastoralists may be far from any medical facility when they need healthcare services.

Secondly, there is a lack of healthcare infrastructure and facilities in pastoralist areas. Many pastoralist communities reside in remote and marginalized regions with minimal or no access to basic healthcare facilities. The absence of health clinics, hospitals, and trained healthcare providers denies them essential medical attention. Furthermore, the limited availability of medical supplies and equipment in these areas hampers effective diagnosis and treatment.

Thirdly, language and cultural barriers contribute to healthcare access challenges. Pastoralist communities often have their own languages, which may not be understood by healthcare providers who speak different languages or dialects. This communication barrier can hinder effective diagnosis and treatment. Additionally, cultural beliefs and practices may influence the utilization of healthcare services, leading to reluctance or avoidance of modern medical care.

Lastly, conflicts and drought in pastoralist areas further compound the challenges to healthcare access. Pastoralist communities residing in conflict and natural disaster-affected regions often face disruptions in healthcare services. Insecurity, displacement, and destruction of healthcare infrastructure during conflicts hinder access to timely and quality healthcare. Furthermore, the aftermath of conflicts can create long-lasting health consequences, such as trauma and psychological distress, which require specialized care often lacking in these communities. Addressing these challenges requires a multi-faceted approach that focuses on strengthening healthcare infrastructure, ensuring culturally sensitive healthcare services, improving health literacy, and addressing socioeconomic inequalities. Collaborative efforts between governments, non-governmental organizations, and local communities are necessary to overcome these barriers and ensure equitable healthcare access for pastoralist communities.

PASTORALISTS



12-15 million people) of the country's human population and 2-3 million households are pastoralists.

TB prevalence rate of 316 (163-468) per 100,000 populations

HOMELESS

A recent report by the Ministry of Labour and Social Affairs places the number of homeless people in Addis Ababa at around 24,000 in 2018; approximately 10,500 street children and 13,500 homeless adults. Bacteriologically confirmed TB incidence among homeless in Addis Ababa was 1054 per 100,000 populations, where as in Dessie and Debre Birhan towns, Northeast Ethiopia study finding implies that there were 505 smear positive PTB per 100,000 homeless individuals. They may face significant challenges when trying to seek medical help for their condition because the streets typically lack adequate access points for medical care or financial capability for costly treatments due to sigma barriers which could start off chains of discrimination from medical providers preventing them from receiving necessary means. Socioeconomic factors play a role in healthcare access challenges for homeless. Poverty and limited economic opportunities make it difficult for these communities to afford healthcare expenses. Lack of financial resources results in difficulties in paying for transportation costs to reach healthcare facilities or purchasing necessary medications. Additionally, limited education and health literacy among homeless impede their ability to navigate the healthcare system and understand their healthcare rights. Importantly, although everyone can get TB regardless of where they come from having necessary resources accessible to maintain hygiene guidance found in clinics surrounding these homeless communities can eliminate some dangers that cause its increased prevalence amongst groups most commonly facing such challenges.

More specifically, Ethiopian cities have also a realm of homeless people where live in dirty tents, slums, caves, pipes, under flyovers and along roads with relative inadequate facilities. Such people do not easy get job, access all social services because a majority of them lives without any records regarding their birth date, place, address of identification, photo identity and so on. This directly related to Community Based Health Insurance (CBHI) access limitation. Homeless are among those who cannot access health insurance as they do not qualify for federally funded health programs due to their current status. Despite the state offering community health centers that offer primary health care services to undocumented individuals, many still lack access to comprehensive packages dealing with chronic diseases and other specialized care. Furthermore, language barriers and fear of stigma may cause non-direct seeking of medical treatment, further limiting their access to basic care.

CRG BARRIERS

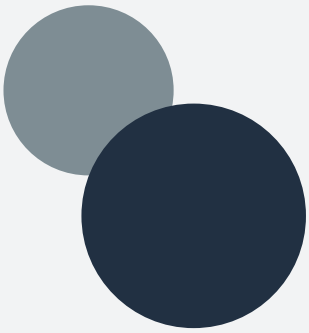
TB KEY AND VULNERABLE POPULATIONS PRIORITIZATION

Key vulnerable populations face various challenges that contribute to their increased vulnerability to TB. Addressing these challenges requires tailored and comprehensive strategies that consider the specific needs and circumstances of these populations in order to effectively prevent, diagnose, and treat TB. Ensuring quality and reaching the most vulnerable for TB with limited health resources is the key complement of this assessment. National TB program need to make strategic prioritization to use of public funds in efficient and effective manner as well as introduce tailored TB case finding interventions allow for optimized resource management. By identifying specific risk factors, geographic areas, or populations that require targeted interventions, resources can be directed where they are most needed. Recognizing the varying needs, challenges, and contexts of different populations, these interventions enhance the detection and diagnosis of TB cases, ensure equitable access to care, and optimize the use of limited resources.
There are several KVPs Prioritization parameters that can be considered to prioritize TB case finding interventions for vulnerable communities in our consultative meetings. These parameters help in identifying and addressing the specific needs of these communities, ensuring that interventions effectively reach those who require them the most. These include cost effectiveness, the severity of the barriers, the ability to have a measurable impact on the TB epidemiology and estimated incidence in the key and vulnerable communities.

1. CRG Barriers: One important prioritization is evaluating the CRG status of the community. Low-income areas and populations facing poverty, unemployment, or lack of education often experience significant barriers in TB case finding interventions. Prioritizing interventions for these communities can help bridge the gap and ensure equitable access to TB case finding interventions.

2. Demographic Considerations: Understanding the demographic composition of a vulnerable community is crucial in identifying their unique health needs. Age, gender, ethnicity, and cultural factors can significantly impact access to healthcare. For instance, interventions can be tailored to address specific health concerns faced by elderly populations, pastoralist, prisoners, or vulnerable groups within the community.

3. Epidemiological Indicators: Assessing the public health impact within a vulnerable



60.5% of the total market share is increased in 2020

community helps to prioritize KVPs in resource limited settings. This can include analyzing data on disease prevalence, mortality rates, health behaviors, and risk factors. Prioritizing interventions based on these indicators allows for targeted efforts in prevention, treatment, and health promotion specific to the community's needs.

4. Health System: Evaluating the existing healthcare infrastructure and its capacity to serve vulnerable populations is another crucial parameter. Insufficient healthcare facilities, inadequate staffing, or limited resources can create significant barriers to access.

Prioritizing interventions in areas with limited healthcare infrastructure will help strengthen their capacity and improve accessibility for vulnerable communities. It is essential to consider these parameters holistically to prioritize TB case finding interventions effectively. Tailoring interventions based on human right perspectives, demographics, health indicators, and human rights and gender sensitive programing can lead to more equitable and impactful healthcare interventions for vulnerable communities.

	KVPs	Popn	TB Prevalence per 100,000	Most Affected
1	Internally displaced people (IDPs)	2.73 Million	N?A	Women and Children
2	Prisoners	130,680	458	Men
3	People living with HIV/ AIDS	610,000	4X N.V.	Women
4	Urban Slums	14.08 Million	N/A	All
5	Malnutrition	21.6 Million	31.1% of cases	All
6	Khat Chewers	19.55%	N/A	Men
7	Mega Projects	N/A	N/A	Men
8	Diabetic Patients	1.6 Million	5.8%	Men
9	Congregate settings	N/A	7.4X N.V.	All
10	Smoking and Alcohol	3.6 Million	20% of all cases	Men
11	Migrants, refugees and returnees	2.76 Million	1072	Women and Children
12	Miners	1.24 Million	3000-7000	Men
13	Pastoralists	13.5 Million	316	All
14	Homeless	24,000	1054	All
15	Health Care workers	273,601/Public Only	1.9 to 5.7X N.V.	All

OVERALL PROGRESS

Andicipi ssunt, quaspella soluptas mincill esequidias voluptatquia dol Ferionest, sero coris sandae moluptatur aute volorer umquiae everae quatus ius, imusant odicipsam et poris rem velitatis aut que re voluptatus re nestinu lparchic tem quuntent dolupta turions.Offictatem non plit officid moluptate volles era nihil idemperit elenestiunt magnis apedign atquiaestium sequi dolorem porisit officiis modit eos aute con nis sequisi tem faceperum seque quo exero es essit.

LOR SIT QUAS VELLO- **13% //**

PROSPECTIVE

Orientation Company
134-34 New york

$120

Simple Start For Your Personal to Cor-

BASICEARNING
$ 3598

EARNING SHARE
$ 3.5

UNITE SHARE
1.6%

PRODUCTION
21%

UNITE SHARE
1.6%

UNITE SHARE
1.6%

UNITE SHARE
1.6%

Lorenda volest poribus vent laborum quos sum ex et eosant odisi

CHAPTER THREE

GENDER BARRIERS

TB and Gender Perspectives in Ethiopia

The gender perspective dimension of the right to health framework encompasses states' obligation to "integrate a gender perspective in their health-related policies, planning, programmes and research," including the disaggregation of health data according to sex. Indid Gender is relevant to all aspects of the TB response. It shapes who is at risk of infection and disease, when and how diagnosis occurs, treatment access, the likelihood of adherence and treatment completion, and the social and monetary consequences of TB disease. A gender-based approach to TB acknowledges and responds to the social, legal, cultural, and biological issues that underpin gender inequality and contribute to poor health outcomes. Gender-based responses to TB are further built on the acknowledgment that all TB interventions have the capacity to either reinforce or mitigate harmful gender norms. This section outlines the legal and practiclal measures, and evaluates TB gender perspectives in Ethiopia for better policy action.

The 2019 UNDP human development report indicates that Ethiopia is among countries with the least gender development index with female and male human development index (HDI) of 0.424 and 0.501, respectively. The country ranks 123rd among 162 countries in gender inequality index (UNDP Human Development Report 2020). Key inequalities, such as in access to and control over assets and resources, education, financial and health services are reflections of the gender inequality in the country.

In both men and women, TB predominates in the younger age group, with more than 70% of nationally notified all forms of TB in the age group of 15-44 years, with the highest among 15-34 years of age (Final Draft TBL-NSP 2020). Analysis of service level data in some settings show that among persons with presumptive TB, those between 18-24 years of age have more than 6.7 times and those aged 25 -34 years 4.5 times likelihood of being diagnosed with TB compared to those ≥ 45 years of age.

There is gender disparity in TB case notification. Forty three percent of the 2018 notified TB cases are female in contrast to 57% male. The greater share of TB cases among men (with a ratio of 1.2) in Ethiopia is consistent with global reports and indicates higher TB treatment coverage gap among men compared to women (Final Draft TBL-NSP 2020).

The TB treatment coverage gap is higher among adult men, compared to women. In both men and women, the largest treatment coverage gap is among 15 to 34 years age group. A multi-year synthesis of burden of TB in Ethiopia indicates that all-cause mortality, while on TB treatment, is higher among men compared to women.

A longitudinal community-based intervention study in Southern part of Ethiopia shows that HEWs identify more female than male patients with TB, while health centres identify more men than women with TB (Datiko DG, Yassin MA, Theobald SJ, et al 2017). This may signify gender differences in the choice of health facility visit for TB or health services in

"ADDIS ABABA HAS THE LOWEST PROPORTION OF FEMALES WITH NO EDUCATION (19%), WHILE SOMALI HAS THE HIGHEST PROPORTION (65%)."

higher among women, HIV positive men are lagging in terms of knowing their HIV status. In urban Ethiopia, 83% and 70% of women and men knew their HIV status, respectively.

Work-related financial barriers accounts high in accessing TB services among men in Ethiopia. Several young men in the lower income quantile work in the informal sector, tend to be migrant workers or employed in small businesses, where paid-sick leave is "a luxury". When sick, several have to choose between their daily income and visiting clinics. On the other hand, routine health services are provided during working hours, so are household visits for contact investigation. Outreach services will need to incorporate flexibility and innovativeness to reach young men.

Women

Gender-related barriers in healthcare access in Ethiopia are complex and multifaceted, with several factors contributing to the disparGender-related barieres in healthcare access in Ethiopia are complex and multifaced, with several factors contributing to the disparities experienced by women. The key barriers include socio-cultural factours, health litracy, financial constriants, lack of gender-responsive services,gender based violence, unequal power dinamics, and health infrastructure and transportation.

Women in Ethiopia generally access biomedical healthcare to a greater extent than men, largely because they start to engage with the healthcare system through family planning and pregnancy. Due to involving female community health workers in TB screening activities, more women are detected and successful treated (Datko DG. And Lindtjorn B 2009). However, women specially rural women experience more challenges in accessing health services. Compared to men, women would be more affected by the high TB patient cost. Economic barriers pose a significant challenge for women seeking healthcare services. Poverty rates tend to be higher among women, making it difficult for them to afford transportation costs, consultation fees, medications, and other healthcare expenses. Inadequate financial resources often force women to choose between healthcare and meeting their basic needs. Rural women, for instance, are less likely to have disposable cash; hence, financial barrier (due to OOP at time of service use) might be more dismal to them.

Additionally, experience from other health services highlight rural women's differing experience in travelling long distance to reach to the "nearest health facility", both in terms of "lost time" and ''travel costs'', partly due to their multiple social and household re-

general. It could also be related to the all-female HEWs and HDAs more frequent contact with women at community level to provide MNCH and family planning services.
Main national TB programme data are disaggregated by gender. Further gender disaggregation, from the initial TB screening across the care continuum, is essential to better understand gender equity in access and reimagine service delivery models that reach all. In Ethiopia, efforts have been made to mainstream gender in the health sector with the objective of promoting equitable access to services and empower women. National guidance and support are provided to address structural issues and institutionalize equity. Addressing gender inequality and barriers with concrete gender-responsive interventions is essential. There is a need for an in-depth analysis of role of gender in TBL related health needs and preferences; and explore opportunities to support various communities. The underlying reasons for gender-based differences through the entire patient pathway and care continuum need to be articulated in designing informed equitable service delivery models.

Accessibility, Availability, Acceptability, Quality of Services, Vulnerability and Impact to infection

Men

In Ethiopia, there is a significantly increased TB risk among men compared to women. There are several reasons why men are at higher risk of TB infection and disease than women in Ethiopia. Men are at increased risk of TB infection due to higher rates of cigarette smoking compared to women. Smoking prevalence among male adults in Ethiopia is 7.3% compared to 0.4% in women (Ethiopia STEPS Survey 2015), which increased there risk of TB infection. Men also have higher levels of substance use, including alcohol and drugs than women. Studies linked alcohol consumption to increased TB risk and non-adherence to treatment in Ethiopia (Matiwos Soboka et al. 2016; Alemu YM et al. 2016). The percentage of men who engage in heavy episodic drinking is higher (20.5%) compared to women (2.7%)(Ethiopia STEPS Survey 2015). Diabetes Mellitus (DM) which have a 3-4 times increased risk of developing TB, as compared to the general population, and also delays smear conversion and isassociated with increased mortality and relapse after successful completion of TB treatment (A.D Harries et al. 2016), is slightly higher among male than female adults (5.8% Vs 5.0%).
Men are also at increased risk of TB infection due to occupations with a high risk of TB infection. Workplaces such as mines, mega development projects, and constructions are traditionally dominated by men. For instance, there are an estimated more than a million artisans in 40 woredas of five regions of Ethiopia (Ethiopia STEPS Survey 2015). The majority of traditional miners are young men and migrant workers. Only six percent of miners are formally organized (i.e. licensed); most are unlicensed and informally operating. A project-based screening, from 2016-2018, of persons engaged in mining indicates a very high TB notification per population.
The Ethiopian labour law provides all employees with the right to be protected from occupational injury and disease and the right to compensation. In practice, however, participants in this research seemed unaware of their rights to a safe working environment, to compensation for occupational injury and disease and to access to justice for rights violations.
Men's number also tends to be higher in prisons and other congregated settings (such as homeless shelters, police custody, and military camps). Several men working in mines, mega development projects, and living in urban congregated settings are young migrant workers. Though the HIV prevalence in Ethiopia, is

SCHOOLING

Almost half (48%) of women in rural areas have never attended school, as compared with 25% of urban women.

27% WOMEN 54% MEN.

Percent of women and men who own a mobile phone

MEDIA ACCESS

Nearly three in four (74%) women and 62% of men have no access to radio, television, or newspapers on a weekly basis.

HEALTH INSURANCE

Overall, 95% of women and 94% of men age 15-49 are not covered by any type of health insurance

sponsibilities, and the high TB stigmatization in women than in men (Final Draft TBL-NSP 2020). The limited healthcare infrastructure, especially in rural areas, coupled with inadequate transportation options, further restricts women's access to healthcare services. The lack of nearby clinics or hospitals forces women to travel long distances, resulting in increased costs, time constraints, and logistical challenges.
Women also reported greater stigma with family members as well as psychosocial consequences, feelings of isolation, and lack of proper care from the family. Furthermore, women were described as more likely to be stigmatized in communities where the level of family stigma was reported as low, but the community perception of TB as associated with immoral behavior was high. Divorce as a direct consequence of TB is more likely to affect females, and, TB-infected females are more likely than TB-infected males to face difficult marital prospects.
Studies revealed the sociocultural context of women's roles and status in society permeated the observed gender differences, clearly demonstrating that norms of practice and social hierarchies lead men and women to face different barriers to accessing TB services. For women, the primary barriers included the lack of autonomy, the need to seek permission from male partners or family members before accessing healthcare, the requirement to be chaperoned to a consultation, and lack of family support, leading to delays denial of necessary care. These unequal power dynamics within households and communities hinder women's decision-making authority concerning their own health.
Inaddition, women generally wait longer than men to seek healthcare because of household duties. Families (including women the selves) often deprioritie women's health needs in the long list of social and family/household responsibilities. Furthermore, the pri itization of men and children's health, and the expectation that an ill wife must take care of her husband, but not vice versa are furtl barriers to accessing TB services.
Lack of gender-responsive services poses the other barriers to accessing TB services for women in Ethiopia. Healthcare systems of fail to adequately address women's specific health needs. Services are designed without considering gender dynamics, resulting inadequate reproductive healthcare, limited access to contraceptives, and insufficient mental health support, among other issu The lack of privacy in health clinics with the use of directly observed therapy (DOTS) posed a particular problem for women who perienced greater embarrassment and anxiety than men and this pose a barrier to seeking treatment (Daniel G. Datiko , Degu Jere

and Pedro Suarez 2020).
Gender-related differences in health literacy is the other barriers to accessing TB services. Several studies reported that women in Ethiopia has lower levels of TB-related knowledge than men (Daniel G. Datiko et al. 2019). This disparity corresponded with largely due to higher male educational attainment and gender-related differences in general literacy. In traditional Ethiopia, girls have been denied schooling opportunities in most regions and societies. According to the Ethiopia Mini Demographic and Health Survey 2019, 43% of females age 6 and older have never attended school and 40% of women age 15-49 have no formal education. Among most of the female population, primary school is the highest level of schooling attended or completed; 43% of females age 6 or older have completed some primary schooling, and 4% have completed their primary education. Only 1% of women have completed secondary school, and 3% have more than a secondary education. The median number of years of education for Ethiopian women is 0.6 years. Over the past two and a half decades, while great progress has been made in increasing education access and achieving gender parity, substantial barriers exist in terms of progression, completion and learning outcomes, with girls in more rural and remote areas facing the greatest difficulties. Level of literacy of women has an effect on there health literacy. In addition, both general literacy and health literacy are important predictors of health status (Sørensen K, Van den Broucke S, Fullam J. 2012). Poor literacy can affect health directly by limiting personal, social and cultural development of individuals, as well as hindering the development of health literacy(Ibid). The lack of accurate TB-related knowledge impacts individual and community perceptions of disease and can also perpetuate stigma (I. S. Kickbusch 2019). The poor litracy of women in Ethiopia leading to lower health literacy rates, which hinder their ability to understand and engage with the healthcare system.
Accordingly, community-level programs that provide education on TB symptomatology, risks, and treatment options will continue to be important. However, to prompt more women to seek TB diagnosis and treatment, existing strategies as a mode of TB education delivery will need to be supplemented with novel genderspecific approaches. For example, interventions that increase the general literacy of women might expand the uptake and impact of existing TB education campaigns that use written materials to explain TB disease mechanisms and treatment. In addition, to optimize the access and uptake of general literacy and TB education programs among women, tailored health communication strategies need to be developed that take into account the financial dependence, lack of autonomy, deprioritization of care, and household roles that impact women's lives. Integrating health education programs with innovative interventions that foster intrinsic motivation and self-advocacy among women may also help overcome the substantial sociodemographic challenges that women face when seeking TB care.
Furthermore, a strong correlation exists between women's empowerment and health, as measured in the EDHS by household decision-making and women's reported acceptance of wife-beating in some circumstances. With increased empowerment, women's health-seeking behavior increase. The prevalence of gender-based violence in Ethiopia creates significant barriers to healthcare access for women. Fear of stigmatization, lack of legal protection, and inadequate support systems prevent many women from seeking necessary care and support.

Legal and Policy Framework Impacting on TB and Gender equality

At international and regional levels, Ethiopia has ratified several binding conventions relevant to protecting gender equality, many of which have been set out above. The Beijing Platform for Action (1995), though not legally binding, outlines a number of actions to respond to and prevent gender-based violence against women. It aims at removing all the obstacles to women's active participation in all spheres of public and private life via ensuring equal share in economic, social, cultural, and political decision-making. It also calls for an increase in the role of States in the elimination of violence against women, ending discrimination, and promoting health, education, and economic opportunities for women.
More recently the UN Millennium Development Goal to which Ethiopia acceded, on Gender Equality and Women Empowerment has become an effective way to bridge the gender gap in education, combat feminized poverty, and improve health and HIV/AIDS, and other sectors to stimulate development.
At national level, a lot has been done in Ethiopia in terms of putting in place a policy framework providing for the protection of the rights of women that may have a direct or indirect relevance to addressing the vulnerability of women to TB. In addition to the National Policy on Ethiopian Women (NPEW) and the Health Sector Transformation Plan (HSTP-I, HSTP-II), the National HIV/AIDS Policy, several setoral policy documents have attempted to address the issue in different ways.
The last decade has also seen a significant legislative reform endeavor directed at providing better protection of the rights of women in Ethiopia. In addition to the

ing women (Article 597), prostitution of another for gain (Article 634), and physical violence within marriage or in an irregular union (Article 564), and abduction (Articles 587- 590). Traditional practices including Female Genital Mutilation (Articles 565-6), and early marriage (Article 649) are also considered as harmful traditional practices and lead to a penalty for contraventions. Furthermore, Where communicable disease has been transmitted to a women who is victm of rape, articles of the code which creminalise intentional and negligent transmition of communicable human disease (includes TB) applys concurrently (Article 620(4) and Article 522(1) and (2)). This is relevant in addressing factors increase women vulnerability to TB infection and disease. Indid, the fact that the criminal code criminalized harmful traditional practices that cause injuries, health problems, and the deaths of human lives, and those forms of violence against women, addresses the patriarchal social and cultural norms that impact women's decision-making autonomy and increase their vulnerability infection and disease, in general and specifically in context to TB.
The Ethiopian government also has recently amended its legislation by excluding rape crimes from pardon and amnesty laws as it lengthened jail terms for sex offenders.
Sex work is not criminalised in Ethiopia. Considering that sex workers are at high risk of HIV exposure and its co-infections, including TB; the fact that the law hasn't criminalised sex work positively impact on their ability to access services - including health care services.
The Labor Proclamation No.1156/2019 is one of the laws that address discrimination at workplaces. The Proclamation affirms that women shall not be discriminated against in all respects based on their sex (Ar.87). The principle of equal remuneration for equal work is recognized by the Labour Proclamation and women can't be discriminated against, in matters of remuneration, on the grounds of sex (Article 14(1)(b)). It also introduced a new regime to regulate workplace sexual harassment and sexual violence by prohibiting any attempt to commit sexual harassment or sexual violence at the workplace and physically abusing anyone in the workplace (Article (14)). Employees that have suffered sexual harassment or sexual violence will be entitled to terminate their contracts without notice, and will also be eligible for severance payment and compensation. The law provides a higher amount of compensation payment for employees who are forced to terminate their contract, without notice, for reasons of sexual harassment and sexual violence. Forced termination of contracts by employees for reasons that are unlawful acts of the employer will entitle the employee to a one-month compensation payment whereas sexual harassment and sexual violence victims will be granted three months of compensation pay-

FDRE Constitution of 1995 which has several provisions relevant to women's rights, many other laws have been enacted and the existing ones have been revised in a particularly gender sensitive manner.
The first National Policy on Ethiopian Women was promulgated in 1993 with the objective of ensuring human and democratic rights of women; modifying and nullifying previous legal instruments, laws, regulations, and customs which exacerbate discrimination against women. The policy also stated to safeguard women's rights and did promise a step –by step elimination of the abuse. Ensuring women's right to have easy access to basic health care facilities is one of the strategies for the implementation of the policy. The Policy is being revised in a way that takes in to account the current economic, social and political environment. The draft National Policy on Gender equality and women empowerment policy includes transformative measures, such as the positive engagement of men and women in the process of addressing gender inequality and enhancing social protection. It also acknowledged and aimed to transform the structural root of gender inequality, and the role of actors outside the government in the process of implementing the policy. On the other hand the government is also preparing Gender Based Violence Policy that can play a huge role in systematic prevention and effective response to all the gender based violence.
However, the National Policy on Ethiopian Women is conspicuously shy in addressing TB in general and the gender dimension of the disease in particular. The Policy precedes the TB policy, the FDRE Constitution, the Revised Family and Criminal Codes. It thus came at a time when women's rights were not fully implanted in the country's legal system and TB was not high on the agenda. There have been significant changes since 1993 in addressing gender issues in the context of TB. There is thus an absolute need to revise the NPEW with a view to capture the developments since 1993 particularly in relation to the link between TB and women's rights. The ongoing revision of the national policy on Ethiopian women could provide a good opportunity to address the issue.
The notable provision of the FDRE Constitution (Article 35) is devoted exclusively to the rights of women and enlists the specific rights of women. These rights, which the Constitution grants to women inter alia includes equal rights in marriage; privileges to affirmative action/measures; protection from harmful traditional practices, right to maternity leave with full pay, right to consultation in projects affecting their lives; property rights (to acquire, administer, control, use and transfer); right to equality in employment (promotion, pay, pension, entitlements) and the right to access to family planning education, information and capacity building. To increase women's political participation the Constitution (Article 38) addresses their right to vote and to be elected. To avoid disproportionate wages, the Constitution (Article 42) guarantees that women workers have the right to equal pay for equal work. The fact that poverty has played its role for women being subjected to all aspects of victimization, the Constitution (Article 89) calls upon the government to ensure the participation of women equal with men in all economic and social development endeavors.
Furthermore, the constitution provides the right to health for every one regardeless of gender and ethnisity. Article 41(4) provides the States obligation to allocate ever-increasing resources to provide public health. This right has been interpreted to include the right to treatment and medicines, the right to healthcare services, the right to emergency medical treatment, and the right to be free from stigma and discrimination on the basis of health status. It applies equally to women in the context of TB, guaranteeing the right to healthcare services for TB without discrimination.
The Ethiopian Federal Revised Family Law which is one of such laws enacted in 2000 and is used to protect and safeguard equality between sexes in their relation concerning marriages (Proc. No. 213/2000). The Revised Family Law has played a great role and has influenced some of the parts of the Civil Code that deal with marriages. Subsequently, it has abolished most of the discriminatory articles in the 1960 Code concerning marriage. For instance, it abolished provisions from the 1960 Code that naturalized gender hierarchy by stating that a wife ''owes [her husband] obedience on all lawful things which he orders'' (Article 635(2)), that ''the husband was to give protection to his wife'' (Article 644(1)) and that the husband ''watch over [the wife's relations and guide her in her conduct'' (Article 644(2)).
The Revised Family Law also raised the legal age of marriage from 15 in the 1960 Code to 18, ensured women's equal rights in selecting their family residence, and granted them equal footing in family administration and decisions about family property. The progress in the Family Law requires respect, support, assistance, faithfulness between the couples and requires the joint management of the family (Articles 49, 50 & 56).
Whilst the family law has not specifically mentioned TB, it has agreat relevance for women in the context of TB, in which it addresses the patriarchal norms in Ethiopia that limits women's decision-making autonomy (includes health-related decision-making autonomy), impede their access to health services(includes TB health services), and increase their vulnerability to infections and diseases, which includes TB.
The Criminal Code is another instrument that can be refereed to make judicial measures and corrective justice on perpetrators in Ethiopia. The whole Chapter III of the Criminal Code of Ethiopia is dedicated to criminalizing harmful traditional practices that cause injuries, health problems, and the deaths of human lives. Though the Chapter is of general application to men and women, it is particularly relevant to women. The Criminal Code, therefore, has criminalized those forms of violence against women including rape (Articles 620-28), traffick-

ment.
Another proclamation that considers gender-sensitive issues at the workplace is the Federal Civil Servants Proclamation No.1064/2017. The Proclamation under Article 48 obligates any government institution to take affirmative actions that enable female civil servants to improve their competence and to assume decision-making positions. It also prohibits workplace sexual harassment and sexual violence. Under Article 70(13) of the Proclamation, committing sexual harassment or abuse at the workplace is among the offenses that entail rigorous penalties.
While both the Labor Proclamation No.1156/2019 and the Federal Civil Servants Proclamation No.1064/2017 prohibit discrimination and sexual harassment in the work place, neither of these are penal law; thus they do not criminalize discrimination and sexual harassment.
Furthermore, both Labor Proclamations (1156/2019 and 1064/2017) provides every employee – including women employees with TB – with the right not to be unfairly dismissed or subjected to an unfair labour practice. Which protect women employees with TB from being treated unfairly or dismissed in the workplace simply on the basis of their TB status or TB history, without regard to their capacity to work.
Under both proclamations, employees are entitled to annual leave with pay and paid sick leave (see section ….), which protects employees(both men and women) with TB from being dismissed from their work simply they got ill with TB, gives them job security, and decreses the financial burden of TB both indirectly and directly because illness limited their ability as breadwinners, and seeking TB treatment drained their financial resources.
In the case of Wizero Yewebdar Negatu v Genet Hotel the court found that Illness should be considered as a sufficient reason for absence from work and the right to receive sick leave is legal right eventhough the employee failed to notifi the employeer in person, notifing the employeer in other meanse suffice to receive sick leave. Though, the decision is not on TB, the decision would be a precedent to all courts on any case including cases related to TB litigations. Thus, infected (geting ill) with TB is considered as a sufficient reason for bing absence from work. Where a worker absents himself from work due to sickness arised from TB, he shall, except where the employer is in a position to be aware of the sickness or it is impractical, notify the employer on the day following his absence. However, not required to notifay in person.

Employment Exchange Services Proclamation No. 632/2009 regulates employment and migration that provide a measure of protection against violence. However, the proclamation does not have strong mechanisms for following up on or enforcing the obligations of employment agencies to protect migrant workers from discrimination and violence, nor does it provide any protection to women workers affected by TB.

The Proclamation on the Prevention and Suppression of Trafficking and Smuggling of Person No. 1178/2020 provides stricter punishment and better protection for women and children victims of trafficking. Ethiopia has also made revision to its electoral framework and enacted the Ethiopian Electoral, Political Parties Registration and Election's Code of Conduct (Proclamation 1162/2019). The proclamation states that gender representation should be ensured for appointment of election officials as well as observers. In addition, the amount of government support provided for political parties depends on the number of female candidates it presents and the number of female members and females in leadership positions in the party. The Civil Society Organization was also officially proclaimed in 2019 which has opened the space for civil society organizations working on gender to operate in more freedom.

Definition of Powers and Duties of the Executive Organs of the FDRE Proclamation No. 1263/2021 and National Risk Management Commission Establishment Council of Minsters Regulation No. 363/2015:- Both men and women, particularly womean are at risk of TB in situation of disaster and conflict. Approaches to assessing risks of TB and designing mechanisms to respond to TB cases in situation of disaster and conflict should be attuned to the impacts of being a women and the role of gender relations in these situations. As per Article 13 of the definition of Powers and Duties of the Executive Organs of the FDRE Proclamation No. 1263/2021, the Ministry of Peace is the main federal executive body responsible to disaster and conflicts in the country. On the other hand, inaccordance to Article 36 of the Proclamation the the Ministry of Women and Social Affairs has the overall responsibility of protecting the rights of women in all activities. In accordance with Article 19(11) of the proclamation, while all the Ministries including the Ministry of Peace have the overall responsibility of protecting the rights of women in all activities, there is no legal requirement for a gendered approach to disaster and conflict risk management and response. This is also evident in the National Risk Management Commission Establishment Council of Minsters Regulation No. 363/2015.
While Ethiopia unveiled the Ten Years Economic Development Plan (2020-2030), the Ministry of Women, Children, and Youths prepared its own respective plans and programs. The plan, which was prepared by the National Planning and Development Commission, incorporated, among others, gender-sensitive strategies. However, it do not incorporate prevention, protection and treatment of TB in context of women.

1.3.1. Health laws, plans, policies, guidelines, and structures Impacting on TB and Gender equality

Different and unequal access to as well as use of preventive protective and promotive health resources due to inequality, the major barrier to attain the highest standard of attainable health among women, is well recognized within the Health Policy framework of the country. In addressing this, guarantees to women's equal right to health are provided for in the Constitution, subsidiary legislation and health policy frameworks such as the **second Health Sector Transformation Plan (HSTP-II), the Guidelines for Clinical and Programmatic Management of TB, TB/HIV, DR-TB and Leprosy in Ethiopia, Reproductive Health Strategic Plan (2021-2025**), **National Strategic Plan for Elimination of Obstetric Fistula 2021-2025, Antenatal Care Guideline, Obstetric Protocols for health centers and hospitals and the Adolescent, Youth Reproductive Health strategy** has adopted as a strategic direction and a major focus area gender mainstreaming within the health sector with the objective of promoting gender equality & the empowerment of women and increasing the utilization of health services by women. Targets also have been set in maternal, neonatal, child and adolescent health.

The Second **Health Sector Transformation Plan (HSTP-II) (2020–2025**) recognizes the gender disparities in health, limited enforcement of existing laws and policies on the rights of women, limited capacity among health care workers in designing and implementing gender-responsive health services. Ensuring equity in delivery of quality health services by creating high-performing primary health care units, ensuring active engagement of the community in service delivery, and continually improving clinical care outcomes are one of the priority issues identified as part of the transformation agenda for HSTP-II. It also stratises to mainstream gender in all health programs and operations, and empower women by ensuring their representation at all levels.
The Reproductive Health Strategic Plan (2021-2025) aims to improve the reproductive health status of women and their

There is substantial gender-related programmatic, legal, and policy gaps in the national TB responses. These include the lack of explicit legal prohibition of gender-based discrimination in health care and the failure to consider the role of gender in TB programs, policies, guidelines, and monitoring and evaluation frameworks. Furthermore there is limited availability of gender-sensitive TB health services, due to the lack of gender-sensitivity training for TB health workers, among other things.

The Constitution and labour law provide all employees with the right to fair labour practices and to be protected from, and compensated for, occupational injury and disease, as detailed in Section …. However, we heard no mention among our participants about their rights to a safe working environment and to compensation for men who contracted TB at work. This suggests that there is a need to increase awareness of their rights and support access to compensation. Constitutional and health law protects the rights of all persons to equality and nondiscrimination, including within the healthcare setting and specifically in terms of gender. However, it appears that this legal framework is inadequate to protect women from discrimination on the basis of TB status. On the other hand, laws that not criminalized sex work are reported to positively contribute towards their access to services - including health care services.

In addition, legal commitments towards promoting gender equality, including a clear commitment within the NSP to recognize and respond to the gender dynamics in the national response to TB, have not resulted in adequate, gender-transformative health responses. Given the clearly gendered dynamics of TB infection and treatment access, it is notable that there is an inattention to the impact of gender in TB infection and treatment in policy, programming and data use. The National Guidelines for Clinical and Programmatic Management of TB do not specifically refer to gender, other than providing guidance on the diagnosis and treatment of pregnant and breastfeeding women. The policy guidelines for the treatment of drug-resistant TB only refer specifically to females when warning to provide contraception to women of childbearing age, due to the damage that treatment can cause to the fetus. Even though, the main national TB program data are disaggregated by gender, further gender disaggregation, from the initial TB screening across the care continuum, is essential to better understand gender equity in access and reimagine service delivery models that reach all.

families, new-borns, adolescents and youths through realization of enhanced progress towards Universal Health Coverage, protection of people from health emergencies, and improvement of health system responsiveness. Gender equality is one of the key guiding principles of the strategic plan. Furthermore, integrating RH/HIV services (FP, STI, TB, OIs) in to PMTCT service is one of the major strategic Initiatives under the strategic plan.
Ethiopia has developed a system for a universal coverage and a **community based health insurance** (CBHI) with a recent report indicating a positive trend for the number of areas and households covered (from 125,142 in 2012 to 6,944,784 in 2020). A large proportion of women from CBHI member households reported that it encouraged them seeking health services for their own and their children's without waiting for approval from their husbands. The issue of public health insurance or other insurance schemes of health services are important, as financial barriers are a major hindrance to access to health services in general and specifically to the context of TB in rural areas, by women.

The current **Guidelines for Clinical and Programmatic Management of TB, TB/HIV, DR-TB and Leprosy** do not specifically refer to gender, other than providing guidance on the diagnosis and treatment of pregnant and breastfeeding women. The guidelines for the Provision of TPT for special populations only refer specifically to females when warning the potential risk of decreased contraceptive efficacy because of Rifampicin and rifapentine interact with oral and hormonal contraceptive medications. The MDR-TB guidelines do, however, include a PART on responding to healthcare workers affected by MDR-TB - the majority of who are women.

Generally, Ethiopia has a very rich legal and policy environment that should enhance gender equality and equity and ensure access to health services. The major policy documents on TB, while somehow recognizing the link between TB and gender inequality, have failed to translate this into specific programs. The link between TB and gender inequality has not thus been clearly articulated in TB prevention and control programs provided in the policies. In the face of growing evidence on the link between TB and gender inequality, it is high time that the gender dimension of TB be clearly and unequivocally addressed in the different TB policy documents. The ongoing revision of the TB policy could provide a good opportunity to address the issue. All stakeholders should actively participate in the revision work with a view to ensuring that the link between TB and gender is well taken care of in the policy.
The current legal framework is fragmented and lacks comprehensiveness and coherence especially when addressing the rights of women in the context of TB. This could be remedied by issuing specific laws dealing with TB where the issue of the vulnerability of women is adequately addressed. To that end, stakeholders should actively engage in the on-going drafting process of the TB legislation. Limited enforcement of existing laws and policies on the rights of women are also among the major challenges in the addressing gender disparities in context of TB.
While the Constitution generally recognized the right to equality and non-discrimination, existing laws lack specific provisions of clauses that explicitly prohibits TB-related discrimination. Nor do existing laws establish mechanisms for the judicial or administrative investigation and remedy of violations of the right so equality and non-discrimination in context of TB. However, people affected by TB have used the courts to combat employment discrimination with some success using the constitution and other employment-related laws.

Discussion on the Gender Perspective of TB Epidemic

Understanding gender-related differences in barriers and delays that limit access to TB care is important to inform interventions designed to optimize the impact of TB services. Our assesment revealed that the TB burden in Ethiopia is distinctly gendered. Infection and disease rates differ by gender, as do experiences of illness and treatment. Men have higher morbidity and mortality rates than women and are more reluctant to enter into biomedical care.

In Ethiopia, the primary issue is the impact of patriarchal social and cultural norms, including around domestic gender roles and household finances. Patriarchal norms limit women's health-related decision-making autonomy, impede their access to TB health services, and increase their vulnerability to TB infection and disease. Women affected by TB experience more frequent or more intense stigma and discrimination than men in their families and communities, sometimes leading to abuse, gender-based violence, divorce, or abandonment. In addition, women in Ethiopia lack access to information and are less knowledgeable than men about TB disease and TB health services. Women specially, rural women report differing experience of challenges in accessing health services, including the high TB patient cost due to luck of disposable cash, travelling long distance to reach to the "nearest health facility", both in terms of "lost time" and ''travel costs'', partly due to their multiple social and household responsibilities. Whereas men face unique challenges, in which they experience heightened risks of exposure to TB infection, reduced access to TB health services, and higher mortality rates from TB due to a host of factors, including employment insecurity, occupational exposure, labor migration, and social and behavioral factors such as smoking, excessive alcohol consumption, and problematic drug use.

CHAPTER FOUR

LEGAL BARRIERS

1. INTERNATIONAL, REGIONAL, AND NATIONAL LAWS AND STANDARDS

This section contains information regarding the overarching legal and regulatory framework that protects and promotes the rights of all people, including vulnerable and key populations, in the context of health – including TB – in Ethiopia.
The first section discusses those provisions relevant to all persons and that apply broadly to protect and promote the right to health in Ethiopia. And looks at specific international and regional commitments as well as national laws and policies particularly relevant in the context of gender. The second section sets out similar information for the four key populations selected for priority focus in this research. Legal, policy, and regulatory issues are raised and dealt with in further detail, and discussion is made on the human rights and gender-related barriers experienced by key populations, to identify key gaps and challenges and make recommendations for strengthened laws, policies, and access to justice.

Laws, Regulations, And Policies Impacting on Gender Equality, Harmful Gender Norms And Gender-Based Violence

At international and regional levels, Ethiopia has ratified several binding conventions relevant to protecting gender equality, many of which have been set out above. The Beijing Platform for Action (1995), though not legally binding, outlines a number of actions to respond to and prevent gender-based violence against women. It aims at removing all the obstacles to women's active participation in all spheres of public and private life via ensuring equal share in economic, social, cultural, and political decision-making. It also calls for an increase in the role of States in the elimination of violence against women, ending discrimination, and promoting health, education, and economic opportunities for women.

At national level, a lot has been done in Ethiopia in ter/ms of putting in place a policy framework providing for the protection of the rights of women and girls that may have a direct or indirect relevance to addressing the vulnerability of women and girls to TB. In addition to the National Policy on Ethiopian Women (NPEW) and the Health Sector Transformation Plan (HSTP-I, HSTP-II), the National HIV/AIDS Policy, several sectorial policy documents have attempted to address the issue in different ways.

The **first National Policy on Ethiopian Women** was promulgated in 1993 with the objective of ensuring human and democratic rights of women; modifying and nullifying previous legal instruments, laws, regulations, and customs which exacerbate discrimination against women. The policy also stated to safeguard women's rights and did promise a step –by step elimination of the abuse. More recently the UN Millennium Development Goal to which Ethiopia acceded, on Gender Equality and Women Empowerment has become an effective way to bridge the gender gap in education, combat feminized poverty, and improve health and HIV/AIDS, and other sectors to stimulate development. However, TB has not specifically mentioned.
Ethiopia has developed a system for a universal coverage and a **community based health insurance (CBHI)** with a recent report indicating a positive trend for the number of areas and households covered (from 125,142 in 2012 to 6,944,784 in 2020). A large proportion of women from CBHI member households reported that it encouraged them seeking health services for their own and their children's without waiting for approval from their husbands. The issue of public health insurance or other insurance schemes of health services are important, as financial barriers are a major hindrance to access to health services in rural areas, especially by women. This also has importance for women in the context of TB

Different and unequal access to as well as use of preventive protective and promotive health resources due to inequality, the major barrier to attain the highest standard of attainable health among women, is well recognized within the health policy framework of the country. In addressing this, guarantees to women's equal right to health are provided for in the Constitution, subsidiary legislation and health policy frameworks such as the second Health Sector Transformation Plan (HSTP-II), the Guidelines for Clinical and Programmatic Management of TB, TB/HIV, DR-TB and Leprosy in Ethiopia, National reproductive health strategy and the Adolescent, Youth Reproductive Health strategy has adopted as a strategic direction and a major focus area gender mainstreaming within the health sector with the objective of promoting gender equality & the empowerment of women and increasing the utilization of health services by women. Targets also have been set in maternal, neonatal, child and adolescent health.

The last decade has also seen a significant legislative reform endeavor directed at providing better protection of the rights of women in Ethiopia. In addition to the FDRE Constitution of 1995 which has several provisions relevant to women's rights, many other laws have been enacted and the existing ones have been revised in a particularly gender sensitive manner. Chief among these laws are the Revised Family Law and the Revised Criminal Code.

The notable provision of the FDRE Constitution (Article 35) is devoted exclusively to the rights of women and enlists the specific rights of women. These rights, which the Constitution grants to women inter alia includes equal rights in marriage; privileges to affirmative action/measures; protection from harmful traditional practices, right to maternity leave with full pay, right to consultation in projects af-

fecting their lives; property rights (to acquire, administer, control, use and transfer); right to equality in employment (promotion, pay, pension, entitlements) and the right to access to family planning education, information and capacity building. To increase women's political participation the Constitution (Article 38) addresses their right to vote and to be elected. To avoid disproportionate wages, the Constitution (Article 42) guarantees that women workers have the right to equal pay for equal work. The fact that poverty has played its role for women being subjected to all aspects of victimization, the Constitution (Article 89) calls upon the government to ensure the participation of women equal with men in all economic and social development endeavors. Despite the tremendous effort, the Ethiopian Constitution has enabled in the march toward gender equality, women are behind men in all parameters used to evaluate the rights achieved.

The Ethiopian Federal Revised Family Law which is one of such laws enacted in 2000 and is used to protect and safeguard equality between sexes in their relation concerning marriages (Proc. No. 213/2000). The Revised Family Law has played a great role and has influenced some of the parts of the Civil Code that deal with marriages. Subsequently, it has abolished most of the discriminatory articles in the 1960 Code concerning marriage. For instance, it abolished provisions from the 1960 Code that naturalized gender hierarchy by stating that a wife ''owes [her husband] obedience on all lawful things which he orders'' (Article 635(2)), that ''the husband was to give protection to his wife'' (Article 644(1)) and that the husband ''watch over [the wife's relations and guide her in her conduct'' (Article 644(2)).

The Revised Family Law also raised the legal age of marriage from 15 in the 1960 Code to 18, ensured women's equal rights in selecting their family residence, and granted them equal footing in family administration and decisions about family property. The progress in the Family Law requires respect, support, assistance, faithfulness between the couples and requires the joint management of the family (Articles 49, 50 & 56).

The Criminal Code is another instrument that can be refereed to make judicial measures and corrective justice on perpetrators in Ethiopia. The whole Chapter III of the Criminal Code of Ethiopia is dedicated to criminalizing harmful traditional practices that cause injuries, health problems, and the deaths of human lives. Though the Chapter is of general application to men and women, it is particularly relevant to girls and women. The Criminal Code, therefore, has criminalized those forms of violence against women including rape (Articles 620-28), trafficking women (Article 597), prostitution of another for gain (Article 634), and physical violence within marriage or in an irregular union (Article 564), and abduction (Articles 587- 590). Traditional practices including Female Genital Mutilation (Articles 565-6), and early marriage (Article 649) are also considered as harmful traditional practices and lead to a penalty for contraventions.

The Ethiopian government also has recently amended its legislation by excluding rape crimes from pardon and amnesty laws as it lengthened jail terms for sex offenders. Sex work is not criminalized in Ethiopia. Considering that sex workers are at high risk of HIV exposure and its co-infections, including TB; the fact that the law hasn't criminalized sex work positively impact on their ability to access services - including health care services.

The Labor Proclamation No.1156/2019 is one of the laws that address discrimination at workplaces. The Proclamation affirms that women shall not be discriminated against in all respects based on their sex (Ar.87). It also introduced a new regime to regulate workplace sexual harassment and sexual violence by prohibiting any attempt to commit sexual harassment or sexual violence at the workplace and physically abusing anyone in the workplace (Article (14)). Employees that have suffered sexual harassment or sexual violence will be entitled to terminate their contracts without notice, and will also be eligible for severance payment and compensation. The law provides a higher amount of compensation payment for employees who are forced to terminate their contract, without notice, for reasons of sexual harassment and sexual violence. Forced termination of contracts by employees for reasons that are unlawful acts of the employer will entitle the employee to a one-month compensation payment whereas sexual harassment and sexual violence victims will be granted three months of compensation payment.

Another proclamation that considers gender-sensitive issues at the workplace is the Federal Civil Servants Proclamation No.1064/2017. The Proclamation under Article 48 obligates any government institution to take affirmative actions that enable female civil servants to improve their competence and to assume decision-making positions. It also prohibits workplace sexual harassment and sexual violence. Under Article 70(13) of the Proclamation, committing sexual harassment or abuse at the workplace is among the offenses that entail rigorous penalties.

While both the Labor Proclamation No.1156/2019 and the Federal Civil Servants Proclamation No.1064/2017 prohibit discrimination and sexual harassment in the work place, neither of these are penal law; thus they do not criminalize discrimination and sexual harassment.

Employment Exchange Services Proclamation No. 632/2009 regulates employment and migration that provide a measure of protection against violence. However, the proclamation does not have strong mechanisms for following up on or enforcing the obligations of employment agencies to protect migrant workers from discrimination and violence, nor does it provide any protection to

PAGE 2

LEGAL BARRIERS

women workers affected by TB.

Definition of Powers and Duties of the Executive Organs of the FDRE Proclamation No. 1097/2018 and National Risk Management Commission Establishment Council of Minsters Regulation No. 363/2015:- Women are particularly at risk of TB in situation of disaster and conflict. Approaches to assessing risks of TB and designing mechanisms to respond to TB cases in situation of disaster and conflict should be attuned to the impacts of being a women and the role of gender relations in these situations. As per Article 13 of the definition of Powers and Duties of the Executive Organs of the FDRE Proclamation No. 1097/2018, the Ministry of Pease is the main federal executive body responsible to disaster and conflicts in the country. In accordance with Article 10(3) of the proclamation, while the ministry of peace has the overall responsibility of protecting the rights of women in all activities, there is no legal requirement for a gendered approach to disaster and conflict risk management and response. This is also evident in the National Risk Management Commission Establishment Council of Minsters Regulation No. 363/2015.

While Ethiopia unveiled the Ten Years Economic Development Plan (2020-2030), the Ministry of Women, Children, and Youths prepared its own respective plans and programs. The plan, which was prepared by the National Planning and Development Commission, incorporated, among others, gender-sensitive strategies. However, it do not incorporate prevention, protection and treatment of TB in context of women. The current Guidelines for Clinical and Programmatic Management of TB, TB/HIV, DR-TB and Leprosy do not specifically refer to gender, other than providing guidance on the diagnosis and treatment of pregnant and breastfeeding women. The guidelines for the Provision of TPT for special populations only refer specifically to females when warning the potential risk of decreased contraceptive efficacy because of Rifampicin and rifapentine interact with oral and hormonal contraceptive medications. The MDR-TB guidelines do, however, include a PART on responding to healthcare workers affected by MDR-TB - the majority of who are women.

Policy and legal barriers:-In addition to the policy and legal barriers expressed under each laws and policies above, in general, the major policy documents on TB, while somehow recognizing the link between TB and gender inequality, have failed to translate this into specific programs and strategies. The link between TB and gender inequality has not thus been clearly articulated in TB prevention and control programs provided in the policies. In the face of growing evidence on the link between TB and gender inequality, it is high time that the gender dimension of TB be clearly and unequivocally addressed in the different TB policy documents. The ongoing revision of the TB policy could provide a good opportunity to address the issue. All stakeholders should actively participate in the revision work with a view to ensuring that the link between TB and the rights of women and girls is well

ETHIOPIA HAS RATIFIED A NUMBER OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS TREATIES THAT PROTECT RIGHTS RELEVANT TO ALL PERSONS, INCLUDING THE RIGHTS OF VULNERABLE AND KEY POPULATIONS IN THE CONTEXT OF TB.

taken care of in the policy.

The National Policy on Ethiopian Women is conspicuously shy in addressing TB in general and the gender dimension of the disease in particular. The Policy precedes the TB policy, the FDRE Constitution, the Revised Family and Criminal Codes. It thus came at a time when women's rights were not fully implanted in the country's legal system and TB was not high on the agenda. There have been significant changes since 1993 in addressing gender issues in the context of TB. There is thus an absolute need to revise the NPEW with a view to capture the developments since 1993 particularly in relation to the link between TB and women's rights. While the Constitution recognized the right to equality and non-discrimination, existing laws lack specific provisions of clauses that help to define the scope and content of these rights. Nor do existing laws establish mechanisms for the judicial or administrative investigation and remedy of violations of the right so equality and non-discrimination. Such a law should recognize the intersectionality of gender and other factors of advantages and disadvantage combine to create different experiences of discrimination and privilege. By recognizing the intersectionality of gender, the law consciously acknowledges that other markers of social inclusion such as social and economic status, age, religion and disability operate in tandem with gender to compound discrimination and oppression in context of TB.
The current legal framework is fragmented and lacks comprehensiveness and coherence especially when addressing the rights of women in the context of TB. This could be remedied by issuing specific laws dealing with TB where the issue of the vulnerability of women and girls is adequately addressed. To that end, stakeholders should actively engage in the on-going drafting process of the TB legislation. Limited enforcement of existing laws and policies on the rights of women and girls are also among the major challenges in the addressing gender disparities in context of TB.

The Relevant Legal Framework

International, Regional, And National Laws And Standards

This section contains information regarding the overarching legal and regulatory framework that protects and promotes the rights of

all people, including vulnerable and key populations, in the context of health – including TB – in Ethiopia. The first section discusses those provisions relevant to all persons and that apply broadly to protect and promote the right to health in Ethiopia. And looks at specific international and regional commitments as well as national laws and policies particularly relevant in the context of gender. The second section sets out similar information for the four key populations selected for priority focus in this research. Legal, policy, and regulatory issues are raised and dealt with in further detail, and discussion is made on the human rights and gender-related barriers experienced by key populations, to identify key gaps and challenges and make recommendations for strengthened laws, policies, and access to justice.

Laws, Regulations, And Policies Relevant For The Health Rights Of All Affected Populations

Ethiopia has ratified a number of international and regional human rights treaties that protect rights relevant to all persons, including the rights of vulnerable and key populations in the context of TB. According to the Constitution of the Federal Democratic Republic of Ethiopia (FDRE Constitution) International instruments are an integral part of the laws of the land upon ratification. The Constitution further elevates the horizon of human rights through reference to international and regional human rights instruments as thresholds, in which whenever a fundamental right as contained in the FDRE Constitution is relevant, it needs to be interpreted in such a manner that no conflict arises with a human rights treaty provision. Hence, legislation and other acts of government may indirectly be interpreted in the light of human rights treaties, thus these international and regional commitments play an important part in Ethiopia jurisprudence. Various treaties ratified by Ethiopia, set out below are of importance; although they do not make specific reference to TB, they require states to respect, protect, promote and fulfill fundamental human rights important for all persons in the context of TB.

Ethiopia has ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR), which entails provisions that carry importance to all persons in the context of TB. While all of the provisions of the Covenant cover all citizens of contracting State Parties, this document focuses on the right to health (framework) which is a valuable tool in "aligning law and policy with human rights, operationalizing the pledge to leave no one behind, [and promoting] accountability and participation" to achieve the health-related SDGs.

The Committee on Economic Social and Cultural Rights (CESCR)(Monitoring body of the Covenant) under General Comment 14 states that, the right to health comprises the right to access to health facilities, goods and services, to healthy occupational and environmental conditions, and protection against epidemic diseases and rights relevant to sexual and reproductive health. The Committee also recognises that right to health is dependent on and contributes to the realization of many other human rights. It includes a wide range of factors, the "underlying determinants of health" such as safe drinking water, food, adequate nutrition, housing, healthy occupational and environmental conditions, education etc.

The rights enshrined in the Covenant, including the right to health, are generally subject to progressive realization due to states' resource constraints. While Article 2(1) sets out the general obligation of progressive realization, the CESCR clarified the nature and scope of the duty to progressively realize ESC rights within General Comment 3. Here, the CESCR highlighted that the concept of progressive realizing ESC rights demands the active effort to take necessary steps to the maximum of its available resources, demanding that the State move expeditiously and effectively towards realizing such rights. Thus, a right can be translated into a series of obligations, some of which are immediate and others of progressive nature. Accordingly, some rights under the Covenant, such as freedom from discrimination in the enjoyment of all Economic Social and Cultural Rights (ESC rights) and core obligations, give rise to obligations of immediate effect. Accordingly, the right to health imposes certain obligations on States that are of immediate effect. These include the obligations to ensure that the right is enjoyed equally by all without discrimination of any kind and to take "deliberate, concrete and targeted" steps toward fully realizing the right.
This assessment depends on seven dimensions of the right to health framework: (1) availability, accessibility, acceptability, and quality (AAAQ); (2) nondiscrimination and equal treatment; (3) health-related freedoms; (4) gender perspective; (5) remedies and accountability (6) vulnerable and marginalized groups; and (7), participation, which is discussed in detail in the next section.
Ethiopia also ratified The International Covenant on Civil and Political Rights (ICCPR) which sets out the civil and political rights of all persons, including the rights of all persons to life, equality and non-discrimination, privacy, freedom of movement, freedom of expression, freedom from arbitrary arrest and detention and right to a fair trial, among others. These rights protect people with TB in various ways, such as; people with TB have the right to be protected from ill health and to access life-saving diagnostics and treatment. Key populations - such as prisoners, health workers, and people who use drugs, should be provided with diagnostics and treatment and not denied treatment. People with TB should not also be refused medical treatment or denied and fired from jobs on the basis of their TB status.

Information related to an individual's TB status and treatment must also be kept private and shall not be disclosed to any party, unless approved by appropriate medical professionals under narrowly and expressly tailored circumstances enumerated in law, including to protect third parties who are at serious and imminent risk of infection and to share essential health information with medical professionals providing care to the patient. Furthermore, Information about a patient's migrant, HIV drug use, or other status should be kept confidential.
People with TB shall also be free to move within and outside the country and able to receive free treatment in the location where they reside. They should not be unnecessarily isolated, quarantined or detained, or refused treatment because they are not in a specific location or because they lack identity documents in a country.

The International Convention on the Rights of Persons with Disabilities (CRPD) aims to promote the equality rights of persons with disabilities to ensure their meaningful participation in society and their development as persons. It provides, among other things, for the health rights of persons with disabilities. The State's obligation "in the case of vulnerable and disadvantaged groups is to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to people with disabilities in order to achieve the objectives of full participation and equality within society for all persons with disabilities." States are required "to make available additional resources for this purpose and a wide range of specially tailored measures."
While the approach to reasonableness and the review of policies for compliance with the Covenant will be different in the context of period reviews and General Comments than when it is situated in the context of particular rights claims, in the CESCR's view all reasonable strategies must be informed by equality framework, prioritizing the need of the disadvantaged group and ensuring protection from discrimination. Furthermore, Article 5(2) prohibits all discrimination on the basis of disability and guarantees to persons with disabilities equal and effective legal protection against discrimination on all grounds, providing for equal rights in health care, education, and employment, among others, of all persons with TB who may experience temporary or permanent disability as a result of TB.

PAGE 3

LEGAL BARRIERS

the newborn, the infant, the pre-school child, the school-age child, and the adolescent, with a particular focus on those children who are living in poverty or are in other ways marginalized, economically and/ or socially excluded.

Article 2 of the CRC makes explicit the principle of non-discrimination for the overall implementation of the Convention. The grounds for discrimination mentioned in the Convention are not an exhaustive list due to the reference in Article 2 to "other status". The Committee also identified additional grounds for discrimination in paragraph 8 of General Comment 15, which refers to sexual orientation, gender identity, and health status. The application of the principle of non-discrimination is thus key to addressing inequalities in the impact of TB.

The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment protects all persons and has been applied particularly to protect persons in detention, among others, from cruel, inhuman, or degrading treatment or punishment committed by a public official or other person acting in an official capacity. This provides prisoners and those hospitalized with TB with the right to appropriate TB-related healthcare. Prisoners with TB and those at risk of contracting the disease in prison should be provided with appropriate TB testing and treatment during detention and appropriate prison conditions to avoid transmission of the disease. People with TB who use drugs should also have access to substitution treatment or other forms of drug treatment if hospitalized for TB treatment, so as not to be forced into withdrawal.

The Convention on the Elimination of All Forms of Discrimination against Women and its optional protocol, commits states to take various measures to end gender inequality, including in access to healthcare, supporting gender-sensitive responses to TB that recognize the ways in which gender, and gender inequality, impact on health care needs of women in the context of TB. The duty of States to ensure, on a basis of equality of men and women, access to health care services, information and education, implies an obligation to respect, protect and fulfill human rights related to women's health. States have the responsibility to ensure that legislation, executive action and policy comply with these three obligations. They must also put in place a system that ensures effective judicial action. The Covenant has a significant role in placing a gender perspective at the center of all policies and programs affecting women's health, which include TB.

The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) provide for the rights of prisoners to be treated with respect and dignity, to be protected from torture and other cruel, inhuman, or degrading treatment or punishment, and to conditions of dignity, including reasonable accommodation that meets the requirements of health , access to health care services at the same standards that are available in the community , transfer to specialized medical services where necessary and the right to medical confidentiality , among other things. These Standards protect the health and related rights of prisoners, including their right to be protected from TB infection and to receive treatment for TB.

THE FDRE CONSTITUTION FURTHERMORE PROTECTS OTHER IMPORTANT HUMAN RIGHTS THAT PROTECT PEOPLE WITH TB, VULNERABLE AND KEY POPULATIONS FROM DISCRIMINATORY AND PUNITIVE LAWS, POLICIES, AND PRACTICES IN THE CONTEXT OF TB.

ILO Conventions

Ethiopia has been a member state of the ILO since 1923 and has ratified 19 conventions to date: Unemployment convention No.2/1919, Rights of Association (agriculture) conv. 11/1921), Weekly rest (Industrial) Convention No.14/1921, Freedom of Association and protection of the right to organize conv 87/1948, Employment service conv. No 88/1948, Fee-charging employment agencies Conv. No. 96/1948 which is replaced by Convention No. 181 of 1997, The right to organize and bargain Collectively Convention No. 98/1948, Equal remuneration Convention No. 100/1951 , Abolition of forced labour No.105/1957, Weekly rest commerce Convention No. 106/1957, Discrimination(employment) Convention No. 111/1958, Minimum age convention No. 138/1973, Occupational safety and health and working environment Convention No 155/1981, Workers with family responsibilities /equal opportunity & treatment/ Convention No. 156/1981, Termination of employment /employers initiative / Convention No 158/1982, Vocational rehabilitation and employment /disabled persons/ Convention No 159/1983, Private employment agencies convention No. 181/1997, Forced labour convention No. 29/1990, and Worst forms of child labour No. 182/1999 2 – 09 – 2003- promotes decent work for all by ensuring rights at work, right to employment , social protection and social dialogue. Cross-cutting themes are poverty reduction and social inclusion, ensuring gender equity, communications, and international partnership. The tripartite convention of ILO, adopted in 1981, and Involving representatives of governments and employers and employees organizations, provides the institutional framework for the development of policies on health and the workplace.

ILO places emphasis on the issue of TB because besides being a global concern, it is a workplace issue and because workplaces can contribute to the control of TB. ILO has therefore played an active role in TB control by formulating guidelines for TB Control activities in the workplace in collaboration with WHO. The basic principles of a workplace policy are recognition of TB as workplace issue, non-discrimination, and confidentiality, promotion of a healthy work environment, care and support, augmented by continuous social dialogue. Regionally, the African Charter on Human and Peoples' Rights provides for the rights of all persons in Africa. It contains several provisions that protect the equality rights of all persons, including gender equality, and prohibit discrimination including on the basis of race, ethnic group, color, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or any status. Accordingly, legal frameworks should prohibit discrimination against people with TB in both public and private settings, including, but not limited

to, health care, employment, education, and access to social services. It also includes many of the key rights that are important for people in the context of TB as in the ICCPR, ICESCR, and other core international treaties discussed above, including rights to liberty and security, freedom of movement, health and fair labour practices, among others, which are relevant of in the context of TB.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol): The Maputo Protocol provides for the protection of women and girl children, as well as for the eradication of discrimination against women. Significantly, the Protocol includes commitments towards the elimination of harmful cultural practices and specifically recognises the sexual and reproductive health rights of women, which protects women from HIV and its co-infections, including TB.

The African Charter on the Rights and Welfare of the Child sets out the rights of the African child, including the rights to equality, non-discrimination, education, and health, among others. Article 14 guarantees every child to enjoy the best attainable state of physical, mental, and spiritual health. State Parties are also obliged to ensure the provision of necessary medical assistance and health care to all children reduce infant and child mortality rates. Thus, the Charter has significance for TB prevention and control in children, in helping to see children affected by TB as rights holders, and urging State Parties to incorporate the principles and standards of the CRC for the benefit of children affected by TB.

Domestic Legal and Policy Framework

At the national level, the FDRE Constitution and national laws, including health laws, employment laws, and criminal laws, among others, also contain important provisions in the context of TB-related healthcare for vulnerable and key populations.

The FDRE Constitution

The FDRE Constitution is the supreme law of the land and it forms the baseline upon which the national TB response is based. It binds all parties (public and private) and places an obligation on them to respect, promote, protect, and fulfill the rights enshrined under the Bill of Rights. It also sets out the standards that all laws, policies, and conduct must comply with. These relevant provisions of the Constitution include:

Human dignity, equality, and non-discrimination

The Constitution preamble requires full respect for individual and people's fundamental freedoms and rights, to live together on the basis of equality and without any sexual, religious, or cultural discrimination. Furthermore, Article 25 recognizes the equality of all persons and guarantees effective protection without discrimination on grounds of race, nation, nationality, or other social origins, color, sex, language, religion, political or other opinions, property, birth, or other status. While TB is not specifically mentioned as a protected ground for non-discrimination, the term 'other status' under Article 25 includes TB. Moreover, there is ample evidence of the protection of the rights of persons to non-discrimination on the basis of their health status in Ethiopia jurisprudence.

The right to Health

Article 41(4) provides the States obligation to allocate ever-increasing resources to provide public health. This right has been interpreted to include the right to treatment and medicines, the right to healthcare services, the right to emergency medical treatment, and the right to be free from stigma and discrimination on the basis of health status. It applies equally to people in the context of TB, guaranteeing the right to healthcare services for TB without discrimination.

Rights of Labour

Article 42 of the Constitution provides workers the right to reasonable limitation of working hours, to rest, to leisure, to periodic leaves with pay, to remuneration for public holidays as well as a healthy and safe work environment. These rights are the basis for protecting all people – including employees such as farm workers, healthcare workers, and miners, among others within the workplace. It also strengthens the right to a safe working environment, necessary to prevent accidents and injuries and to protect workers from contracting occupational diseases, which protects employees from exposure to TB within the working environment.

Right to legal remedy

Article 37 guarantees the right of every person (individually or collectively) to access Justice. This guarantees access to justice for people living with TB, as well as vulnerable and key populations, whose rights have been violated.
The FDRE Constitution furthermore protects other important human rights that protect people with TB, vulnerable and key populations from discriminatory and punitive laws, policies, and practices in the context of TB, including the rights to privacy, liberty, and security of the person, protection from cruel, inhuman and degrading treatment of punishment, freedom of expression, freedom of movement and the right to treatments respecting persons held in custody and convicted prisoners human dignity.

While the Constitution recognized the right to equality and non-discrimination, existing laws lack specific provisions of clauses that help to define the scope and content of these rights. Nor do existing laws establish mechanisms for the judicial or administrative investigation and remedy of violations of the right so equality and non-discrimination. This is also evident in the context of TB.
Human rights are interconnected, interdependent and indivisible, and the failure to realize a basic right – such as the right to information, e.g. health information or information regarding legal rights and redress mechanisms – may impact on the realization of other rights, such as the right to health or the right to access remedies for violations. An enabling legal and regulatory framework for the rights of people in the context of TB requires recognition of the need to respect, protect, promote and fulfil civil, political, socio economic and cultural rights, in order to protect and promote the health and well-being of all persons.

Several laws have been enacted in order to give effect to these constitutional rights. The section below sets out some of the main pieces of legislation and important policies as they relate to health. However, since several rights are invoked, we also provide an outline of non-health, but relevant legislation and policies. Laws, regulations, and policies relevant to gender and to specific key populations are dealt with in separate sections, below.

Health laws, plans, policies, guidelines, and structures

The National Health Policy, upon which health sector strategies and plans are anchored, outlines the following as core principles:

PAGE 4

LEGAL BARRIERS

HE FEDERAL PRISON PROCLAMATION NO. 1174/2019 PROVIDES THAT PRISONERS SHALL BE TREATED WITH RESPECT TO THEIR HUMAN RIGHTS, DIGNITY, AND HEALTH.

democratization and decentralization of health services; preventive and promotive health service development; health service accessibility by all; inter-sectoral collaboration and private sector involvement; and self-reliance in health development through mobilization and efficient utilization of resources. Since the National Health Policy is issued in 1991, the Government of Ethiopia has implemented five successive Health Sector Development Plans (HSDPs). Each HSDP followed critical reviews and analysis of the nature, magnitude and root causes of public health problems, with broader consideration of emerging challenges in the country. Ethiopia is currently implementing a five-year Health Sector Transformation Plan (HSTP-II) 2020/21-2024/25, from which the national TBL strategic plan emanates.

To address the quality arm of the HSTP-I agenda, the National Quality Strategy (NQS) was developed. It focuses on ensuring reliable, excellent clinical care, protecting patients, staff, and attendants from harm, and improving the efficiency of the delivery of care, while increasing access, equity, and dignity of care for Ethiopians. NQS prioritized five major areas, in which communicable diseases is one of them. Accordingly, a number of service and/or program specific quality improvement initiatives were developed and implemented. However, a range of problems undermined implementation, including lack of coordination at national and sub-national level, weak accountability mechanisms, sub-optimal quality measurement data and tools, weak information use culture, shortage of a wide range of service inputs (including finance, competent and compassionate workforce, medical supplies and public health infrastructure). Community preference for higher-level care (secondary and tertiary) and lack of integration across service components along the continuum of care (such as poor referral and follow-ups services) contribute to the challenges.

Despite intensive ongoing to address the equity gaps, disparities remain in delivery and coverage of high-quality health services, persisting across domains of geography, age, gender, and disability. These disparities, in turn, contribute to inequities in use of health services, health outcomes, and population-level impacts.

The second Health Sector Transformation Plan (HSTP-II) also includes Prevention and Control of Communicable Diseases strategies. This strategic direction focuses on the prevention, control and management of major communicable diseases including tuberculosis. The prevention and control strategy plan includes increasing TB detection rate from 71% to 81%, increasing TB treatment success rate from 95% to 96% and increasing number of DR TB cases detected from 720 to 1,365. The health system will focus on high-impact interventions aimed at reducing the burden of these communicable diseases, and on health promotion and disease prevention; and will strengthen screening, diagnosis, and treatment of communicable diseases.

Major strategic initiatives includes, enhance implementation of integrated, patient-centered TB prevention and care (shift from a TB control to ending the TB epidemic mode), Strengthen TB and leprosy case finding, contact tracing and screening services, Strengthen TB/DR-TB diagnostic services, including sample referral network and access to a more sensitive screening tools such as chest X-Ray and GeneXpert, Enhance provision of Community TB screening and treatment support services, Engage private facilities in TB diagnosis and treatment services, Strengthen and expand TB prevention therapy for HIV+ cases and household contacts, Strengthen and expand universal drug susceptibility testing services, Strengthen and expand drug-resistant TB treatment initiating and follow up sites and strengthen rehabilitation services for people with a major disability.

Ethiopia is also one of the signatories to the International Health Regulations (2005) (IHR) and is expected to take the necessary steps to prepare and carry out appropriate national implementation plans to ensure the required strengthening, development, and maintenance of the core public health capacities. Accordingly, in addition to the National Health Policy and Health Sector Transformation Plan (HSTP-II) 2020/21-2024/25, the government developed the National Action Plan for Health Security (NAPHS) aimed to improve the health, social, and economic status by reducing health security threats through multi-sectorial coordination; quality human infrastructure and financial resources; and health management system that assures continuous community participation and engagement. Several objectives and activities have been planned under the 46 JEE indicators of the 19 thematic areas to improve national health security and are expected to be implemented in one health approach.

Food and Medicine Administration Proclamation No.1112/2019 regulates the provision of health care in Ethiopia. It also sets out the rights of health users, such as the right to equality in access to healthcare, the right to have full knowledge of one's condition, to participate in decisions regarding one's health, to consent to healthcare services, and the right to medical confidentiality, among other things. It provides the right to lay complaints about unprofessional healthcare services as well.

According to the Proclamation the Ethiopian Food and Drug Control Authority (EFDA), a national regulatory agency, is mandated to ensure the safety, quality and efficacy of medicines and medicine devices by undertaking the major regulatory functions including market authorization, quality testing/, regulatory inspection (Good manufacturing practice and supply chain inspection), pharmacovigilance, market surveillance, and control and clinical trial monitoring. No medicine and medical devices, obtained either from local manufacturers or foreign sources, can be marketed and made available for use in the country without market authorization or permission from EFDA. EFDA is authorizing marketing or availability for use of medicine and medical devices in the country after ensuring the safety,

efficacy, and quality of medicines and medical devices through dossier evaluation, Good Manufacturing Practice Inspection, and Laboratory Quality testing, as well as issuing pre-import approval and port clearance permit. EFDA is also undertaking and coordinating post-market or use surveillance: including undertaking regulatory inspection, marketing surveillance and control, and pharmacovigilance to ensure safety, efficacy and quality of medicine and medical device after are made available for use in the country.
The current Guidelines for Clinical and Programmatic Management of TB, TB/HIV, DR-TB and Leprosy encompasses a strong coalition with communities, a human rights-based, ethical and equitable approach to implementation, and adaptation of the strategy to end TB strategy.

Labour laws

Labour Proclamation No.1156/2019 regulates the employment relationship, providing for an employee's right to fair labour practices, prohibiting discriminatory acts in the workplace, and protecting workers from unfair dismissals – such as dismissals based on unfair discrimination. Regarding civil servants, the Federal Civil Servants Proclamation No.1064/2017 regulates the employment conditions of employees within the public service, ensuring their rights to fair labour practices.
The proclamations provides every employee – including employees with TB – with the right not to be unfairly dismissed or subjected to an unfair labour practice. Dismissals based on an arbitrary ground are automatically unfair dismissals; other unfair dismissals are dismissals that do not relate to a person's conduct, capacity to work or the operational requirements of the employer. Unfair labour practices include unfair conduct relating to promotions and demotions, unfair suspensions and unfairly failing to reinstate an employee. These provisions protect employees with TB from being treated unfairly or dismissed in the workplace simply on the basis of their TB status or TB history, without regard to their capacity to work.

The Labour Proclamation places a general obligation on employers to provide and maintain a working environment that is safe and without risk to the health of their employees. It sets out the rights of employees (which would include farm workers and healthcare workers) to a safe working environment and to receive information and training on health and safety measures. Employers have a duty to provide a safe environment, including organising work, equipment and machinery in such a way that they are safe, providing information and training and enforcing the necessary health and safety measures. In the context of TB, this means that employers have a duty to take steps to ensure conditions at work do not place employees at higher risk of TB infection - e.g. by reducing risks such as poor ventilation and by providing equipment and training to support employees to use infection control measures in the health care environment, for instance (detailed further below in the section on healthcare workers).

Laws Regarding Persons Held In Custody And Convicted

The Federal Prison Proclamation No. 1174/2019 provides that prisoners shall be treated with respect to their human rights, dignity, and health. The premises and compounds of prisons shall also not be hazardous to health, and they shall have fresh air and sufficient lights. This is important due to the fact that the prison environment and conditions - overcrowding, congestion, poor ventilation, - may place prisoners at high risk of TB exposure and infection; prisoners have a right to be protected from ill health within the prison environment. Thus, the implementation of these provisions is vital to protect the health of prisoners and to decrease their risk of exposure to TB. The Proclamation also provides that the commission shall maintain prisoners' health care, and provide prisoners with free medical treatment. It also undertakes and encourages tasks, services, and activities necessary for the physical and mental well-being of prisoners.
The Proclamation also established the Committee of Community Leaders which combination of voluntary individuals recognized in the community, especially religious leaders, cultural leaders, elders, human rights advocates, famous individuals, and the like. The Committee shall ensure the treatment of prisoners by the Commission respects the Constitution, international human rights agreements Ethiopia has accepted, the Proclamation, and other relevant laws, which positively impact the respect of human rights of prisoners affected by TB and enhance accountability.

The Treatment of Federal Prisoners Council of Ministers Regulations No. 138/2007 provide that the treatment of prisoners shall be treated based on the basic principle of respect to their human dignity and no discrimination on ground of gender, language, religion, political opinion, nation/nationality, social status or citizenship (Article 3(1) and(2)). Prisoners are also subjected to medical examination when admitted to a prison and prisoners with communicable diseases will have separate accommodation from other prisoners (Article 4(3) and 5(3)(d)). The Directive also provides that the premises in which prisoners live shall have windows large enough to allow adequate fresh air to circulate. Prisoners are also should be provided with medical treatment free of charge with adequate medical equipment and medical facility (Article 11). The implementation of these provisions is vital to protect the health of prisoners and to decrease their risk of exposure to TB. New directive also under the way on the

THE RIGHT TO HEALTH FRAMEWORK

AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND QUALITY (AAAQ)

The AAAQ dimension of the right to health framework encompasses the right to physical and mental health facilities, goods, and services that are available, accessible, acceptable, and of good quality. Availability requires that these facilities, goods, and services be available in "sufficient quantity" in the country. Accessibility includes nondiscrimination and physical, economic, and information accessibility. Acceptability requires that health facilities, goods, and services be culturally appropriate, sensitive to gender and life-cycle requirements, and respectful of medical ethics, including confidentiality. Quality requires that they be "scientifically and medically appropriate" and administered by skilled health workers.

In Ethiopia lack of privacy and confidentiality in TB clinics and health services, is one of acceptability issue. A prohibitively long distance to TB clinics, a physical accessibility challenge, appears the other challenge. Acceptability problems with the standard TB treatment, particularly the length of treatment, treatment side effects, and the nature of DOT, all of which are also quality concerns. A low awareness and lack of access to information about TB disease and TB health services are the leading information accessibility issues, in Ethiopia. Furthermore the limited availability of trained TB health workers in TB centers, primary health care and other clinics, and prisons. Additional availability issues include a lack or limited availability of TB treatment support services, particularly counseling and other mental health care. There is limited availability of rapid molecular diagnostics for TB that is faster and more accurate than traditional sputum smear microscopy and detect resistance to first-line TB drugs. First-line TB drug stock-outs.

The two principal discrimination accessibility challenges identified are discriminatory treatment of TB key and vulnerable populations in health care and discriminatory administrative barriers to health services. The latter includes residency and identification requirements to access TB health services, impacting mobile populations, internally displaced persons, and people with a history of imprisonment. Lack of access to nutritional support during TB treatment is another major concern in Ethiopia. The additional acceptability challenges related to operational issues, including limited hours, long wait times, and overcrowding at TB clinics. These operational issues are also accessibility and quality concerns. The primary quality issue in Ethiopia is the limited availability of trained TB health workers, which is noted above as an availability concern. The misdiagnosis or delayed diagnosis and inappropriate treatment of people with TB are also major quality concerns.

REMARKABLY, DESPITE THE EVIDENCE OF WIDESPREAD DISCRIMINATION AGAINST PEOPLE AFFECTED BY TB, ETHIOPIA HASN'T EXPLICITLY PROHIBITS TB-RELATED DISCRIMINATION IN LAW, THUS LACK LEGAL PROHIBITIONS TARGETING DISCRIMINATION AGAINST PEOPLE AFFECTED BY TB.

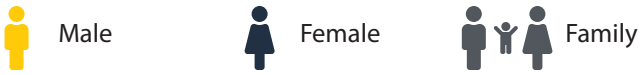
Nondiscrimination and equal treatment

The nondiscrimination and equal treatment dimension comprises the prohibition against discrimination in health care and the underlying determinants of health, and a positive dimension requiring states "to provide those who do not have sufficient means with … health groups" in the process and content of their public health strategies and action plans and to ensure that health workers are "trained to recognize and respond to the specific needs of vulnerable or marginalized groups."
Identifying groups who are especially vulnerable to TB infection or disease or who experience barriers to accessing TB health services is a unique component of the CRG assessment. There is various programmatic, legal, and policy gaps and barriers that negatively impact TB key and vulnerable populations in Ethiopia. These include an absence of policies, programs, and dedicated resources in national TB programs recognizing and prioritizing these populations in national disease responses.
The national TB programs do not effectively disaggregate data for TB key and vulnerable populations to understand their size, locations, and unique vulnerabilities. The fear of Criminal or administrative laws and policies and law enforcement deter the use of TB health services among these populations, such as people who use drugs, sex workers, undocumented migrants, and people with a history of imprisonment.

Remedies and accountability

The remedies and accountability dimension of the right to health framework embodies the importance of accountability and effective remedies for health-related human rights violations, enabled by courts and non-judicial mechanisms at the national and international levels. In Ethiopia, people affected by TB have limited access to justice and accountability mechanisms in the TB response. There are a range of issues for which remedies and accountability were out of reach. These include discrimination in employment and health care, violations of the rights to privacy and confidentiality, denial of health services, and compensation for occupational exposure to TB, including for health workers. Furthermore, people affected by TB lack access to justice due to the absence or limited availability of legal aid services. In addition, the limited use of courts by people affected by TB is due to low levels of legal literacy and knowledge about legal rights. There also existed lack of accountability for preventable TB deaths, inappropriate medical treatment of people with TB, and other issues of serious neglect of people affected by TB, including in prisons.

Participation



insurance and health-care facilities."
In Ethiopia people affected by TB experience discrimination in health care, including when they seek TB care but also in primary health care settings. People affected by TB experience employment discrimination at the hands of both employers and coworkers. Discriminatory and stigmatizing treatment of people affected by TB in families and communities are exhibited as well. In the family context, women affected by TB are sometimes divorced or abandoned because of their experience with the disease. Children and young people affected by TB also experience discrimination in education, in both schools and higher education.
Remarkably, despite the evidence of widespread discrimination against people affected by TB, Ethiopia hasn't explicitly prohibits TB-related discrimination in law, thus lack legal prohibitions targeting discrimination against people affected by TB. However, the law and policies governing the TB response in Ethiopia does not contain stigmatizing and discriminatory terminology. Instead the laws or executive decrees address discrimination against all person, which includes and some aspects of discrimination against people with TB, including in employment.

Health-related freedoms

Health-related freedoms include the rights to privacy, to confidentiality, and to be free from nonconsensual medical treatment (i.e., the right to informed consent), as well as the freedoms of association, assembly, and movement.
The lack of protection for the privacy and confidentiality of people affected by TB in law, policy, and practice is the central challenge to health-related freedoms in Ethiopia. These include a lack of privacy and breaches of confidentiality in health care that deter the use of TB testing and treatment services and challenge treatment adherence. The laws protect confidentiality in health care more generally. In practice there existed privacy concerns related to TB public health activities, including contact tracing and disease notification procedures. Furthermore, TB clinics' infrastructure and operational procedures impinge on privacy with exterior and interior signs and waiting room practices. Involuntary isolation and hospitalization of people with TB is also the other concern. Ethiopia has laws authorizing the quarantine or compulsory hospitalization of people with infectious diseases which includes people with TB. There is arbitrary arrest, detention, or imprisonment of people with TB or multidrug-resistant TB for posing a threat to public health or for stopping treatment. Regarding testing or treatment of people affected by TB, there is lack of protection of the right to informed consent for TB treatment and testing or during the collection of personal health data for public health purposes.
The Criminal Code of the Federal Democratic Republic of Ethiopia (FDRE Criminal Code) under Article 514, criminalize the transmission of a communicable human disease, that include TB, which discourage health-seeking behavior among people affected by TB and created barriers to health services for people affected by TB, including for TB key and vulnerable populations.

Gender perspective

The gender perspective dimension of the right to health framework encompasses states' obligation to "integrate a gender perspective in their health-related policies, planning, programmes and research," including the disaggregation of health data according to sex..
In Ethiopia, the primary issue is the impact of patriarchal social and cultural norms, including around domestic gender roles and household finances. Patriarchal norms limit women's health-related decision-making autonomy, impede their access to TB health services, and increase their vulnerability to TB infection and disease. Women affected by TB experience more frequent or more intense stigma and discrimination than men in their families and communities, sometimes leading to abuse, gender-based violence, divorce, or abandonment. In addition, women in Ethiopia lack access to information and are less knowledgeable than men about TB disease and TB health services.

Men affected by TB also face unique challenges. Men experience heightened risks of exposure to TB infection, reduced access to TB health services, and higher mortality rates from TB due to a host of factors, including employment insecurity, occupational exposure, labor migration, notions of masculinity, and social and behavioral factors such as smoking, excessive alcohol consumption, and problematic drug use.

There is substantial gender-related programmatic, legal, and policy gaps in the national TB responses. These include the lack of explicit legal prohibition of gender-based discrimination in health care and the failure to consider the role of gender in TB programs, policies, guidelines, and monitoring and evaluation frameworks. Furthermore there is limited availability or lack of gender-sensitive TB health services, due to the lack of gender-sensitivity training for TB health workers, among other things.

Vulnerable and marginalized groups

The vulnerable or marginalized groups dimension comprises states' obligation to "give particular attention to all vulnerable or marginalized

The participation dimension represents the right of affected communities to participate "in all health-related decision-making at the community [and] national … levels."
In Ethiopia, there is significant lack of mobilization and meaningful engagement of people affected by TB and TB key and vulnerable populations in the national TB responses. These includes low number of civil society and community groups working on TB, limited influence of such groups, and limited financial and other support available to these groups to facilitate their meaningful participation in the TB response. Furthermore, national TB programs fail to meaningfully engage people affected by TB in designing, implementing, monitoring, and evaluating TB policies and programs. This gaps or barriers in law and policy hinder the meaningful participation of communities affected by TB.

Legal and Policy Frameworks For Selected Key Populations

Healthcare workers

Healthcare workers (HCWs) are protected by the broad rights set out in the Constitution as well as by the range of general labour-related legislation and health laws, which are stated above. These protect the rights of HCWs to fair labour practices, non-discrimination in the workplace as well as protection from occupational injury and disease. The Ethiopian Constitution is the foundation for the governance of OSH. It has numerous articles that ensure the protection of citizens and workers from environmental and work related hazards. The Ethiopian Labor Proclamation No. 1156/2012 has established the provisions of OSH in work places. The proclamation enforces that the employer has a legal obligation to protect workers from injuries and illnesses, including the provision of occupational health services.

The National Health Policy of 1993. The policy has clearly indicated principles that directly deal with the issues of occupational safety and health. Under Article 2(2) the policy states that emphasis will be made in order to the promotion of occupational health and safety in industries and production sectors. It also states the development of environmental health which also include occu-

THE RIGHT TO HEALTH FRAMEWORK

AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND QUALITY (AAAQ)

pational health (Article 2(3)). Under strategies to implement the policy it is clearly stated that inter sectorial collaboration shall be made in order to develop facilities and mechanisms for workers health and safety in production sectors (Article 3(9)). The Federal Government also approved National Occupational Health and Safety Policy 2014. However, a lack of local policy statements at the enterprise level and the existence of inadequate awareness of the existing regulatory provisions are challenges that still require immediate attention to reflect the National level of OSH Policy.

Regarding healthcare professionals occupational health and safety specifically, these provisions provides that health establishments must implement measures that minimize injury or damage to the person or property of HCWs. This means that HCWs must be protected from physical harm and their working environment made safe and free from any hazardous incidents. The proclamation establishments to ensure compliance with these standards. Various infection control policies have been developed in the healthcare sector to give effect to these legal provisions. Specifically in relation to TB, the Guidelines On Programmatic Management Of Drug Resistant Tuberculosis focus on the clinical management, referral mechanisms and models of care and cover psychosocial support to ensure comprehensive management of patients, strategies for infection prevention and control, and occupational health services for healthcare workers (HCWs). These guidelines provide, among others, that the management of MDR-TB will be conducted in dedicated MDR-TB units, in other health care facilities and in the community by trained healthcare workers in an environment with appropriate infection control measures to prevent nosocomial transmission of DR-TB. The health extension system aims to support community health workers, working with health professionals, to form the bridge between communities and health service provision within health facilities, to bring healthcare closer to communities. It contains important guidelines for strengthening the management and training of community health workers in various ways, including in terms of improved occupational health and safety processes.

These Guidelines also provide additional protection for the labour rights of healthcare workers who contract drug-resistant TB through work: they note that as a general rule, HCWs who contract DR-TB through work should not be dismissed on the basis of incapacity at the expiry of their paid sick leave. A fair procedure should be followed, including an investigation into the nature and extent of the incapacity, the effects of treatment, and alternatives to dismissal. This would usually result in extended sick leave being granted. The provision of extended sick leave to an employee, at least on an unpaid basis or at less than full pay, in order to undergo treatment for MDR-TB would be regarded as fair. Fairness can only be tested in the circumstances of each particular case, and factors such as disability insurance and ill-health retirement benefits as alternatives would be relevant." The Guidelines for Clinical and Programmatic Management of TB, TB/HIV, DR-TB and Leprosy stipulate that all staff and persons residing in the congregate setting should be given information and be encouraged to undergo

THE FEDERAL GOVERNMENT ALSO APPROVED NATIONAL OCCUPATIONAL HEALTH AND SAFETY POLICY 2014.

periodic TB screening and diagnostic investigation if they have signs and symptoms suggestive of the disease. If diagnosed with TB and/or HIV, they should be offered a package of prevention and care that includes regular screening for active TB.

People Who Use Drugs

Addressing any health disparity, including highly contagious yet highly manageable TB, is impossible without involving the communities of people who use drugs (PWUD) and acknowledging their fundamental rights to health, dignity and life. Recognizing that PWUD as individuals and as a group have agency to take charge of their own health, while providing access to the necessary services and support, is the only way forward for curbing TB in this population.
WHO have produced consolidated guidelines for an integrated package of HIV and TB care for people who use drugs, guiding national health responses for people who use drugs. People who use drugs have the same rights as all persons, including the right to equality and non-discrimination and the right to access healthcare services. However, national drug laws and policies in Ethiopia are prohibitionist and punitive, supporting abstinence and justifying negative attitudes towards drug use and people who use drugs in the public healthcare sector. Newer policies and guidelines have started to move towards aligning with international standards for harm reduction for people who use drugs.

At international level Ethiopian has ratified international conventions adopted by the UN to control drug abuse include; the 1961 Single convention on narcotic drugs, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against illicit traffic in psychotropic and narcotic drugs offers legal apparatuses for implementing the former conventions and has also established organizational structures such as Drug Administration and Control Authority of Ethiopia, the Illicit drug control units in the Federal and Regional police commissions, drug treatment centers to deal with drug issues. Pursuant to Article 9 (4) of the FDRE Constitution all the three United Nations Conventions on drug control are considered as the integral part of the national laws on drug control.

At national level, the Health Policy of 1993 mentions in its Information, Education and Communication Strategy to "discouraging the acquisition of harmful habits such as cigarette smoking, alcohol consumption, drug use and irresponsible sexual behavior". The Gov-

ernment promulgated The National Drug Policy of 1993 as a follow up to the health policy and commensurate with the Transitional period charter and the economic policy of Ethiopia. This policy provides the power to the then Drug Administration and Control Authority (DACA) of Ethiopia, now Ethiopian Food, Medicines and Health Care Administration and Control Authority (EFMHACA) provides to make the necessary efforts to deter the illegal manufacturing, distribution and consumption of narcotic and psychotropic drugs and the control of precursor chemicals. In 2013, EFMHACA developed three important guidelines that are being implemented currently. The National Drug Policy 2015 – 2020 reinforces the provisions of the previous one.

The Food and Medicine Administration Proclamation No: 1112/2019 regulates drugs and medicines in Ethiopia. In terms of drugs, the proclamation draws on the UNODC 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances, determining which substances are classified as illicit drugs and under what circumstances they are scheduled medicines. The Criminal Code criminalizes the use of certain drugs in Ethiopia. It provides for the prohibition of the use or possession of, or the dealing in, drugs, defining illegal acts, the roles and processes of law enforcement and penalties for drug use or possession. This code predominantly guides law enforcement and sets up an overarching legislative framework in which all drug use and people who use drugs are criminalized. This have been shown to create barriers to healthcare services for people who use drugs; it would also impact on their access to TB-related healthcare services and have a profound impact on health-seeking behavior among people who use drugs. Punitive drug policies and criminalization also lead to complete disregard for the human rights of PWUD, widespread harassment and violence by police, and the reinforcement of societal stigma. Both in police lock-ups and in health settings, criminalization translates into discrimination against PWUD, denial of care and treatment, and other practices that can be characterized as cruel, inhumane and degrading, such as the use of withdrawal during interrogations or while in pre-trial detention.

The National Mental Health Strategy addresses the needs of those who suffer from common substance abuse. The goal of this strategy addresses the mental health needs of all Ethiopians(which includes people who use substance) through quality, culturally competent, evidence-based, equitable and cost-effective care, along with accessibility, the need to protect human rights, efficiency and sustainability, and community involvement and participation, are the principles and values from which this strategy was developed.

The National Drug Control Master Plan (NDCMP) 2017-2022 under section 2.5.2.2 incorporated treatment, rehabilitation and social reintegration. The master plan mandated the Ministry of Health to use its national infrastructure to bring quality and affordable drug use disorders treatment closer to communities. It also mandated the Ministry to build the capacity of its cadres of professionals to offer a spectrum of treatment services, ranging from Brief Interventions, screening and diagnosis, psychosocial support and pharmacological treatment when indicated.
The NDCMP objectives for the treatment, rehabilitation and social reintegration priority area, includes to offer affordable and accessible treatment for substance use disorders and improve the quality of life of people who use drugs (PWUD), to intervene at the earliest possible point in order to reduce the negative consequences associated to drug use, to strengthen the national capacity for the provision of rehabilitation and social reintegration to people who use drugs, and to ensure the availability of the relevant medication for the treatment of substance use disorders.
The NDCMP also uses human rights-based terminology in relation to drug use and includes people who use drugs as a target population for stigma and discrimination reduction measures.
The Guidelines On Programmatic Management Of Drug Resistant Tuberculosis provide TB healthcare services for people who use drugs but require “rehabilitation” for those who fail to adhere to treatment, in order to continue treatment. However, drug treatment centers are unable to accept patients with MDR-TB, so the policy is, in effect, exclusionary.

Mineworkers

Mineworkers are protected by the broad rights set out in the Constitution as well as by the range of general labour-related legislation, which are stated above. These protect the rights of Mineworkers to fair labour practices, non-discrimination in the workplace as well as protection from occupational injury and disease.
The Constitution is the foundation for the governance of occupational safety and health in work places. Article 42(2) stipulates that “Workers have the right to reasonable limitation of working hours, to rest, to leisure, to periodic leaves with pay, to remuneration for public holidays as well as healthy and safe work environment”. Under Article 89(8) the constitution states that “Government shall endeavor to protect and promote the health, welfare and living standards of the working population of the country.” It also has numerous articles derived from this Constitution that ensure the protection of citizens and workers from environmental and work related hazards.

The Economic Policy of 1992 indicate the need for a labour law that determines fair and applicable labour relation, occupational safety and health and working conditions in the spirit of market economy. According to the policy, the labour law to be issued this way will facilitate the development of private ownership as prime and sole actor in the economic development of the nation. Accordingly, The Ethiopian Labor Proclamation No. 1156/2012 has established the provisions of occupational safety and health in work places. The proclamation enforces that the employer has a legal obligation to protect workers from injuries and illnesses, including the provision of occupational health services.

The National Health Policy of 1993 has clearly indicated principles that directly deal with the issues of occupational safety and health. Under Article 2(2) the policy states that emphasis will be made in order to the promotion of occupational health and safety in industries and production sectors. It also states the development of environmental health which also includes occupational health (Article 2(3)). Under strategies to implement the policy it is clearly stated that inter sectorial collaboration shall be made in order to develop facilities and mechanisms for workers health and safety in production sectors (Article 3(9)).
The Federal Government also approved National Occupational Health and Safety Policy 2014. However, a lack of local policy statements at the enterprise level and the existence of inadequate awareness of the existing regulatory provisions are challenges that still require immediate attention to reflect the National level of OSH Policy.

Miners face numerous barriers to diagnosis and treatment. Small-scale and illegal mining operations most likely do not provide healthcare services for their employees, who therefore rely on public services that may be difficult to access. Mine workers at larger mines are likely to have access to occupational health services while they are working, but continuity of care, adherence, support and access to diagnostic facilities are not always available once they return home. Furthermore, miners sometimes avoid seeking diagnosis or treatment because of fear of stigma from family members and HCWs. Mineworkers often return or are sent home after acquiring TB, where social networks and support systems may be stronger, to convalesce and possibly to die .
People returning to labour-sending communities tend to have poor treatment outcomes and carry their infections with them. Moreover, miners returning home sick places additional strain on the families and communities they come from who have to carry the

THE RIGHT TO HEALTH FRAMEWORK

AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY, AND QUALITY (AAAQ)

burden and costs of care, as well as the risks of infection without the income that the miner would have sent home as remittances. Women in rural labour-sending communities lose their primary breadwinner and have the combined burden of having to look after the sick, care for children and look for a job - causing not only physical distress, but also emotional distress in many of these women and their families. The TB epidemic in peri-mining and labour-sending communities is often exacerbated by misinformation, TB stigma and healthcare mistrust. Additional barriers to care in these communities include lack of access to mine occupational health services and having to travel long distances to access care.

Compensation for occupational diseases such as silicosis and TB remains difficult for miners' families to obtain. This compensation typically includes only work shifts lost due to hospitalization, and requires evidence of second-degree tuberculosis or permanent lung damage from a medical doctor. Families typically report no compensation or delayed compensation, which contributes to poverty after the loss of the household breadwinner. This also means that the families of disabled miners and ex-miners bear the direct costs of care.

Prisoners/Inmates

The Federal Prison Proclamation No. 1174/2019 provides that prisoners shall be treated with respect to their human rights, dignity, and health. The premises and compounds of prisons shall also not be hazardous to health, and they shall have fresh air and sufficient lights. This is important due to the fact that the prison environment and conditions - overcrowding, congestion, poor ventilation, - may place prisoners at high risk of TB exposure and infection; prisoners have a right to be protected from ill health within the prison environment. Thus, the implementation of these provisions is vital to protect the health of prisoners and to decrease their risk of exposure to TB. The Proclamation also provides that the commission shall maintain prisoners' health care, and provide prisoners with free medical treatment. It also undertakes and encourages tasks, services, and activities necessary for the physical and mental well-being of prisoners.
The Proclamation also established the Committee of Community Leaders which combination of voluntary individuals recognized in the community, especially religious leaders, cultural leaders, elders, human rights advocates, famous individuals, and the like. The Committee shall ensure the treatment of prisoners by the Commission respects the Constitution, international human rights agreements Ethiopia has accepted, the Proclamation, and other relevant laws, which positively impact the respect of human rights of prisoners affected by TB and enhance accountability.

IN ETHIOPIA TO THE SAME RIGHTS AND FREEDOMS, AND PROHIBITS DISCRIMINATION BASED UPON RACE, NATIONALITY, GENDER, COLOR, LANGUAGE, RELIGION AND POLITICAL OPINION (CHAPTER III, ARTICLE 25).

The Treatment of Federal Prisoners Council of Ministers Regulations No. 138/2007 provide that the treatment of prisoners shall be treated based on the basic principle of respect to their human dignity and no discrimination on the ground of gender, language, religion, political opinion, nation/nationality, social status or citizenship (Article 3(1) and(2)). Prisoners are also subjected to medical examination when admitted to prison and prisoners with communicable diseases will have separate accommodations from other prisoners (Article 4(3) and 5(3)(d)). The Directive also provides that the premises in which prisoners live shall have windows large enough to allow adequate fresh air to circulate. Prisoners are also should be provided with medical treatment free of charge with adequate medical equipment and medical facility (Article 11). The implementation of these provisions is vital to protect the health of prisoners and to decrease their risk of exposure to TB. A New directive is also underway on the health of prisoners.
The current Guidelines for Clinical and Programmatic Management of TB, TB/HIV, DR-TB and Leprosy stipulate that buildings in congregate settings should comply with regulations for ventilation in public buildings as well as specific norms and regulations for prisons. Relating to the management of tuberculosis in correctional facilities, it stipulates that TB identification must be conducted upon entry/periodically and upon exit, separation, and effective treatment of those diagnosed with TB. Symptomatic inmates must provide sputum samples for further investigation as well.

The guideline requires cough etiquette and respiratory hygiene to be implemented to decrease TB transmission in congregate settings (prisons). This should be done with early identification, followed by separation and proper treatment of infectious cases. In particular, all inmates of long-term stay facilities and inhabitants of other congregate settings should be screened for TB before entry into the facility. People suspected of having TB should be diagnosed as quickly as possible. They should always be separated and/or isolated in an adequately ventilated area, until sputum smear conversion. Directly observed therapy (DOT), while a patient is on treatment, is also recommended. In short-term stay congregate settings, such as jails and shelters, a referral system for proper case management of cases should be established. In congregate settings, patients living with HIV and other forms of immunosuppression have to be separated from those with suspected or confirmed infectious TB.

People with Diabetes

A study documented the prevalence of diabetes (8.3%) among Ethiopian TB patients to be twice higher than the diabetes prevalence (3.9%) reported in the general population. Another locally published study indicated that 5.8% of DM patients were reported to have

active TB. The rate of diabetes co-morbidity was more than double the prevalence estimate in the general population of Ethiopia.

The current Guidelines for Clinical and Programmatic Management of TB, TB/HIV, DR-TB and Leprosy stated the management principles of TB/DR-TB in patients with diabetes similar to non-diabetic patients; However, with reconsideration in view of the increased treatment failure rates seen in patients with uncontrolled diabetes. The guideline recommended aggressive treatment for patients with uncontrolled diabetes since these patients have increased rates of relapse and recurrence. It required very close monitoring of the patient to optimize glycemic control. It also states priority to be placed on early detection of both diseases through active screening, monitoring of adherence to medications for both diseases, and integration of TB and DM management strategies that would facilitate the provision of more comprehensive services that TB patients with DM require.

However, the high proportion of people with DM and TB remaining undiagnosed in Ethiopia or being diagnosed at a late stage is mainly because of the lack of early detection of the diseases which leads to more severe disease presentations, higher mortality, and higher cost of treatment. If DM is diagnosed early in TB patients and optimal glycemic control is maintained during TB treatment, the treatment outcomes can be improved. However, data on the rate of undiagnosed DM, treatment outcome and DM screening using risk scoring among TB patients is limited in Ethiopia.
In Ethiopia almost all of TB clinics are not doing routine screening for DM, requiring deliberate actions to initiate the practice. However, the clinicians in the TB clinics promptly learned how to do DM screening once training, tools and test kits were made available. Ensuring continuity of this practice will depend on the longer-term availability of resources including adequate funding and technical expertise.

A fragmented healthcare system necessitated patients with TB-diabetes multi-morbidities to attend a variety of different healthcare facilities, undermining their health-seeking behavior. Often co-morbidity and healthcare require that referrals be made to an appropriate facility for tuberculosis treatment.
National programs need to establish a coordinated response to these two diseases at both the organizational and clinical levels. Given the growing epidemic of DM, it is necessary to add DM prevention and control strategies to TB control policies and programs and vice versa and to evaluate their effectiveness.

Internally Displaced People (IDPS) and Refugees

TB is most severe in migrants, refugees, and displaced populations due to reasons including poor shelter and living conditions, poor health and nutritional status, overcrowding, and inadequate access to TB care and prevention. Thus, these key populations face higher risk to TB infection and diseases progression, contracting or developing MDR-TB, and unsuccessful TB treatment outcome. Reports showed lower treatment success rate in TB patients among refugee populations (74.2%) compared to surrounding communities (88.1%) in Gambella region in Ethiopia.

Tuberculosis control programs are disrupted in conflict situations. Emphasis is placed on ensuring early detection of cases, response and close follow up. TB treatment in the initial phases of an emergency is provided at closer public health facilities until the service is established in the refugee camps. All TB cases are linked to HIV prevention and treatment and are screened for HIV.
All the supplies to diagnose TB in the laboratory and treat cases are obtained from the Ministry of Health, through the Regional Health Bureau and are provided to ARRA to run the health facilities, which provide the service free of charge. ARRA is also a member of the Steering Committee for TB at the Ministry of Health. In order to improve the health system's ability to undertake proper case detection, treatment and follow up, ARRA has discussed with the Ministry on the possibility of organizing joint supervision of health facilities in the camps. This joint supervision is expected to the TB program among the refugee population by strengthening case detection, diagnostic capacities of the laboratories, the treatment and follow up services.

Principles of equality and non-discrimination provide the foundations for the realization of all other human rights, including the right to health. In keeping, the Constitution entitles all people. in Ethiopia to the same rights and freedoms, and prohibits discrimination based upon race, nationality, gender, color, language, religion and political opinion (Chapter III, Article 25).
In addition, Refugee Proclamation No. 1110/2019 states that every recognized refugee and asylum seeker shall have access to available health services in Ethiopia (Part IV, Article 25), and is entitled to the rights and subjected to the obligations contained in the International Refugee Convention, the OAU Refugee Convention and other applicable international laws (Part IV, Article 22). The Proclamation enables refugees in Ethiopia to be more independent and better protected, and to have greater access to local solutions. It also has been praised by many as "one of the most progressive refugee policies in Africa."
The passage of Refugee Proclamation was followed by the development of a ten-year National Comprehensive Refugee Response Strategy (NCRRS). The NCRRS has been accompanied by a multi-sectorial RRP 2020-2021. The RRP 2020-2021 is grounded in the spirit of the GCR and aims to contribute to the ten-year NCRRS.

In keeping, the RRP 2020-2021 outlines the collective response of concerned humanitarian and development partners in support of registering all refugees in the country. Among its strategic objectives and operational priorities, the RRP 2020-2021 calls for improving documentation and strengthening refugee protection through the expansion of improved community-based and multi-sectorial child protection and sexual and gender-based violence (SGBV) programs, as well as improving access to health related services.
In keeping with the RRP 2020-2021, the modality for improving refugees access to health services is intended to occur by strengthening existing health care facilities in refugee camps. To ensure sustainability, the plan is to integrate refugee health services into health service delivery provided by RHBs and the MoH. The National Health Policy was under revision and incorporated into Section II was a mention of refugees as a specific population group, along with elderly, disabled and others. Given the National Health Policy is a high-level strategic document that provides overall guidance and direction, having a focus on refugees is important and helps to bring national policy in line with international commitments of the GoE and with the Refugee Proclamation No. 1110/2019.

In light revisions to the National Health Policy, it is reasonable to expect that Health Sector Transformation Plans (HSTPs) will be more considerate of the country's legal commitments to address the health needs of refugees, particularly those in humanitarian settings, including women, children and adolescents. HSTPI, on which many of the current guidelines are based, never referred to refugees; however, HSTPII 2021-2025 mentions refugees and IDPs in its SWOT analysis and risk mitigation sections. The strategy outlined in HSTPII 2021-2025 is to establish service delivery points at IDP sites and refugee centers, and to strengthen health services in these sites. The more challenging aspect of ensuring access to health services in humanitarian settings requires addressing gender barriers embedded in legal and policy frameworks, particularly barriers that hinder demand and access to health services in humanitarian settings. Although the GoE has made some progress to address barriers faced by refugees in accessing health services, there are barriers that remain at national, regional and local levels. Consultations with key stakeholders revealed some interesting findings about barriers faced by refugees when it comes to accessing health services. Data from this assessment revealed a discrepancy between policy and current practices in delivery of health services in humanitarian settings, as revealed in two refugee camps in Gambella Region.
Advocating for the integration of refugee health care into the national health system, and working toward bridging the gap between policy and local practices is a strategic and sustainable way to address and improve refugee's access to health services. To this end, legal and policy frameworks play critical roles in addressing the needs of refugees in humanitarian settings, either by facilitating or serving as barriers to demand their rights and access to life-saving health services.

CHAPTER FIVE

CRG CASE STUDIES

"Empowering communities, upholding rights, advancing gender equity, and promoting people-centered care are vital for effective TB prevention, control, and treatment."

TB Affected communities Focus group discussions were held in selected health facilities. They were conducted during v-club experience sharing events. Attention was paid to their discussion to include all concerns that had been made, which is related to CRG key assessment quires. In addition, More than 50 survivors detail TB experience and biographies were collected via informant interviews.

The process of conducting case studies involving vulnerable patients begins with careful consideration of ethical guidelines and informed consent. Our consultants ensure that appropriate measures are taken to protect the confidentiality and privacy of participants. This includes obtaining permission from relevant ethical review boards and requesting consent from the patients or their representatives. The selection process for case studies should be comprehensive, taking into account factors such as the specific vulnerability being studied, the availability of suitable cases, and the potential benefits and risks involved.

Once the cases have been identified, consultants began data collection. This typically involves a thorough review of the patient's medical records, interviews with the patient and relevant healthcare providers, and any necessary assessments or tests. It is crucial to approach this process with sensitivity and empathy, as vulnerable patients may have complex physical, emotional, or socio-economic circumstances that influence their experiences. We tried to adapt our data gathering methods to accommodate any special needs or limitations of the patients being studied. After collecting the necessary data, consultants analyzed the information by identifying key patterns, themes, or trends. This analysis often involves coding and categorizing the data to identify common factors or issues related to vulnerability. Consultants may use various analytical frameworks or theories to guide their interpretation of the findings. It is important to acknowledge the unique experiences and perspectives of each patient, while also considering broader health disparities and social determinants that contribute to vulnerability.

Finally, consultants developed a protocol or framework based on the insights gained from the case studies. This protocol acts as a guide for future healthcare interventions, policymaking, or educational initiatives aimed at addressing the needs of TB key and vulnerable populations. The narration includes background, case details, specific barriers and possible recommendations for tailored support systems, targeted interventions, or improved access to care. Dissemination of the findings and best practices is an essential part of ensuring that the knowledge gained from the case studies can be translated into practical improvements in healthcare delivery for vulnerable populations.

Case Study 1: Gemechu Terefe- Daily laborer

Background: Gemechu is a daily laborer in a small-scale marble producing company around Sululta city. Due to inadequate safety measures and lack of healthcare access, he contracted tuberculosis.

Case Study: Gemechu working in a dusty environment with limited safety precautions, faces exposure to various occupational health hazards, including dust, toxic chemicals, and poor ventilation. These conditions increase his risk of contracting respiratory diseases, such as Pneumonia and tuberculosis. Furthermore, the lack of access to healthcare services specific to small industries prevents Abebaw from receiving timely medical intervention and preventive measures. His working conditions and the absence of regular health screenings contribute to delayed diagnosis and treatment, may exacerbating the spread of infectious diseases within the mining community.

Challenges: The lack of occupational health protections and inadequate access to healthcare violate Gemechu's human rights and exacerbate his health risks. The infectious disease negatively impacts his physical well-being, causing respiratory symptoms, lung damage, and potential long-term complications. The absence of appropriate medical care and preventive measures also heightens the risk of transmission to other miners and their surrounding communities.

Recommendations: Cement and marble companies, regulatory bodies, and healthcare providers collaborate to address the occupational health hazards and healthcare needs of daily laborer. Strict enforcement of safety regulations and implementation of proper ventilation systems, protective equipment, and regular health screenings aim to minimize the risk of infectious diseases.

Accessible and specialized healthcare services are established to provide comprehensive medical care to daily laborer, including diagnosis, treatment, and preventive measures tailored to their specific occupational health risks. Education and training programs are conducted to raise awareness among miners about the importance of safety precautions, early detection, and seeking timely medical assistance.

Advocacy efforts focus on improving the rights and working conditions of daily laborer, advocating for stricter regulations, fair compensation, and access to quality healthcare. Collaboration between companies, government agencies, healthcare providers, and community organizations aims to address the systemic issues contributing to the health risks faced by miners and protect their human rights.

 Male

 Female

 Family

Case Study 2: TB, Disability and Stigma

Shimeles is 39-year-old man who lives alone in Slums called Koshe. Due to his leprosy, he has limited mobility, relying on a walker to move around. Since, he had no job; he is struggling to put food in his table. On the top of that, having TB has made him more vulnerable in terms of physical and psychological well-being.

Physically, Mr. Shimeles faces challenges in performing daily activities such as bathing, cooking, and cleaning. His limited mobility and injuries make it difficult for him to complete these tasks independently, increasing the risk of accidents or further injuries. He requires assistance from family members or caregiver to carry out these activities safely, but he doesn't have any.

Mr. Shimeles faced significant stigma and discrimination due to misconceptions surrounding leprosy. Some community members believed that leprosy was highly contagious, despite evidence to the contrary, leading to fear and avoidance. People treated him as an outcast, and his disability contributed to the negative perception and exclusion.

The combination of the physical disabilities resulting from leprosy and the social stigma surrounding TB had a profound impact on Shimeles's life. He faced barriers to employment, education, and social participation. The isolation and discrimination he experienced contributed to feelings of low self-esteem and a diminished sense of belonging.

Recommendations: Disability rights organizations and healthcare providers collaborate to address the healthcare needs of individuals like Shimeles. Efforts are made to ensure that healthcare facilities are fully accessible, with ramps, elevators, accessible examination tables, and appropriate signage.

Healthcare professionals receive training on disability sensitivity and inclusive care, improving their ability to meet the specific needs of individuals with disabilities. Accommodations, such as sign language interpreters or alternative communication methods, are provided to facilitate effective communication between healthcare providers and patients with disabilities.

Advocacy initiatives focus on raising awareness about the rights of individuals with disabilities to accessible healthcare and the importance of removing physical and communication barriers. The implementation and enforcement of disability rights legislation ensure that healthcare facilities comply with accessibility standards.

Case Study 3: Stigma and Discrimination against TB affected individual

Sarah is a teacher who was diagnosed with DRTB two years ago. She takes anti-TB medication, which helps manage her condition and prevent transmission. However, she has faced significant stigma and discrimination from various aspects of her life.

Sarah worked as a teacher in a primary school. When her colleagues discovered her TB status, they started treating her differently. They refused to share office or workstations with her, fearing they would contract TB. Some even spread rumors about DRTB, further fueling the stigma. Sarah's work environment became hostile, impacting her mental health and force to leave her Job. Sarah also faced discrimination in her community. Some neighbors shunned her, believing that living near someone with DRTB would put them at risk.

The stigma and discrimination Sarah experienced took a toll on her emotional well-being. She felt isolated, depressed, and anxious. The hostile work environment caused her to consider leaving her job, affecting her financial stability. The discrimination in her community led to social exclusion and strained relationships with neighbors, adding to her overall distress.

Sarah reached out to local TB support organizations, where she found counseling and support groups. These resources helped her regain her confidence and cope with the emotional impact of discrimination. She also collaborated with advocacy groups to educate her colleagues and community members about TB transmission and dispel misconceptions.

These case studies highlight the real-life experiences of individuals who face stigma and discrimination due to factors beyond their control. By understanding these examples, society can work towards creating more inclusive and accepting environments for all individuals.

Case Study 4: Employee Contracted TB – Sick leave policies

Zinash is a private bank employee who contracted drug resistance tuberculosis. Following her diagnosis, she experienced sever challenge because the paid number of days each year that an employee is allowed to be away from work didn't consider her situation.

Zinash faced the unfortunate consequence of being fired from her job due to having to miss work consistently as a result of TB treatment follow-up. In order to prevent the infection from spreading to other staffs, she had to quarantine herself and unable to take care of her workplace commitment for an extended period.

When Zinash informed her employer about her condition, she felt so pressured to come to work even when she is unwell, which can negatively impact her productivity and basic human rights. On the other hand, her boss faces difficulties in ensuring a healthy work environment and managing absences effectively in the absence of clear regulations.

The lack of a legal framework to manage patients who are unable to fulfill their workplace obligations due to illness can pose significant challenges for both the employees and the employers. Employers may find it difficult to handle such situations appropriately without clear guidelines in place. This can lead to confusion, disputes, and potential legal implications.

Recommendations: A well-defined legal framework could help address these issues by providing guidelines on employee rights, sick leave policies, and workplace accommodation for individuals with illnesses or disabilities. It would outline the rights and responsibilities of both employees and employers in managing such situations, ensuring that employees receive the support they need while maintaining the productivity and efficiency of the workplace.

Having a proper legal framework in place is crucial for effectively managing cases where employees are unable to fulfill their workplace obligations due to illness. It provides clarity, protection, and guidance for both employees and employers, helping strike a balance between supporting the individual's health needs and maintaining a productive work environment.

Case Study 5: Zewednesh Assefa, PLHIV

Background: Zewednesh Assefa is a person living with HIV (PLHIV) who contracted TB as well. She faces stigmatization and discrimination due to her HIV status and TB.

Case Study: Zewednesh, already living with HIV, contracts another infectious disease called tuberculosis due to a weakened immune system. However, when she seeks medical assistance, she faces stigmatization and discrimination from healthcare providers and the broader community.

Healthcare providers exhibit discriminatory behavior, refusing to provide adequate care or maintaining unnecessary precautions based on misconceptions about HIV transmission. Zewednesh also faces stigmatization from the community, experiencing social exclusion, isolation, and denial of basic services.

Challenges: The stigmatization and discrimination experienced by Zewednesh violate her human rights and have a detrimental impact on her well-being. The combined effect of HIV stigma and

discrimination related to TB contributes to increased emotional distress, mental health issues, and decreased self-esteem.
The stigmatization and discrimination also create barriers to accessing appropriate medical care and support, hindering her ability to manage her health effectively. It further exacerbates the burden she already experiences as a PLHIV, affecting her overall quality of life.
Recommendations: Efforts are made by HIV/AIDS organizations, advocacy groups, and healthcare providers to address the stigmatization and discrimination faced by PLHIV like Zewednesh. Educational campaigns and awareness programs are conducted to dispel myths and misconceptions about HIV and TB transmission and emphasize the rights and dignity of PLHIV.
Healthcare providers receive training on TB/HIV sensitivity, stigma reduction, and inclusive care practices. They are encouraged to provide non-discriminatory, person-centered care that respects the rights and autonomy of PLHIV.
Legal measures and policies are implemented to protect the rights of PLHIV and ensure equal access to healthcare services without discrimination. Complaint mechanisms and support systems are established to address instances of stigma and provide recourse for individuals like Anna.
Community engagement initiatives aim to foster empathy, understanding, and social inclusion for PLHIV and those affected by TB. Partnerships between HIV/AIDS organizations, healthcare providers, and community groups work towards creating an inclusive society that supports the rights and well-being of PLHIV.

Case Study 6: Birtukan Borru, exploitative labor practices/ low wages

Background: Birtukan Borru works as a daily laborer in special zones around the capital. Due to exploitative labor practices and inadequate living conditions, she contracted TB.
Case Study: Birtukan, employed in a mining operation characterized by exploitative labor practices, faces numerous challenges that impact her health. Long working hours, insufficient rest periods, exposure to hazardous substances and inadequate access to clean water and sanitation facilities contribute to her risk of contracting TB.
The living conditions provided by the mining company, such as overcrowded and unsanitary dormitories, further exacerbate the spread of infectious diseases among the miners. The lack of healthcare benefits or limited access to medical care prevents Maria from receiving necessary treatment and timely intervention for the infectious disease she contracts.

Challenges: The exploitative labor practices and substandard living conditions violate Birtukan's human rights and significantly impact her health. The infectious disease affects her physical well-being, causing discomfort, pain, and potential long-term complications. The lack of access to adequate healthcare denies her the right to receive timely medical assistance, exacerbating the spread of infectious diseases within the mining community.
Furthermore, the exploitative labor practices, including low wages, unsafe working conditions, and limited labor protections, contribute to economic vulnerability and perpetuate cycles of poverty and inequality.
Recommendations: Efforts are made to address the exploitative labor practices and improve the health and well-being of miners like Birtukan. Advocacy initiatives focus on improving labor laws and enforcement mechanisms, ensuring fair wages, reasonable working hours, and improved working conditions for daily laborers.
Private companies are encouraged to implement responsible working practices that prioritize the health and safety of workers. Access to clean water, sanitation facilities, and adequate living conditions are essential in minimizing the risk of contracting TB.
Educational programs were conducted to promote understanding and empathy among employees regarding TB. Birtukan Borru received support through counseling and access to mental health resources to address the emotional impact of the discrimination she faced.
To restore a positive work environment, the company fostered inclusivity and encouraged open dialogue about health issues. Measures were taken to ensure that all employees are treated with respect and dignity, provide a nutritional support.
These case studies demonstrate the importance of upholding human rights in the workplace, especially when employees contracted TB. Proper workplace protection, non-discrimination policies, privacy safeguards, and appropriate interventions are crucial in creating a supportive and inclusive work environment for all employees.

Case Study 7: TB and Divorce

Background: Aleganesh and Zebene have been married for 9 years and have two children. Aleganesh diagnosed with Resistance Tuberculosis (DR-TB), with severe symptoms of TB, such as persistent cough, fatigue, weight loss, and night sweats, which affect her physical look. Over time, her symptoms worsened, impacting her mobility and daily functioning. The strain of illness on their marriage ultimately led to divorce.

Case Study: DR-TB brought significant changes to their relationship dynamics. She used to be bread winner as well as a caregiver for the household, while Aleganesh grappled with the emotional and physical challenges of her condition. The stress of managing her medical needs and the financial burden of her treatments caused tension between them. Aleganesh's declining health affected their intimacy and communication, leading to feelings of frustration and isolation for both partners.
As Aleganesh symptoms progressed, she required more assistance with everyday tasks, such as bathing and dressing. Her husband felt overwhelmed and struggled to cover her caregiving role with other responsibilities. The constant strain and lack of support led to increased resentment and marital discord. Aleganesh experienced rejection from her spouse and even pressured to undergo a divorce, experienced self-stigma, and a fear of rejection or judgment from her spouse, hindering open communication about her health status.
Sexual intimacy also affected due to concerns surrounding transmission and the need for safer sex practices. The couple may experience a decline in sexual satisfaction, as fear and anxiety about TB transmission loom over their intimate encounters. These challenges can lead to a strain on the relationship and a decrease in overall marital satisfaction.
The challenges posed by Aleganesh's medical condition and the subsequent strain on their marriage eventually became unsustainable. The economic, emotional and physical toll on both individuals led to a breakdown in their relationship. The accumulated stress, lack of effective coping mechanisms, and shifting dynamics ultimately contributed to their decision to separate.
When a man divorces a woman solely because she is sick, it not only exacerbates her physical and emotional struggles but also adds to the psychological distress that comes with the breakdown of a marriage. This act of abandonment can have severe consequences on the overall well-being of the women involved, resulting in feelings of isolation, helplessness, and loss of dignity.
Recommendations: While her marriage ended in divorce, it is essential to highlight that divorce is not the only outcome in such situations. In some cases, In addition to the emotional toll it takes on women, divorcing them when they are sick often leaves them financially vulnerable. Many women who become ill face increased medical expenses and reduced earning capacity, making it extremely challenging for them to sustain themselves and maintain a decent standard of living. This further exacerbates their already precarious situation and reinforces the inequalities and disadvantages they experience as a result of their gender. Efforts need to be made at various levels to address this problem. Education and awareness campaigns that promote gender equality, empathy, and respect can play a crucial role in challenging the societal attitudes and norms that

perpetuate this harmful practice. Legal frameworks should be strengthened to protect the rights of individuals who are sick or disabled, ensuring fair treatment during divorce proceedings and providing adequate financial support.
More importantly, the harmful cultural practice of men divorcing women when they are sick highlights the urgent need for broader social change, where women are valued as equal partners and supported unconditionally during times of illness and hardship rather than being abandoned or mistreated. It requires collective efforts to challenge discriminatory practices and promote a more compassionate and inclusive society for all.

Case Study 8: Workplace Exposure - Lack of Protective Measures

Mohamed is a TB focal in one of rural healthcare facility in Amhara region, He contracted TB while he was working, He thinks, this is due to inadequate protective measures and safety protocols.
The healthcare professionals in this facility were providing care to TB patients without sufficient access to personal protective equipment (PPE) and proper infection control measures. As a result, several healthcare workers are vulnerable and at great risk, putting their own health and the health of their families at risk.
The lack of resources and training on infection prevention and control compromised the health professionals' safety. He was exposed to coughing, worked in close proximity to TB patients without appropriate barriers, and lacked access to regular testing and prevention. These conditions contributed to the spread of TB disease among the healthcare staffs.
Challenges: The exposure healthcare professionals for TB had significant consequences. They experienced physical and emotional distress, requiring medical treatment and isolation. The infected healthcare workers had to take time off work, leading to staffing shortages and disruptions in patient care. The situation also caused fear and anxiety among the healthcare staff, affecting morale and overall job satisfaction.
Recommendations: The healthcare facility need to take urgent measures to provide adequate PPE, train staff on infection prevention protocols, and establish regular testing and motivation programs for healthcare workers. Additionally, support services, including counseling and mental health resources, were made available to address the emotional impact on the affected professionals.
Efforts were also made to improve working conditions, including addressing staffing shortages and workload management. Regular monitoring and auditing of infection control measures were implemented to ensure ongoing compliance and the safety of healthcare professionals.

Case Study 9: TB and Homelessness

Background: Chuchu is a homeless individual living on the streets of Addis. Due to his unstable living conditions and limited access to healthcare, he contracted TB.
Case Study: Chuchu, without a stable home, faces numerous challenges in maintaining good health and Problems getting enough food. Living on the streets exposes him to unsanitary conditions, lack of food, and limited hygiene facilities. Additionally, his limited financial resources make it difficult for him to access healthcare services.
As a result, Chuchu contracted tuberculosis, due to the unhygienic environment and lack of preventive measures. However, without a stable address or means to seek medical assistance, timely diagnosis and treatment are delayed, leading to the spread of the infection within the homeless community.
Challenges: The lack of access to healthcare and stable housing violates Chuchu's human rights and exacerbates his health risks. TB affects his physical health, leading to discomfort, pain, and potential long-term complications. Moreover, the inability to access timely medical care pushed him to the verge of death, further endangering his physical health and well-being.
Recommendations: Homeless outreach programs, community organizations, and healthcare providers collaborate to address the healthcare needs of individuals like Chuchu. Mobile clinics and healthcare vans are deployed to reach homeless populations and provide essential medical services, including diagnosis, treatment, and preventive measures.
Temporary shelters and housing programs are established to provide stable accommodation for the homeless, ensuring access to clean water, sanitation facilities, and a safer living environment. Outreach workers and social workers connect individuals with healthcare services; assist with navigating the healthcare system, and advocating for the inclusion of homeless population in community health insurance, so as to drive their rights to receive medical care.
Awareness campaigns are conducted to educate the broader community about the challenges faced by the homeless population and to promote empathy, understanding, and support. Collaborative efforts are made to address the systemic issues contributing to homelessness, such as poverty, affordable housing, and healthcare disparities.

Case Study 10: TB Catastrophic cost

Having tuberculosis (TB) as a farmer can present several challenges for the individuals involved as well as their families and communities. Here, we will discuss some of these challenges in Mr. Takele Degefa scenario. In a typical rural setting, access to healthcare facilities can be limited, with inadequate health infrastructure and trained medical professionals. This lack of resources can hinder early detection and treatment of TB, leading to delayed diagnosis and potentially worsening the condition.

In our case study, Mr. Takele is living in a remote village with his wife. He has been diagnosed with TB, but due to the limited healthcare facilities, they have to travel long distances to access treatment, which may be financially burdensome and consume a considerable amount of time. The economic impact of TB can be significant, particularly in rural areas where livelihoods primarily depend on agriculture or unskilled labor. In our case study, Mr. Takele TB diagnosis resulted loss of income due to his inability to work during treatments. The financial strain can further exacerbate the challenges, affecting not only the couple's well-being but also their ability to afford treatment and necessary support.
Stigma and discrimination was also significant challenges faced by TB patients in any community. However, rural areas often have close-knit societies, where everyone knows each other. This can lead to heightened stigma towards TB patients and their families. In our case study, the couple might face social ostracization, judgments, and exclusion from community events or gatherings, which can have severe psychological effects on their mental well-being.

Additionally, rural communities often have a lack of awareness and misconceptions about TB. People may associate it with being a highly contagious disease, causing fear and avoidance towards those affected. Due to misinformation, affected individuals may not receive the support and understanding they require. Therefore, in our case study, the couple may find it challenging to educate and inform their family and community about the true nature of TB and dispel any misconceptions.
Recommendations: It is important to note that the challenges mentioned here may apply broadly to TB cases in rural marriages, but specific circumstances may vary from case to case. Addressing these challenges requires a multi-faceted approach, including improved healthcare access, public awareness campaigns, stigmatization efforts, and financial support for TB patients and their families.

CHAPTER SIX

CRG KEY STRATEGIC INTERVENTIONS

Through our CRG assessment we came up with these ten key strategic interventions, a systematic approaches used to ensure people center care and reduce TB burden in key and vulnerable communities. It involves the implementation of evidence-based interventions that are tailored to specific, measurable objectives. It aims to enhance collaboration between stakeholders, optimize the allocation of resources, and promote accountability to improve population health. It is a proactive and collaborative process that enables continuous quality improvement. Furthermore, these strategic interventions help our national TB program to adapt to changing affected community's needs, such as human right barriers, gender, catastrophic cost and stigma. When health systems have a plan in place that takes into account potential risks and challenges, they can respond more effectively to emergencies while ensuring the continuity of essential health services. It requires a comprehensive approach involving multiple stakeholders, including government agencies, TB affected communities, private sectors, and healthcare providers. These stakeholders need to work together to identify and prioritize public health challenges, develop and implement interventions, monitor progress, and adjust strategies as necessary to drive more robust CRG initiatives. These are prioritized and recommended interventions

INTERVENTIONS

- ☑ Address human rights and gender related barriers
- ☑ Ensure Meaningful engagement of KVPs
- ☑ Bold policies and supportive systems
- ☑ Engage media, religious leaders and line ministries
- ☑ Eliminate TB stigma and discrimination
- ☑ Effective and integrated CRG Programmatic management
- ☑ Community System Strengthening
- ☑ Critical Enablers including Resource, partnership and collaboration
- ☑ Addressing TB catastrophic healthcare costs
- ☑ Community feedback mechanism or Community lead monitoring

Address human rights and gender related barriers

Ensure Meaningful engagement of KVPs

Eliminate TB stigma and discrimination

Critical Enablers including Resource, partnership and collaboration

Engage media, religious leaders and line ministries

Bold policies and supportive systems

Addressing TB catastrophic healthcare costs

Community feedback mechanism or Community lead monitoring

CHAPTER SIX

CRG KEY STRATEGIC INTERVENTIONS

WE CAN END TB.

1. ADDRESS HUMAN RIGHTS AND GENDER RELATED BARRIERS

Ensuring that policy frameworks and implementation of healthcare systems adopt a human right perspective when considering key and vulnerable populations is essential to achieving equitable health outcomes. These policies must address systemic factors such as discrimination, marginalization, and structural inequality, and promote access to affordable and appropriate healthcare services for everyone. By prioritizing the needs of marginalized communities, we can build healthier and more inclusive societies that benefit us all. Policies that affect key and vulnerable populations should be grounded in a human rights perspective to ensure that their rights are protected and respected. Such policies should promote equality, non-discrimination, and the right to access basic social services such as healthcare, education, housing, and employment opportunities.

1.1 Human rights

Addressing human rights-related barriers to health access require a multifaceted approach that involves investment in health infrastructure, addressing social determinants of health, and community involvement in advocacy efforts. By working together, individuals, organizations, and governments can create a world where everyone has access to quality health care services.

1.1.1 State need to make a commitment to ensuring that everyone has access to affordable, quality health care. It is important to prioritize health as a human right and to invest in creating sustainable health systems that are accessible to all individuals. By prioritizing the development of health infrastructure in marginalized communities and investing in health education and awareness campaigns, governments can ensure that everyone can access needed healthcare services.

1.1.2 There is a need to be concerted efforts to address social determinants of health such as poverty, stigma, and other barriers. These factors often lead to the marginalization of certain populations and further limit access to healthcare. Addressing these root causes of health inequalities is key to promoting healthy outcomes and wellbeing for all vulnerable populations.

1.1.3 Advocacy and mobilization: - there needs to be greater community involvement in advocating for health equity. Community based organizations and affected community networks need to play an active role in advocating for better access to healthcare for marginalized communities. This may include organizing outreach and educational campaigns as well as engaging with policy makers and public health authorities to ensure that health concerns are brought to the forefront of public discourse.

1.2 Gender

1.2.1 Increase awareness and education: There is a need to increase awareness and education among the community about the importance of equitable healthcare access. In particular, there needs to be more education surrounding the benefits of preventative care and the importance of addressing gender related socio-economic barriers. This will help address cultural norms and ensure that women can access these services without stigma or discrimination.

1.2.2 Strategic leadership and accountability: To address gender-related barriers to health access, it is critical that strategic leadership and accountability are established between the government, civil society, affected communities, and the private sector. Inclusion of women leaders and feminist organizations is the key to design and implement effective policies, programs, and interventions that take into account the social and cultural dimensions of gender in TB care. Policy reforms should embed gender and human rights principles in health system governance and service delivery, to provide leadership and accountability on this issue.

ADDRESSING BARRIERS

2. ENSURE MEANINGFUL ENGAGEMENT OF KVPS

Empowering affected communities in healthcare is critical if we are to ensure that everyone has access to quality medical care, regardless of their socioeconomic background. First and foremost, we should prioritize patient-centered care that views patients as active participants in their healthcare. Patients should be given the necessary resources, tools, and information to effectively manage their health, make informed decisions, and feel confident about their healthcare choices. This can be achieved through patient education initiatives, support groups, and providing easy access to healthcare providers. Secondly, it is important to address the social determinants of health, such as poverty, access to healthy food, and safe living conditions, which disproportionately impact certain communities. These factors can lead to a higher incidence of chronic diseases, preventable hospitalizations, and higher rates of mortality. Addressing these issues requires collaboration between healthcare providers, community leaders, and other stakeholders to identify solutions that can improve the health outcomes of affected communities. Ultimately, empowering affected communities in healthcare means providing them with the tools, resources, and opportunities they need to take control of their health and wellbeing in meaningful ways. Overall, by ensuring that affected communities have equitable access to healthcare, we can create a healthier, more just society where everyone has the opportunity to reach their full potential.

2.1 Ensuring meaningful engagement of affected communities: - meaningful engagement of affected communities in healthcare will require a sustained effort by all stakeholders including NTP, donors, healthcare providers, policymakers, and community members. It involves involving communities in the entire health care planning process, ensuring trust-established channels of communication, and empowering community affected community networks with adequate training and financial support to foster better relationships with affected communities.

2.2 **Engage communities in designing and implementing** health care programs can ensure their needs are effectively addressed. Communities can provide valuable insights into their unique needs, values, and priorities that can guide the development of effective healthcare interventions. This approach requires creating opportunities for communities to participate in the planning process from the earliest stages, ensuring that they have a voice in design, implementation, evaluation, and improvement.

2.3 Establish trust between affected communities and healthcare providers: - Trust is essential in ensuring effective communication and promoting community engagement in health care. Healthcare providers can establish trust by providing transparent information about their services, policies, and decision-making processes. Lastly, Community workers are key actors in ensuring meaningful engagements. Community health workers play a critical role in bridging the gap between healthcare providers and affected communities through their interactions and information dissemination among community members.

2.4 Prioritize funding: Governments must prioritize funding towards affected communities networks and civil societies. This requires creating targeted funding streams, which can be used to implement specific strategic interventions, such as providing contact tracing, social support, advocacy or funding outreach activities specific to KVPs. It is equally important to ensure these funds are used effectively and monitored regularly for impact. This will improves their ability to engage with affected community, empower them to access healthcare, and act as the crucial link between healthcare providers and vulnerable communities.

3. BOLD POLICIES AND SUPPORTIVE SYSTEMS

To ensure bold policies and supportive systems in health, it is essential to prioritize the health sector's provisioning. This prioritization can be implemented through increased budget allocation to TB care and prevention, ensuring universal healthcare access to all citizens, and developing appropriate policies for effective healthcare delivery. Another way to ensure bold policies and supportive systems in health is by promoting research and development. A CRG intervention plays a vital role in expanding the understanding of the needs of different population, ailments, their potential solution, and the development of effective strategies. Therefore, investment in research, the use of modern technology, and collaboration between different research organizations, will improve the quality of healthcare. One crucial method to implement bold policies and supportive systems in health is increasing the number of healthcare professionals by investing in upcoming and existing ones. There will be a need for doctors, nurses, pharmacists, researchers, and other healthcare-related professionals as the world's population continues to grow. By improving the training and well-being of healthcare professionals, societies can have better and accessible healthcare services. Lastly, promoting public education programs and raising awareness of preventive healthcare measures that include regular checkups, hygiene, and proper prevention measures against illnesses, diseases, and unhealthy habits. Educating people about the best practices to maintain wellbeing is important to reduce healthcare costs while averting future complications.

CHAPTER SIX

CRG KEY STRATEGIC INTERVENTIONS

3. IMPROVING ENGAGEMENT OF DECISION MAKERS IN THE FIGHT AGAINST TB

3.1 Capacity Building: It is essential to train high-ranking officials on how to initiate, lead and monitor effective public health programs. Investing in capacity building will enhance their knowledge and skills in understanding the complexities of the health sector and how to implement impactful strategies to fight diseases.

3.2 Advocacy: Involving influential personalities such as politicians, celebrities, or influencers can help create awareness about the importance of public health. Lobbying with these personalities can promote advocacy for health causes, which in turn, will help galvanize the support of high officials to increase their engagement.

3.3 Active Participation: Regular participation in TB related events, forums, and campaigns can help high officials gain valuable insights on the need for preventive measures and the potential impact of TB on the community. They can leverage their position to make policy changes that prioritize the health of citizens, provide necessary resources such as funding, and build support systems to end TB.

3.4 Collaboration: Collaboration between private and public sectors in the fight against TB can also help engage high officials. By working together, they can establish common goals and strategies to fight TB, which will demonstrate a unified approach toward improving public health.

The implementation of bold policies and supportive systems in health is attainable through increased budget allocation, promotion of research and development, training and investing in more healthcare professionals, and promoting public education programs to create awareness about prevention and wellbeing. It is essential to promote the importance of health as it is essential to nation-building economies and personal lives. By investing in capacity building, promoting advocacy, encouraging participation, and building collaboration, we can attract and engage high officials in the fight against TB effectively.

4. ENGAGE MEDIA, RELIGIOUS LEADERS AND LINE MINISTRIES

Engagement of different stakeholders in the fight against TB means bringing together individuals, policymakers, organizations, and institutions to actively participate in research, implementation, and advocacy towards managing and controlling diseases. Improving engagement requires incorporating various strategies that encourage stakeholder participation at different levels. Different approaches can be utilized, including promotion of awareness, involving stakeholders early in the process, providing education and training, and incentivizing stakeholder participation. Overall, stakeholders should be treated as active participants and not as passive recipients of information. Below are some of the ways:

4.1 promoting awareness of the health issues and providing targeted communication. The stakeholders should prioritize creating strong messages and campaigns targeting diseases that are prevalent in a community. This will help create awareness and provide knowledge about the importance of healthy living and the significance of disease prevention. Additionally, information about available resources and how their participation can make a difference should be highlighted.

4.2 Engage at all level: involving the engagement of all relevant stakeholders early in the process of planning, implementation, and evaluation of health interventions. When stakeholders are involved, it helps to increase their sense of ownership, promote accountability, and also ensures inclusivity. Stakeholders should be given an opportunity to voice their concerns and provide suggestions that can streamline the efforts made toward disease management and control.

4.3 Training and education to stakeholders; to improve engagement in the fight against diseases, stakeholders need to have constant training on health issues. This knowledge will equip them with the necessary skills to engage in activities that will aid disease prevention and control. Regular training can take the form of workshops, seminars, and peer-to-peer learning forums.

4.4 Incentivizing stakeholder participation: A core motivation for stakeholders to actively participate can be regular health screenings, access to healthcare facilities, and provision of information, and education on the prevention and control of diseases. Stakeholders should also be rewarded for their active participation through recognition programs or monetary incentives.

6.COMMUNITY SYSTEM STRENGTHENING

Programmatic management of TB is a critical system that aims at effectively controlling, preventing and eradicating diseases. Strategic steps for improving programmatic management of disease include a holistic approach that focuses on prevention, treatment, and follow-up care.

6.1 Efficient planning and monitoring: The first essential step is to create a comprehensive plan that highlights priority CRG issues, sets objectives, identifies interventions, and establishes an accountability framework. This strategy should be informed by research and data and should involve affected communities and key stakeholders from the onset.

6.2 Human resource: The second crucial step is developing human resources that have the requisite skills to manage disease programs effectively. This involves recruiting qualified personnel, training them in technical and management skills, and providing ongoing support to ensure sustained performance. Institutional and regulatory frameworks should also be established to enhance service delivery and governance.

6.3 CRG focal point at NTP: Having a focal point dedicated to CRG within NTP is crucial in ensuring effective coordination and implementation of preventive measures. It involves identifying potential risks, creating awareness campaigns, developing CRG strategies, and coordinating community-wide outreach programs. A CRG focal point also plays a role in monitoring infectious diseases and ensuring preparedness in the event that an outbreak occurs. By having a central point responsible for managing communication with relevant stakeholders such as the government, TB key affected populations, and the general public, it becomes easier to create gender transformative program to address human rights barriers.

ASSESSMENT FINDINGS

7. EFFECTIVE AND INTEGRATED CRG PROGRAMMATIC MANAGEMENT

Disease monitoring and evaluation are essential activities that NTP use to track TB prevention, care and treatment progress. Proper monitoring helps in identifying gaps, detecting their causes, implementing preventive measures, and reducing their impact on public health. A robust monitoring and evaluation framework plays a critical role in TB as well as CRG control and management. Below, we highlight some key strategic activities that can improve CRG monitoring and evaluation:

7.1 Surveillance System Development: NTP and other key stakeholders should optimize DHIS 2/ surveillance system to monitor and track the progress. This system helps in early tracking of TB incidence and prevalence, alerts relevant authorities about potential public health threats, and facilitates timely interventions. An effective DHIS is based on a strong data infrastructure that includes various information sources such as laboratory reports, hospital records, and community health centers' data.

7.2 Data quality: To ensure high-quality data, NTP need to adopt sound data management practices that involve collecting accurate, complete and timely information from various sources. They should also implement appropriate data governance processes such as data quality checks, data validation, and data cleaning to maintain data accuracy and completeness. This will enable NTP to make informed decisions, support evidence-based treatments and develop targeted interventions that improve patient outcomes. By prioritizing data quality, healthcare providers can also enhance the reliability and validity of medical research findings, leading to better health outcomes and improved public health policies.

7.3 Case based data management system: Digital and case-based real-time surveillance systems for TB have several advantages over more traditional paper-based reporting of aggregated data. These include enabling the use of automated data quality checks, timely access to data and the availability of individual-level data for people with TB infection or disease, from the level of health facilities up to national level. These systems also greatly facilitate data analysis (including by age, sex and location) to inform adaptation and targeting of response efforts, both geographically and for specific population groups.

7.4 Data disaggregation: Data disaggregation in TB and CRG refers to the process of breaking down data into smaller components and analyzing them separately. This technique allows for a more sophisticated analysis of access barriers, taking into account factors like age, gender, race, ethnicity, socio-economic status, and geographic location. By disaggregating data along these lines, researchers and policymakers can identify patterns and trends, discover hidden disparities, and design targeted interventions that meet the specific needs of different populations. One of the key benefits of data disaggregation in TB is that it helps to reveal the underlying causes of health inequalities. For example, by breaking down health data by KVPs, researchers may discover that certain KVP groups have higher rates of disease or worse health outcomes than others. This information can then be used to develop more targeted programs and policies that address the unique challenges faced by these populations. Additionally, data disaggregation helps to ensure that healthcare resources are allocated where they are most needed, and that interventions are developed with a deep understanding of the populations they are designed to serve..

6.4 Continues Supervision: This involves strategic planning, coordination, and monitoring of TB program activities at regional, zonal, woreda and level. A proactive approach that involves detecting and correcting potential issues before they result in significant problems can save resources and prevent disruptions ensure accountable and quality ensured TB care services for KVPs. The practice of continually monitoring and overseeing the activities is essential for maintaining the integrity and credibility of the NSP, mitigating risks, and ensuring the safety and welfare of affected communities. In short, effective programmatic management of CRG would require these strategic steps to help fulfill health demands reliably, accurately and sustainably. These steps address the critical components of the overall system and ensure optimal management of resources, ending TB endeavor, and people centered health care.

8. CRITICAL ENABLERS

Domestic Resource Mobilization

The mobilization and securing of resources to fight TB is an essential task that requires the engagement of all stakeholders, including governments, international organizations, health workers, and communities. When it comes to mobilizing resources, it is crucial to have a clear understanding of the kind of resources needed and how to obtain them. Resources could include funding, equipment, medical supplies, medications, and human resources.

8.1 Advocacy: advocating for increased investment and policy makers' engagement in TB, community health systems, and national health security can help mobilize the necessary financial resources. Governments, corporates, and philanthropic foundations should be encouraged to provide financial support to civil societies, research centers, hospitals, and health institutions to aid their efforts in mitigating the impact of TB.

8.2 Partnership: establishing partnerships between national and international health organizations, community-based organizations, and academic institutions can go a long way in mobilizing resources to fight diseases. Such collaborations could lead to sharing of knowledge and expertise, distribution of resources, and capacity building of communities.

8.3 Health system strengthening: A well-functioning health system can help secure resources to combat TB by ensuring that adequate resources are available for research, prevention, diagnosis, and treatment of TB. A well-trained health workforce, supported by robust health information systems, can help identify and manage disease outbreaks effectively.

8.4 Coordination: Effective mobilization and securing of resources to fight TB require coordinated and sustained efforts from various stakeholders at national and international levels. By strengthening health systems, promoting financial investment, and encouraging innovation, we can tackle existing and emerging diseases effectively.

CHAPTER SIX

CRG KEY STRATEGIC INTERVENTIONS

9. ADDRESSING TB CATASTROPHIC COSTS

As out of pocket expenditure continue to raise, TB affected communities' are experiencing significant economic struggle when seeking medical care. These expenses can cause financial strain and even deter some individuals from seeking necessary healthcare services. To minimize these costs, key stakeholders can implement several strategic interventions.

9.1 TB catastrophic cost survey is a crucial tool to ensure people centered care, which helps to identify and understand the financial burden that patients face when accessing medical services. The survey provides insights into the economic factors that affect patient access to healthcare, which includes direct and indirect costs incurred during treatment, such as out-of-pocket expenses, transportation costs, lost income, childcare, and other related expenses. By conducting cost surveys, healthcare providers can develop strategies to reduce the economic impact of healthcare for patients, improve access and quality of care, and ensure that healthcare services are more affordable and accessible for all.

9.2 Community based health insurance: to provide education and support to key and vulnerable population regarding community health insurance coverage. In many cases, patients may not fully understand their insurance benefits and may be surprised by the costs of their medical care. By providing education and resources, patients can make informed decisions about their healthcare and minimize any unexpected expenses. It is important intervention is to increase access to treatment and care services.

9.3 Early TB detection: Early diagnosis of TB is crucial to minimize the unnecessary costs that might arise due to delayed or incorrect diagnoses. Early detection helps in identifying a health problem when it is still in its initial stages or has yet not caused significant damage to someone body. Getting diagnostic tests done early also saves money for TB affected communities as it eliminates the need for more expensive tests in the future when the disease has progressed. Therefore, early diagnosis goes a long way in reducing the economic burden on both patients and society as a whole, in turn improving the efficiency of healthcare systems.

9.4 Social and economic support; Donors, government and key stakeholders need to develop programs and initiatives that support patients in financial need. These programs may include assistance with insurance enrollment, subsidies for medical expenses, food baskets or transportation services to medical appointments.

Overall, implementing these strategic interventions can help minimize patients' out-of-pocket expenditure and improve access to affordable healthcare services. By working to reduce financial barriers, healthcare facilities can improve the health outcomes and overall well-being of their TB patients.

CERTIFIED FROM

Rore pererspe cone nullaceratem rendiam fugiaspit venim doloribus enetur sum latur, as alit vel iur,

10. COMMUNITY FEEDBACK MECHANISM/ COMMUNITY LEAD MONITORING

National TB program should involve TB affected communities in decision-making processes related to healthcare service delivery. TB focals can learn from affected communities in their operational setup and improve the quality of their offerings to suit their needs. By obtaining regular feedback from affected communities, healthcare providers can tailor their services based on community input, thereby improving the quality of care delivered. Here are some ways that we can collect community feedback:

10.1 Surveys: One of the most effective ways to collect community feedback is through surveys. Surveys can be conducted online or in person and should be designed to capture the opinions of the community on the quality of services provided.

10.2 Focus groups: Focus groups are small community gatherings where participants can provide feedback on the quality of services provided. Participants are encouraged to voice their opinions, and moderators are present to ensure that the conversation stays on track.

10.3 Call center or through media platforms: Many organizations use social media platforms to gather community feedback. These platforms provide an opportunity for organizations to engage with the community and receive immediate feedback on the quality of services provided.

10.4 Community consultation: Community meetings provide an excellent opportunity for TB program to gather feedback from the community. Organizations can ask questions, and community members can share their thoughts and ideas on how services can be improved.

10.5 Digital platform: One way to improve data quality is to invest in modern technologies, including OneImpact community lead monitoring platform (CLM), feedback registries, and electronic data capture systems. These systems not only improve feedback data accuracy but also enhance efficiency, data sharing, and communication among key TB control stakeholders.

TOLL FREE CALL

IN YEAR 2022

VHS recived more than 674 call from TB communities and other popullation looking for information.

9839 | TB COMMUNITIES

SUSTAINABILITY

Sustainability ensures that the monitoring efforts can continue over a long period of time. This allows for the collection of comprehensive and accurate data, which is essential for making informed decisions and implementing effective interventions.

ONEIMPACT

Experience of affected community organization on Community feedback mechanism | OneImpact

TB affected Communities have been providing feedback on the quality of health service provision. Gathering, collating and using this information, however, has not necessarily been systematic. Consequently, decision-makers often lack data and analysis from the perspective of affected communities, and interventions may not accurately respond to community priorities and experiences. This imbalance of knowledge and power in service design and provision particularly penalizes minority and stigmatized groups. VHS through the support of Stop TB partnership has been implementing OneImpact CLM project. It empowers people affected by TB to access health and support services, claim their rights, and identify and reduce stigma. Through an innovative mobile app, OneImpact CLM encourages and facilitates the participation of people affected by TB in all aspects of TB programming to activate a human rights based, people-centered response. In doing so, OneImpact CLM combats the central challenges in the TB response at the individual and community levels while generating essential information and data to better understand and combat them at the programmatic level to end TB.

REFERENCES

Alemu, Ayinalem, Zebenay Workneh Bitew, Getu Diriba, and Balako Gumi. 2021. “Co-Occurrence of Tuberculosis and Diabetes Mellitus, and Associated Risk Factors, in Ethiopia: A Systematic Review and Meta-Analysis.” IJID Regions 1 (December): 82–91. https://doi.org/10.1016/j.ijregi.2021.10.004.

Alemu, Ayinalem, Aman Yesuf, Betselot Zerihun, Melak Getu, Teshager Worku, and Zebenay Workneh Bitew. 2020. “Incidence and Determinants of Tuberculosis among HIV-Positive Individuals in Addis Ababa, Ethiopia: A Retrospective Cohort Study.” International Journal of Infectious Diseases 95 (June): 59–66. https://doi.org/10.1016/j.ijid.2020.02.053.

Alene, Kefyalew Addis, Ahmed Elagali, Dylan D Barth, Susan F Rumisha, Punam Amratia, Daniel J Weiss, Kendalem Asmare Atalell, Andargachew Kumsa Erena, Peter W Gething, and Archie C A Clements. 2022. “Spatial Codistribution of HIV, Tuberculosis and Malaria in Ethiopia.” BMJ Global Health 7 (2): e007599. https://doi.org/10.1136/bmjgh-2021-007599.

Ali, Solomon, Abraham Haileamlak, Andreas Wieser, Michael Pritsch, Norbert Heinrich, Thomas Loscher, Michael Hoelscher, and Andrea Rachow. 2015. “Prevalence of Pulmonary Tuberculosis among Prison Inmates in Ethiopia, a Cross-Sectional Study.” Edited by Mark Spigelman. PLOS ONE 10 (12): e0144040. https://doi.org/10.1371/journal.pone.0144040.

Amere, Genet A, Pratibha Nayak, Argita D Salindri, K M V Narayan, and Matthew J Magee. 2018. “Contribution of Smoking to Tuberculosis Incidence and Mortality in High-Tuberculosis-Burden Countries.” American Journal of Epidemiology 187 (9): 1846–55. https://doi.org/10.1093/aje/kwy081.

“Artisan Mining Operation Its Economic Values, Ethiopia.” 2015. **የኢትዮጵያ ማዕድን ኢንዱስትሪ ግሎጵነት ኢኒሼቲቭ.**

Assebe, Lelisa Fekadu, Eyerusalem Kebede Negussie, Abdulrahman Jbaily, Mieraf Taddesse Taddesse Tolla, and Kjell Arne Johansson. 2020. “Financial Burden of HIV and TB among Patients in Ethiopia: A Cross-Sectional Survey.” BMJ Open 10 (6): e036892. https://doi.org/10.1136/bmjopen-2020-036892.

Ayano, Getinet, Mohammed Ayalew, Asres Bedaso, and Bereket Duko. 2022. “Epidemiology of Khat (Catha Edulis) Chewing in Ethiopia: A Systematic Review and Meta-Analysis.” Journal of Psychoactive Drugs, December, 1–10. https://doi.org/10.1080/02791072.2022.2155735.

Azanaw, Melkalem Mamuye, Nebiyu Mekonnen Derseh, Gebeyehu Shumuye Yetemegn, and Dessie Abebaw Angaw. 2021. “Incidence and Predictors of Tuberculosis among HIV Patients after Initiation of Antiretroviral Treatment in Ethiopia: A Systematic Review and Meta-Analysis.” Tropical Medicine and Health 49 (1): 18. https://doi.org/10.1186/s41182-021-00306-2.

Dachachi, Bizuayehu Dengechi, Nigatuwa Worku Woyessa, and Fisseha Mikre Weldmeskel. 2020. “Perceived Discrimination Difference between the Manjo Minority and Non-Manjo Ethnic Group in Kaffa Zone, Ethiopia.” Research, Society and Development 9 (9): e626997386. https://doi.org/10.33448/rsd-v9i9.7386.

Datiko, Daniel G., Degu Jerene, and Pedro Suarez. 2020. “Stigma Matters in Ending Tuberculosis: Nationwide Survey of Stigma in Ethiopia.” BMC Public Health 20 (1): 190. https://doi.org/10.1186/s12889-019-7915-6.

Deribew, Amare, Kebede Deribe, Tariku Dejene, Gizachew Assefa Tessema, Yohannes Adama Melaku, Yihune Lakew, Azmeraw T. Amare, et al. 1970. "Tuberculosis Burden in Ethiopia from 1990 to 2016: Evidence from the Global Burden of Diseases 2016 Study." Ethiopian Journal of Health Sciences 28 (5). https://doi.org/10.4314/ejhs.v28i5.2.

Derseh, Dejene, Feleke Moges, and Belay Tessema. 2017. "Smear Positive Pulmonary Tuberculosis and Associated Risk Factors among Tuberculosis Suspects Attending Spiritual Holy Water Sites in Northwest Ethiopia." BMC Infectious Diseases 17 (1): 100. https://doi.org/10.1186/s12879-017-2211-5.

Diriba, Kuma, and Gemechu Churiso. 2022. "The Prevalence of Mycobacterium Tuberculosis Using Gene Xpert among Tuberculosis Suspected Patients in Gedeo Zone, Southern Ethiopia." European Journal of Medical Research 27 (1): 24. https://doi.org/10.1186/s40001-022-00650-x.

"Ethiopian Demographic and Health Survey 2016. Central Statistical Agency Addis Ababa, Ethiopia." n.d.

Feleke, Y., J. Abdulkadir, and G. Aderaye. 1999. "Prevalence and Clinical Features of Tuberculosis in Ethiopian Diabetic Patients." East African Medical Journal 76 (7): 361–64.

Gelibo, Terefe, Sileshi Lulseged, Frehywot Eshetu, Saro Abdella, Zenebe Melaku, Solape Ajiboye, Minilik Demissie, et al. 2022. "Spatial Distribution and Determinants of HIV Prevalence among Adults in Urban Ethiopia: Findings from the Ethiopia Population-Based HIV Impact Assessment Survey (2017–2018)." Edited by Mona Pathak. PLOS ONE 17 (7): e0271221. https://doi.org/10.1371/journal.pone.0271221.

"General Assembly Resolution 72/268: Scope, Modalities, Format and Organization of the High-Level Meeting on the Fight against Tuberculosis." 2018. United Nations.

Getnet, Fentabil, Meaza Demissie, Alemayehu Worku, Tesfaye Gobena, Rea Tschopp, Alinoor Mohamed Farah, and Berhanu Seyoum. 2021. "Challenges in Delivery of Tuberculosis Services in Ethiopian Pastoralist Settings: Clues for Reforming Service Models and Organizational Structures." BMC Health Services Research 21 (1): 627. https://doi.org/10.1186/s12913-021-06662-3.

"Global Tuberculosis Report." 2022. WHO.

Gostin, Lawrence O, Benjamin M Meier, Rebekah Thomas, Veronica Magar, and Tedros A Ghebreyesus. 2018. "70 Years of Human Rights in Global Health: Drawing on a Contentious Past to Secure a Hopeful Future." The Lancet 392 (10165): 2731–35. https://doi.org/10.1016/S0140-6736(18)32997-0.

Haile, Demewoz, and Yihunie Lakew. 2015. "Khat Chewing Practice and Associated Factors among Adults in Ethiopia: Further Analysis Using the 2011 Demographic and Health Survey." Edited by Delmiro Fernandez-Reyes. PLOS ONE 10 (6): e0130460. https://doi.org/10.1371/journal.pone.0130460.

Joshi, Rajnish, Arthur L Reingold, Dick Menzies, and Madhukar Pai. 2006. "Tuberculosis among Health-Care Workers in Low- and Middle-Income Countries: A Systematic Review." Edited by Mushtaque Chowdhury. PLoS Medicine 3 (12): e494. https://doi.org/10.1371/journal.pmed.0030494.

Kebede, A. H., Z. Alebachew, F. Tsegaye, E. Lemma, A. Abebe, M. Agonafir, A. J. Kebede, et al. 2014. “The First Population-Based National Tuberculosis Prevalence Survey in Ethiopia, 2010-2011.” The International Journal of Tuberculosis and Lung Disease 18 (6): 635–39. https://doi.org/10.5588/ijtld.13.0417.

Labena, Fikru, Yibeltal Kassa, and Eyasu Gambura. 2021. “Tuberculosis and Public Health Care Workers: Infection Prevention and Control Practices and Associated Factors Among Governmental Health Centers and Hospitals in Wolaita Zone, Southern Ethiopia.” Journal of Multidisciplinary Healthcare Volume 14 (August): 2111–22. https://doi.org/10.2147/JMDH.S321592.

Mbuya, Alexander W., Innocent B. Mboya, Hadija H. Semvua, Simon H. Mamuya, and Sia E. Msuya. 2023. “Prevalence and Factors Associated with Tuberculosis among the Mining Communities in Mererani, Tanzania.” Edited by Billy Morara Tsima. PLOS ONE 18 (3): e0280396. https://doi.org/10.1371/journal.pone.0280396.

Ministry of Health,. 2013. “Health Sector Gender Mainstreaming Manual.”

MINISTRY OF WOMEN’S AFFAIRS (MOWA). 2014. “National Action Plan for Gender Equality (NAP-GE) 2006-2010.” MINISTRY OF WOMEN’S AFFAIRS (MOWA).

Mohamed, Abduselam Abdulahi. 2019. “Pastoralism and Development Policy in Ethiopia: A Review Study.” Budapest International Research and Critics Institute (BIRCI-Journal) : Humanities and Social Sciences 2 (4): 01–11. https://doi.org/10.33258/birci.v2i4.562.

“NATIONAL HUMAN RESOURCE FOR HEALTH STRATEGIC PLAN FOR ETHIOPIA 2016-2025.” n.d. FMOH.

Nooh, Faisal, Lisa Crump, Abdiwahab Hashi, Rea Tschopp, Esther Schelling, Klaus Reither, Jan Hattendorf, et al. 2019. “The Impact of Pastoralist Mobility on Tuberculosis Control in Ethiopia: A Systematic Review and Meta-Synthesis.” Infectious Diseases of Poverty 8 (1): 73. https://doi.org/10.1186/s40249-019-0583-z.

NTP. 2020. “Ethiopian TBL-NSP July 2021 – June 2026.” The Federal Ministry of Health.

“PMDT Guidelines.” 2017. FMOH. https://www.afro.who.int/sites/default/files/2019-04/Ethiopia-National%20guidelines%20for%20TB%2C%20DR-TB%20and%20Leprosy%20in%20Ethiopia%20-%20Sixth%20Edition.pdf.

Pugliese, Gina. 1995. “Community Exposure Predicts Healthcare Worker TB Skin-Test Conversion.” Infection Control & Hospital Epidemiology 16 (6): 330–330. https://doi.org/10.1017/S0195941700007840.

Reta, Melese, Nontuthuko Maningi, Gizachew Wubetu, Sas Olorunju, and P Four. 2023. Spiritual Holy Water Sites: Unrecognized Congregate Settings for Pulmonary TB Transmission in Ethiopia. EP-12-714.

Semunigus, Tsedale, Belay Tessema, Setegn Eshetie, and Feleke Moges. 2016. “Smear Positive Pulmonary Tuberculosis and Associated Factors

among Homeless Individuals in Dessie and Debre Birhan Towns, Northeast Ethiopia." Annals of Clinical Microbiology and Antimicrobials 15 (1): 50. https://doi.org/10.1186/s12941-016-0165-x.

Shamebo, Tsegaye, Sindew Mekesha, Muluwork Getahun, Balako Gumi, Beyene Petros, and Gobena Ameni. 2023. "Prevalence of Pulmonary Tuberculosis in Homeless Individuals in the Addis Ababa City, Ethiopia." Frontiers in Public Health 11 (April): 1128525. https://doi.org/10.3389/fpubh.2023.1128525.

Shiferaw, Melashu Balew, Mulusew Alemneh Sinishaw, Desalegne Amare, Genetu Alem, Dawit Asefa, and Eveline Klinkenberg. 2021. "Prevalence of Active Tuberculosis Disease among Healthcare Workers and Support Staff in Healthcare Settings of the Amhara Region, Ethiopia." Edited by Frederick Quinn. PLOS ONE 16 (6): e0253177. https://doi.org/10.1371/journal.pone.0253177.

Stop TB partnership. n.d. "TB Community, Rights and Gender Assessment Protocol and Framework."

"Stop TB Partnership, THE GLOBAL PLAN TO END TB 2023-2030." 2022. Stop TB Partnership.

The Global Fund. 2022. "Information Note Tuberculosis Allocation Period 2023-2025."

Tulu, Begna, Eden Amsalu, Yohannes Zenebe, Melkamu Abebe, Yeshimebet Fetene, Manamnot Agegn, Alemayehu Abate, et al. 2021. "Diabetes Mellitus and HIV Infection among Active Tuberculosis Patients in Northwest Ethiopia: Health Facility-Based Cross-Sectional Study." Tropical Medicine and Health 49 (1): 68. https://doi.org/10.1186/s41182-021-00358-4.

United Nations. 2015. "Illustrated Edition of the Universal Declaration of Human Rights (UDHR)."

UNODC Ethiopia. 2021. "Prison Reform and Rehabilitation in Ethiopia, Fact Sheet 2021." UNODC Ethiopia.

World Food Programme (WFP). 2022. "Ethiopia Annual Country Report 2022 & Country Strategic Plan 2020 - 2025." World Food Programme (WFP).

"African Charter on Human and Peoples' Rights"

CEDAW, "General Recommendation 24"
CESCR, "General Comment No.3:The Nature of States Parties' Obligations" (1990) E/1991/23 ——, "General Comment 14"

"Convention on the Elimination of All Forms of Discrimination against Women"

"Convention on the Rights of the Child"

Giacca G, "Treaty Obligations of States for Economic, Social, and Cultural Rights," Economic, Social, and Cultural Rights In Armed Conflict (Oxford Scholarship Online ovemeber 2014)

Guide STBP, "TB Case Finding with Key Populations"

Human Rights Council, "Contributions of the Rights of Health Framework to

the Effective Implementation and Achievement of the Health-Related Sustainable Development Goals:Report of the United Nations High Commissioner for Human Rights"

"International Covenant on Civil and Political Rights" Arts

"International Covenant on Economic, Social and Cultural Rights"

"'Roadmap towards Ending TB in Children and Adolescents' Launched at the UN High Level Meeting on Ending TB in 2018"

Robindra Basu Roy, Nicola Brandt, Nicolette Moodie, Mitra Motlagh, Kumanan Rasananthan, James A. Seddon, Anna K.Detjen and Beate Kampmann, "Why the Convention on the Rights of the Child Must Become a Guiding Framework for the Realization of the Rights of Children Affected by Tuberculosis" [2016] BMC International Health and Human Rights

"The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment"

UN Committee on the Rights of the Child(CRC), "General Comment No.15(2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health(Art.24)"

United Nations High Commissioner for Human Rights, "Annual Thematic Reports of the Special Rapporteur on the Right to Physical and Mental Health(2021)"

"United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)"

FDRE Constitution

Federal Democratic Republic of Ethiopia Constitution 21, August 1995

Federal Prison Proclamation No 1174/2019, Neg, Gaz. Year 26, No 14

National Human Resource for Health Strategy of Ethiopia, 20216

Ethiopian Demographic and Health Survey (EDHS), 2016

Ethiopian Mini Demographic and Health Survey (EDHS), 2019

Office of the United Nations High Commissioner for Human Rights, Annual thematic reports of the Special Rapporteur on the right to physical and mental health (2021).

Sørensen K, Van den Broucke S, Fullam J. ''Health literacy and public health: a systematic review and integration of definitions and models'' BMC Public Health. 2012;12:80. doi:10.1186/1471-2458-12-80

UNDP Human Development Report, 2020.

https://www.worldbank.org/en/country/ethiopia/overview

Stop TB Partnership hosted by UNOPS

"We simply cannot continue to stand on the sidelines and watch while people around the world fall ill and die from a preventable and treatable disease,"

Dr. Lucica Ditiu,
Executive Director of the Stop TB Partnership

CONNECT WITH US

Toll Free: 9839
+251 (907) 444-555
+251 (113) 854-462
contact@vhsi.org
22 Mazoria, Genet Bldg, 2nd Floor, 33497,
Addis Ababa, Ethiopia

የጤና ሚኒስቴር፣ ኢትዮጵያ
MINISTRY OF HEALTH, ETHIOPIA

VHS
VOLUNTEER HEALTH SERVICES