Availability and Use of Sex-Disaggregated Data in Tanzania

An Assessment

July 2016

TR-16-132

USAID
FROM THE AMERICAN PEOPLE

PEPFAR

MEASURE Evaluation TZ

Availability and Use of Sex-Disaggregated Data in Tanzania

An Assessment

July 2016

Photo: © 2016 Riccardo Gangale/VectorWorks, courtesy of Photoshare

MEASURE Evaluation/Tanzania TCRS Building,
1st Floor, Plot No. 436, Mwai Kibaki Road,
Mikocheni B.
Dar es Salaam, TZ
+255 22 277 3023
www.measureevaluation.org/tanzania

This research has been supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation-Tanzania associate award AID-621-LA-14-00001. MEASURE Evaluation-Tanzania is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of PEPFAR, USAID, or the United States government. TR-16-132

USAID FROM THE AMERICAN PEOPLE

PEPFAR

MEASURE Evaluation TZ

Acknowledgements

This report was prepared by Mahua Mandal (monitoring and evaluation specialist for youth and gender, MEASURE Evaluation), Abby C. Cannon (gender specialist, MEASURE Evaluation), and Joseph Nondi (statistician, National AIDS Control Programme, Tanzania).

MEASURE Evaluation wishes to thank those who contributed to the development and publication of this report. First, we would like to acknowledge the United States Agency for International Development (USAID) for its support of this activity.

We also wish to express sincere gratitude for the contributions of the following individuals and entities throughout this assessment:

- The National AIDS Control Programme, for participating in and supporting our assessment, especially our co-principal investigator, Joseph Nondi
- Essau Amenye, formerly with MEASURE Evaluation–Tanzania, for his assistance in the planning and implementation of the assessment
- Willis Odek, of MEASURE Evaluation–Tanzania, for his leadership and collaboration with the NACP and review of data collection instruments and the final report
- Representatives of government and implementing partners who graciously gave their time and perspectives by participating in key informant interviews

A full list of participants and their affiliations is in Appendix B.

Contents

ABBREVIATIONS

ART	antiretroviral therapy
CTC	care and treatment clinic
DHS	Demographic and Health Survey
GBV	gender-based violence
HBC	home-based care
KI	key informant
M&E	monitoring and evaluation
MCDGC	Ministry of Community Development, Gender and Children
MOHSW	Ministry of Health and Social Welfare
NACP	National AIDS Control Programme
NBS	National Bureau of Statistics
NSGD	National Strategy for Gender Development
PEP	post-exposure prophylaxis
PITC	provider-initiated testing and counseling
PLHIV	people living with HIV
PO-RALG	President's Office-Regional Administration and Local Government
RHIS	routine health information system(s)
TACAIDS	Tanzania Commission for AIDS
TGNP	Tanzania Gender Network Programme
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
TOMSHA	Tanzania Output Monitoring System for Nonmedical HIV and AIDS
VAC	violence against children

PURPOSE

MEASURE Evaluation has been working to support the Government of Tanzania at national and subnational levels to ensure data quality with regard to sex-disaggregated and gender-sensitive data, and to better use data from routine health information systems (RHIS) for health and social service program and policy decision making. In support of these efforts, MEASURE Evaluation-Tanzania conducted a data and gender assessment of the national and subnational RHIS to understand the current availability and use of sex-disaggregated and gender-sensitive indicators.

BACKGROUND

Quality and timely routine health data are one of the building blocks of a health system. Such data provide crucial information about health determinants, healthcare use, and health status, and are fundamental to a well-functioning health system (World Health Organization, n.d.). Collecting and analyzing sex-disaggregated data for RHIS makes possible the examination of sex differences in programmatic outputs and related health outcomes. Disaggregating—that is, stratifying—data by sex reveals areas where gender may be a barrier to reaching program goals and desired health outcomes. For example, according to the 2011–2012 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS), 62 percent of women ages 15–49, compared to 47 percent of men in the same age group, received HIV testing, counseling, and test results (Tanzania Commission for AIDS, et al., 2013). With this information, national, district, and community HIV programs can examine why males are less likely to go for HIV testing and counseling, and develop strategies to overcome such gender-based barriers. Without sex-disaggregated data, program managers and decision makers would not be able to identify the differences in health outcomes between males and females, leading to decisions based on incomplete information. Thus, sex-disaggregated health data are fundamental to informed decision making and a robust health information system.

Despite the utility and necessity of sex-disaggregated health data, health information systems do not consistently retain information based on sex and age variables. A comparative evaluation of indicators for gender equity and health used by key international organizations revealed that sex disaggregation is common in indicators such as life expectancy, education, and workforce; however, most routine indicators were not reported by sex or age (Lin, et al., 2007).

While there is documentation of increasing sex disaggregation of health data, sex disaggregation alone overlooks important gender factors necessary for improving health status and access (Nowatzki & Grant, 2011). Gender-sensitive indicators go beyond sex-disaggregated data to measure dimensions of gender such as gender attitudes and norms (for example, the belief that intimate partner violence is justified), power differences (for example, family members who do and do not control household resources), and level of gender sensitivity in service delivery (for example, requirements that, to receive services, a client must have her husband's permission). Both sex-disaggregated and gender-sensitive indicators can be used in tandem to make changes to program implementation that ensure increased gender equity, which in turn leads to better health outcomes.

Tanzania has recently taken steps to promote gender equality as a crosscutting theme in its health sector. The National Strategy for Gender Development (NSGD) of the Ministry of Community Development, Gender and Children (MOCDGC) has committed to elevating gender equality as fundamental to the health and progress of the country. The NSGD notes that that the lack of sex-disaggregated data is a concern, and Policy Statement 2.1.17.2 sets forth the intention to "ensure availability of gender disaggregated data and provision of guidelines that will enforce compliance to inclusion of gender/sex-disaggregated data by actors at all levels" (MOCDGC, p. 19). While there is greater focus on increasing the availability of sex-disaggregated health data, there is no information on the current state of such data in Tanzania's RHIS.

MEASURE Evaluation-Tanzania jointly with the National AIDS Control Programme (NACP) undertook an assessment from July to December 2015 to understand the current availability and use of sex-disaggregated and gender-sensitive indicators. The findings from this assessment are the focus of this report.

STUDY QUESTIONS

The study sought to answer the following questions:

1. At what level are sex-disaggregated and gender-sensitive health data considered and/or included within the monitoring and evaluation (M&E) plans and data collection tools of Tanzania's RHIS?
2. What types of HIV and AIDS health data within Tanzania's RHIS— including DHIS 2 and Tanzania Output Monitoring System for Nonmedical HIV and AIDS (TOMSHA)—are disaggregated by sex and age?
3. What level of gender analysis is conducted when drafting national health reports?
4. What types of and how often are sex-disaggregated and gender-sensitive health data used for program and policy decision making purposes?
5. What are the facilitators of and barriers to using gendered data for health planning?

STUDY METHODS

The assessment included a desk review of data collection forms and health reports developed by the Government of Tanzania and key informant interviews with government employees.

Desk Review

The assessment team conducted a desk review of the Tanzania RHIS M&E plans, M&E data collection tools, and government reports and documents written using the DHIS 2 and TOMSHA databases. This documentation was collected through Internet searches of the websites of government ministries, departments, and agencies: NACP; the MCDGC; the Ministry of Health and Social Welfare (MOHSW); and Tanzania Commission for AIDS (TACAIDS). We also received information through email communication with relevant government staff in the office of the prime minister's and TACAIDS.

Key Informant Interviews

Additionally, the assessment team conducted interviews with 15 key informants (KIs) from the MCDGC; the MOHSW; the National Bureau of Statistics (NBS); the President's Office-Regional Administration and Local Government; TACAIDS; the Tanzania Gender Network Programme (TGNP); and UN Women. (See Appendix A for a list of these informants by name.) First we interviewed representatives of the nongovernmental organizations in this group to gain a broad understanding of current gender and health issues in Tanzania. Then we interviewed government staff tasked with writing technical reports using DHIS 2 and TOMSHA data and making health program and policy decisions. Here we wanted to understand how sex-disaggregated and gender-sensitive data are collected and used in Tanzania's RHIS and what issues arise in the process.

Analyses

With this information, we assessed the extent to which sex-disaggregated and gender-sensitive data are collected and considered in monitoring and evaluation (M&E) planning and used for health programming. Data collection tools were reviewed for fields for sex and age as well as gender-sensitive indicators. The available reports from field-level perspectives were thoroughly reviewed to assess whether

gender is considered and operationalized within national strategies and M&E plans; whether reports include sex-disaggregated and gender-sensitive data; and whether programmatic and policy discussions and recommendations are based on these data.

Finally, results from the key informant interviews were analyzed to understand the level of gender analysis that government staff conduct when drafting reports; the reasons why their reports do or do not include sex-disaggregated and gender-sensitive data and gender analyses; whether decision making processes incorporate sex-disaggregated and gender-sensitive data; and the barriers decision makers face in using gendered data for health planning.

RESULTS

Nongovernmental Organizations

Tanzania Gender Network Programme

Established in 1993, TGNP focuses on the promotion and application of gender equality and gender empowerment through three program areas: activism and advocacy; research and analysis; and information and communication. Within activism and advocacy, TGNP advocates for equal allocation of government resources for males and females and promotes gender equality in Tanzania's democratic process. TGNP's research and analysis team generates evidence-informed tools and data to use for advocacy. They use participatory action research to identify challenges of Tanzanian people and assist participants in analyzing how to address their challenges. During the analysis process, participants learn how to identify their own needs and challenges, link these to district budgets, and demand more equitable allocation of the budget. The evidence generated is used to engage with high-level actors including ministry officials and parliamentarians, by demonstrating the mismatch between the budget allocated and the funding needed.

According to the TGNP key informant, there is a lack of sex-disaggregated data and gender-responsive budgeting in Tanzania. To address this gap, the most recent Government of Tanzania budget guidelines have a section on gender-responsive budgeting, which tasks four ministries (MOHSW; Ministry of Agriculture; Ministry of Labor and Employment; and Ministry of Finance) and two district councils (Morogoro and Ilala) with collecting sex-disaggregated data. Additionally, at the time of the interview, the national government was in the process of developing the Country Gender Profile for Tanzania. TGNP developed the previous gender profile in 2006.

UN Women

Established in 2010 as the newest organization of the United Nations, UN Women focuses exclusively on gender equality. In Tanzania, UN Women carries out its work in partnership with the MCDGC, focusing its efforts on violence against women, women's economic empowerment, and HIV and AIDS. Although UN Women does not address education or health areas that fall outside the domain of HIV, the key informants acknowledged that gender is a crosscutting issue.

At the time of the interview, UN Women was helping to draft the Country Gender Profile, the development of which involved a highly participatory process with all sectors (for example, health, economics, environment, and HIV). The Country Gender Profile was deemed an important forthcoming tool that would contain sex-disaggregated and gender-sensitive data that could be used in evidence-informed advocacy and decision making. The data within the Country Gender Profile would also be used to provide a baseline for gender-related issues across all sectors[1] and be used to compile evidence regarding the progress of programs in achieving outcomes. UN Women also chairs the Gender Mainstreaming Working Group, which is made up of ministries and nongovernmental organizations and meets quarterly to discuss and collaborate on the design and implementation of policies to support gender equality.

[1] At the time of writing, the Tanzania Country Gender Profile was not yet available to the public.

The KIs from UN Women saw a disproportionate focus on quantitative data and recommended collecting more qualitative data. For example, they referenced the indicator used by the Tanzania government—number of women in Parliament—to express their perspective that women may be in Parliament, but the quality of level of their participation of those women may not make a difference. They suggested more informative indicators would measure not only the number of women but also whether the women have the skills to review the bills to identify the issues and whether they know what their roles and responsibilities are to perform their oversight within Parliament. UN Women suggested that there may be many women in Parliament, but without the necessary skills the women may not be able to make an impact on outcomes of interest.

Government Ministries, Departments, and Agencies

National AIDS Control Programme

The NACP was established under the MOHSW in 1988 to play a leading role in the prevention of the spread of HIV and AIDS and mitigate its impact, by providing essential interventions and high-quality care. The goals of the NACP are to scale up the health sector responses to HIV and AIDS and strengthen the health system's capacity to support HIV and AIDS interventions; promote access to and use of affordable and essential interventions and commodities for HIV and AIDS; and improve the quality of HIV and AIDS interventions for the general public, people living with HIV (PLHIV) and other vulnerable populations, and healthcare providers.

Previously, NACP used three databases to house data on HIV and AIDS: HIV Homebased Care database; CTC2 (previously HIV Care and Treatment) database; and HIV Voluntary Counseling and Testing database. Along with other sub-Saharan African countries, the Government of Tanzania is now moving toward using one streamlined health management information system based on the DHIS 2 platform to collect and analyze data from all health program areas. At the time of the assessment, government workers tasked with data entry were entering data in two parallel systems (DHIS 2 and the previous system used) while also importing data archives from the other data systems into DHIS 2. At the regional level, however, some data entry workers did not have access to the DHIS 2 web-based platform, and therefore entered data in Excel sheets created by NACP.

The form of data available within DHIS 2 mimics the structure of data collection tools used to capture that specific type of data. That is, DHIS 2 allows for entering and displaying data by sex for those indicators that are collected by sex as specified or allowed on data collection forms (see next section, *NACP Data Collection Tools*).

In addition to including HIV data that can largely be disaggregated by sex, DHIS 2 houses some gender-sensitive data: those related to gender-based violence (GBV). The DHIS 2 system can enter, read, and visualize the following GBV indicators, disaggregated by sex and age:

- Number of people receiving post-GBV care
- Number of people completing an intervention pertaining to gender norms that meets minimum criteria
- Number of GBV and VAC [violence against children] services encounters
- Percentage of GBV and VAC survivors referred out for support services
- Percentage of GBV and VAC clients tested for HIV
- Percentage of GBV and VAC survivors who were counseled
- Percentage of GBV and VAC survivors who were screened
- Percentage of sexually assaulted survivors eligible for post-exposure prophylaxis (PEP) who actually received PEP within 72 hours
- Percentage of GBV and VAC clients who returned for a follow-up visit as recommended by national guidelines

The DHIS 2 platform houses routine GBV information dating from July–September 2013, though there is regional variation in reporting rates.

NACP Data Collection Tools

Facility and district levels use many data collection tools to collect raw and aggregate data, which are then entered in the appropriate CTC2 database. The assessment team reviewed the following data collection forms: the National Care and Treatment ART [antiretroviral therapy] Register*;* the CTC2 [care and treatment clinic] Patient Record Form*;* the Quarterly Facility-Based HIV Care/ART form*;* the National PMTCT Services Referral/Transfer Form; HIV Testing and Counseling Monthly Form*;* and a Home-Based Care Monthly Form.

The National Care and Treatment ART Register is a facility level-based register of every person started on ART. It includes information on the date ARVs were started, the WHO clinical stage; CD4 count; and type(s) of regimen the client started. Demographic data—in particular, the sex and age (or date of birth) of the person—are recorded accordingly.

The CTC2 (Care and Treatment) Patient Record Form is used at the facility-level to record every visit from a patient. It records the visit type and related health status of the patient. The sex and age of the person are also recorded.

The Quarterly Facility-Based HIV Care/ART reporting form has three sections: "HIV Care (Pre-ART and ART)"; "ART (Subset of HIV Care)"; and "ART Follow-up." Indicators from the first two sections are sex-disaggregated, but the third section, on ART follow-up, is not. This third section is as follows:

- Number of persons who started on ART at the facility who were not on ART at the end of the quarter
    - Stopped ART
    - Transferred out
    - Death
    - Lost to follow-up

The National PMTCT Services Referral/Transfer Form records referral or transfer of patients who are categorized as follows:

- Antenatal care
- Labor and delivery
- Postnatal care
- Under five years of age

Because patients receiving antenatal care, labor and delivery, and postnatal services are female, sex-disaggregation of data does not apply here. However, the sex of children under five **is not** recorded.

The HIV Counseling and Testing Monthly Form collects data on the number of clients voluntarily counseled; the number tested; the test results; the number of clients who received test results; and the number of clients referred, by their service entry points. The data are disaggregated by sex, age, and type of service site. Data captured on the monthly form is aggregated from HIV testing and counseling (HTC) daily registers (facility-level registers), which collect data on all test activities taking place at the service delivery site. An HTC logbook or register is maintained at the health facility. This logbook or register contains details on a client's arrival date at the site, ID number, referrals made to other facilities with supporting client referral form, and the client's sex and age. A client registration form is used to capture data for all clients visiting an HTC site.

Different approaches to HIV testing and counseling exist in Tanzania, as follows:

- Client-initiated voluntary counseling and testing
- Provider-initiated testing and counseling (PITC)
- Home-based HIV testing and counseling

Reporting Structure and Reporting Level

At the site level, data for the HTC indicator are collected in every section that provides HIV testing. For PITC and voluntary counseling and testing sections, Counselors enter clients' data in the PITC source documents, which are the PITC registers with their respective monthly forms. Then the site's HTC focal person or site managers review the reports before submission to the district AIDS control coordinator. For the reproductive and child health section, nurses enter clients' primary data and other information in health management information system registers with their respective monthly summary forms. Nurses then prepare monthly reports, which the reproductive and child health in-charge and medical officer in-charge review before submission to the district reproductive and child health coordinator.

Data are then aggregated at the district, regional, and national levels. At all these levels, the data are reported by age and sex, using a standard format.

Home-based care (HBC) services refers to health and social services—physical, psychosocial, and spiritual care—provided to clients with HIV and AIDS by formal and informal caregivers in the clients' homes. The *Home-Based Care Monthly Form* records all new clients who receive such services, and covers the following indicators:

- Number of new clients enrolled this month, by sex and age
- Reasons for registration, by type of disease and by sex
- New and continuing clients receiving services this month, by HIV status, by care and treatment clinic (CTC) enrollment status, and by sex
- Number of clients ever enrolled in HBC, by sex
- Number of clients receiving various categories of care this month: medical care, nursing care, psychosocial support, nutritional support, preventative service, by sex
- Number of clients no longer receiving services: died, lost, transferred to other HBC services, migrate, no longer in need of services, opted out
- Number of clients referred to other services: counseling and testing, CTC, OI [opportunistic infections] (by sex), TB [tuberculosis] clinic (by sex), PMTCT, other services
- Number of clients who reported that they received the referral services: counseling and testing, CTC, OI, TB clinic, PMTCT, other services
- Number of individuals providing services during this month and trained according to national guidelines, by sex: community-based HBC provider, health facility-based HBC provider
- Number of individuals providing services during this month but not trained according to national guidelines, by sex: community-based HBC provider, health facility-based HBC provider
- Number of wards providing HBC in the district
- Total number of wards in the district
- Number of districts providing HBC in the region
- Total number of districts in the region

All but one of the above indicators capture sex-disaggregated data. Only the sixth one (number of clients no longer receiving services) is not captured by sex.

NACP Strategy Documents and Results Reports

The assessment team reviewed the NACP's Third Health Sector HIV/AIDS Strategic Plan (2013–2017); a report titled Implementation of HIV/AIDS Care and Treatment Services in Tanzania, May 2013; and the Gender Operational Plan for the HIV Response in Tanzania Mainland (2010–2012).

The Third Health Sector HIV/AIDS Strategic Plan (2013–2017) outlines how the health sector will contribute to the achievement of Tanzania's national goals of achieving zero new infections, zero deaths from HIV, and zero stigma by 2017. The plan is a key instrument in guiding the implementation of prevention, care and treatment, and mitigation programs. In addition to focusing on priority strategies, it outlines performance indicators and targets to be achieved by 2017. This plan addresses gender in several sections. The first section on a gender and rights-based approach states:

> *While more women than men are seen to access HIV testing and ART services, they are on the other hand disproportionally affected by HIV and AIDS as well as other social determinants of health (higher prevalence, incidence, poverty, low education), which in turn is compounded by gender-based discrimination and violence* (p.9).

Another section on stigma and discrimination includes within its priority strategies "…measures to address gender inequality and gender-based violence (GBV) to facilitate safe disclosure" (p. 32).

A section on GBV, in the chapter titled "Smart, Evidence-Based and Innovative Investments," outlines how gender norms and GBV are important factors in HIV transmission, and provides some examples of this pathway. The strategy states that Tanzania will scale up GBV services in specified locations and strengthen linkages between health services and the police force (p. 55).

The strategy outlines 20 core indicators and targets that fall under four objectives or themes:

- Elimination of new HIV infections (4 indicators)
- Reduction of HIV-related mortality (8)
- HIV among key populations (4)
- Health systems to support health sector responses to HIV and AIDS (4)[2]

Three of the 20 indicators have targets disaggregated by sex (all under the objective of elimination of new HIV infections):

- Percentage of women and men ages 15–49 who received an HIV test in the past 12 months and who know their results
- Percentage of women and men ages 15–24 who had higher-risk sex in the past 12 months who reported using a condom the last time they had sexual intercourse
- Percentage of young women and men ages 15–24 who have comprehensive knowledge about AIDS

Sex-disaggregated targets are not specified for the first indicator—*Percentage of young people ages 15–24 who are living with HIV*—of the first objective. The indicators under the remaining objectives do not include sex-disaggregated targets. Collecting and analyzing sex-disaggregated data to measure whether HIV-related mortality is decreasing among males and females at equal rates can help discern whether care and treatment programs are reaching and impacting men and women similarly; and if they are not, then programs can explore places of possible improvement. Similarly, collecting and analyzing data by sex on HIV among key populations can reveal areas that need improvement.

Implementation of HIV/AIDS Care and Treatment Services in Tanzania, May 2013, the third report of its kind, analyzes routine data from clinics throughout Tanzania to provide an update on the impact of ART on PLHIV. The report analyzes and discusses most indicators and outcomes by sex, including enrollment of clients in pre-ART care; enrollment of clients in ART; probability of death after ART initiation; proportion of adults no longer on treatment; improvements in CD4 counts after initiating ART; and proportion of adults switching from first-line to second-line therapy. In general, the document reported sex-disaggregated epidemiological outcomes for both adults and children.

[2] Indicators under the last objective about health systems are at the level of the health facility, laboratory, or health management team levels and therefore cannot be disaggregated by sex.

NACP Key Informant Interview

According to one key informant, NACP is developing a gender-based violence (GBV) curriculum for training of health workers responding to patients who disclosed experience of violence. While NACP did not collect routine gender-sensitive indicators in all regions at the time of the interview, DHIS 2 was tracking GBV data in certain regions. Registers at health facilities in eight pilot regions did collect GBV data, including number of people at facilities who experienced GBV and number of people, disaggregated by sex and age, who initiated PEP. The MOHSW was also training police in the eight pilot regions on protocols of response and data collection after violence was disclosed, and police precincts were asked to record data related to disclosure and services provided.

While most data collected were disaggregated by sex and there was movement toward collecting gender-sensitive data, only one example was provided of how such data were used to make programmatic and policy decisions: Based on a gender analysis of enrollment in ART services, MOHSW proposed various activities that should be undertaken to increase male enrollment. It was indicated that, due to frequent staff turnover and the section rotation system, new staff were not well-informed about how to use sex-disaggregated data for evidence-informed decision making. One key informant recommended building the capacity of staff who analyze and interpret data, so they can help program planners understand the gender gaps, and the capacity of program planners so they know how to use sex-disaggregated data to improve plans. Another key informant recommended providing guidance on how to use sex disaggregated data to make decisions, and designing and using posters, as job aids, to indicate differences in indicators between males and females.

Tanzania Commission for AIDS

TACAIDS was established under the Prime Minister's Office in 2000 to provide strategic leadership and coordinate efforts in the fight against HIV and AIDS. As part of TACAIDS, the TOMSHA database includes all nonmedical HIV services. Because data collected for the TOMSHA database are at the organization (not individual) level, there are no plans for TOMSHA data to be integrated in DHIS 2.

TACAIDS Data Collection Tools

Those in civil society organizations, the public sector, and the private sector who are implementing nonmedical HIV services complete the Quarterly TOMSHA Form. Data in the quarterly report cover HIV and AIDS prevention services, HIV impact mitigation services, training and capacity building for HIV and AIDS, and management and coordination of HIV programs. The quarterly report is based on the daily registers collected by the implementing partners. All variables disaggregated here are also disaggregated on the registers.

Prevention services include the following indicators that **are** disaggregated by sex:

- Number of teachers trained in life skills education for HIV and AIDS
- Number of learners exposed to life skills-based HIV and AIDS education
- Number of key population groups reached with HIV prevention services, also disaggregated by target group (sex workers, men who have sex with men, people who inject drugs, and other)
- Number of general population groups reached with HIV prevention services, also disaggregated by age (24 and below/25 and older)
- Number of community caregivers trained in standard precautions, transmission-based precautions, and infection prevention control
- Number of PLHIV who received skills training or support services
- Number of PLHIV clusters that are established and functional (disaggregated by female, male, and mixed sex PLHIV clusters)
- Number of PLHIV clusters provided with skills training (disaggregated by female, male, and mixed sex PLHIV clusters)

- Number of PLHIV receiving two or more support services
- Number of volunteers, staff, and employees trained (disaggregated by sex and type of training)

Indicators that **are not** disaggregated by sex are:

- Number of income-generating projects for groups (disaggregated by groups: OVC, elderly, widows/widowers, vulnerable households, other vulnerable groups)
- Number of vulnerable groups provided other basic external support (disaggregated by groups: OVC, elderly, widows/widowers, vulnerable households, other vulnerable groups)
- Number of PLHIV clusters that are established and functional
- Number of condoms distributed [the type of condom is differentiated by male and female, but not by which sex received the condom]

TACAIDS Strategy Documents and Results Reports

Guidelines for the Tanzania Output Monitoring System for Non-medical HIV and AIDS (TOMSHA) Interventions, Version 2.7

TOMSHA is a routine information system that collects nonmedical HIV data from implementers. TACAIDS and the council HIV and AIDS coordinators collect data through TOMSHA, analyze them, and report them to implementers so the information can be used to improve services (TACAIDS, 2007). Specifically, *Guidelines for the Tanzania Output Monitoring System for Non-medical HIV and AIDS Interventions, Version 2.7,* details how HIV implementers should report and use data in TOMSHA.

A review of the TOMSHA guidelines for gender reveals little attention to gender in the document. One example in Section 3 explains the benefit of collecting home-based care data, including age and sex of the client, and how those data can be used to identify gaps and optimize outputs (p. 16). While gender is mentioned briefly in the data that might be collected, this section does not discuss the importance of gender or highlight how the data can reveal potential gender differences as an important reason to collect such data.

Few indicators in this document are disaggregated by sex. Fortunately, many of the data collection forms have been updated since 2007 to include sex; however, the indicators in Version 2.7 of the TOMSHA guidelines are not aligned with the data being collected on new TOMSHA data collection forms. See above for TOMSHA indicators that are collected by sex. Additionally, it appears that the PEP indicator in the 2007 TOMSHA guidelines is not being collected on current TOMSHA forms.

TACAIDS National HIV and AIDS Response Report 2013: Tanzania Mainland

The National HIV and AIDS Response Report 2013 provides an overview of Tanzania's progress in the HIV epidemic response, drawing on medical and nonmedical and routine and nonroutine data. The report also presents achievements, challenges, and recommendations.

The National HIV and AIDS Response Report prominently includes gender and GBV in the executive summary; Chapter 8 is exclusively dedicated to gender and HIV. Many of the indicators reported and graphed in the report are also disaggregated by sex. For example, "Figure 1: HIV Prevalence Among Youth by Age and Sex" sets a good example of using and displaying data in a manner that illustrates the large gaps between young women and young men. These types of data and graphs are crucial to awareness of gender gaps and prompting discussion and informed decision making regarding such disparities.

Indicators that are not disaggregated are the number of teachers trained in life skills education for HIV and AIDS; learners exposed to life skills-based HIV and AIDS education; number of persons reached with HIV prevention programmes; and number of community-based caregivers trained in standard

precautions, as well as several impact mitigation indicators regarding income-generating activities and the establishment of PLHIV support groups. Because data collection forms were revised in 2014, we assume these indicators will be disaggregated in future reports.

Data are often presented by sex throughout the report. Discussion of the challenges and recommendations regarding these sex differences could be strengthened. For example, "Chapter 3: HIV Prevention Initiatives" lists challenges such as lack of comprehensive knowledge, stigma, and harmful norms, but does not specifically link these challenges to gender. Furthermore, the recommendations propose increased sexuality education for youth and behavior change communication but do not discuss addressing harmful norms, stigma, or gender inequalities in the HIV epidemic.

"Chapter 8: Gender and HIV" notes that women and girls are especially impacted by HIV and vulnerable owing to cultural norms and inequality. The chapter also discusses significant progress on gender and HIV in Tanzania: for example, the establishment of 417 "Gender and Children" desks at police stations and ongoing advocacy to change the age of marriage from 16 to 18. This report recommends increasing sensitization around GBV and human rights, increasing training and capacity building for all those working on HIV and AIDS, and disseminating the Gender Operational Plan widely. Despite gains, the report acknowledges significant remaining challenges that "compromise efforts to prevent HIV."

The M&E chapter of the report mentions the addition of GBV indicators; a future edition should discuss the importance of analysis, interpretation, and use of sex-disaggregated data. Overall, there is significant attention to gender throughout the National HIV and AIDS Response Report.

Gender Operational Plan for the HIV Response in Tanzania Mainland (2010–2012)

Development of the Gender Operational Plan was led by TACAIDS and involved input from stakeholders, organizations, and Tanzanian citizens. The plan was created to guide the provision of gender-sensitive HIV and AIDS interventions in the national HIV response, prevention, treatment, care, and support programs and in impact mitigation, and in the enabling environment. The plan is aligned with the National Multisectoral Strategic Framework on HIV & AIDS and covers 2010–2012.

The plan's mission is stated as follows:

> *Guiding and safeguarding the intensification and scaling up of gender-sensitive quality HIV and AIDS prevention, care, treatment, support and impact mitigation programs and interventions within a framework of a well-coordinated national multisectoral response programme led by Central Governments, anchored at the LGAs, rooted in communities and actively supported by partnership with all stakeholders*

The plan offers a workplan that lays out current and new gender-sensitive activities related to HIV and AIDS at national and local levels. The workplan specifies the activities, which are mapped to result areas and strategies from the National Multi-Sectoral Strategic Framework for HIV and AIDS (NMSF), as well as the organization/agency responsible, timeframes, and indicative annual budgets. The M&E chapter places the plan's M&E in the Tanzania National Multisectoral HIV M&E System. The chapter does not offer M&E indicators, and key informant interviews did not provide any evidence that the objectives (or outcomes) listed are being implemented.

The plan has ambitious goals, results, and strategies. However, without measureable M&E indicators and regular reporting, how can we know if these objectives are being achieved? An updated version of the Gender Operational Plan was scheduled to be released in 2013, but had not been developed as of December 2015.

TACAIDS Key Informant Interviews

According to one key informant interview, TACAIDS is responsible for collecting data for 15 nonmedical indicators. At times, data that are supposed to be disaggregated by sex are submitted to TACAIDS without disaggregation. This is generally due to challenges at the implementers' level, since implementers must be trained on what types of indicators to collect data for. High staff turnover and lack of financial support to adequately collect data also lead to incomplete or nondisaggregated data.

Recommendations to improve collection of sex-disaggregated data were provided at multiple levels: First, the national and subnational governments should organize forums for implementers to discuss and share ideas about ways to better collect data. Second, managers who are responsible for collecting data need to inform policymakers about the importance of sex-disaggregated data. Finally, advocacy is needed at the policymaker level.

President's Office-Regional Administration and Local Government

The establishment of the Ministry of Regional Administration and Local Government is enshrined in the Constitution of the United Republic of Tanzania, Articles 8 (1) 145 and 146 of 1977, and in several subsequent amendments. The constitution mandates the minister responsible for local authorities to establish them in districts, villages, urban areas, townships, and *mitaa* (Swahili for "streets"—an administrative unit). Over the years, the ministry has gone through several structures of government and attached to different ministries. Following the election of a new government in October 2015, the Ministry of Regional Administration and Local Government was moved from the Prime Minister's office to the President's Office, and is now referred to as President's Office-Regional Administration and Local Government (PO-RALG). The regional administration and local government is operationalized through regional secretariats, which are organized in five clusters, each headed by an assistant administrative secretary, under the overall leadership of the regional administrative secretary. The five clusters under each regional secretary are staff function, management support services, economic development support services, physical planning and engineering support services, and social sector support services.

Insofar as HIV response is concerned, the PO-RALG's responsibilities are:

- Facilitating effective recruitment and deployment of skilled health workers at health facilities, in collaboration with the MCDGC and Presidents Office-Public Services Management
- Collaborating with stakeholders at all levels for planning and implementation of health sector HIV prevention, care, treatment, and support services
- Designing and developing planning guidelines

The regional secretariat also is responsible for providing policy guidance, technical assistance, M&E of local government authority HIV and AIDS interventions.

PO-RALG Strategy Documents

The Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013/14—2017/18) (NMSF II) sets a foundation for Tanzania's response to the HIV epidemic. The introduction of the document states that the framework "calls for scaling up of the comprehensive, national response in prevention, care, treatment, and impact mitigation, in a way that is responsive to issues of gender." The document also includes gender as a strategic area of primary investment and a crosscutting programmatic principle. The strategic framework recognizes the importance structural inequalities and GBV, and in response, promotes comprehensive sexuality and gender education to supplement biomedical HIV curricula, and a broad multisectoral response to stigma, discrimination, and violence. Gender and GBV are woven throughout the framework. However, the implementation strategies for addressing "Priority Area 2: Reduction of Gender Inequalities and Gender-based Violence" do not have clear, measurable outcomes. The framework refers to the Gender Operational Plan for HIV Response for additional strategies to address gender.

PO-RALG Key Informant Interviews

While key informants reported they use sex-disaggregated and/or gender-sensitive data when analyzing reports or making decisions, they also acknowledged that gender issues are not a focus during data analysis. Additionally, while data should be disaggregated by sex at the council and district level, PO-RALG does not receive sex-disaggregated data from all councils and districts. Several barriers to using sex-disaggregated and gender-sensitive data for decisions were identified: for example, gaps in knowledge

about the importance of gender data and lack of availability of sex-disaggregated data. Suggestions for improving availability and use of gender data were developing appropriate data collection tools that capture sex-disaggregated data; drafting standard operating procedures emphasizing sex-disaggregation as a reporting requirement; drafting guidelines and a checklist that explains how to collect and use gender data; and training workshops on gender-sensitive indicators.

Ministry of Community Development, Gender and Children

The MCDGC's mission is to promote community development, gender equality, equity, and children's rights through formulation of policies, strategies, and guidelines, in collaboration with stakeholders active in the country. The ministry's gender equality work largely focuses on women's economic empowerment, education sectors, female genital mutilation (FGM), and GBV. The M&E Unit of the MCDGC monitors the implementation of programs and activities by government ministries and four agencies: Tanzania Women's Bank; Fogarty Development College; Community Development Training Institute; and Women's Development Fund. Additionally, the unit monitors activities and services provided in Dar es Salaam's One Stop Center for GBV: a comprehensive site that offers services from policy officers, lawyers, social workers, and doctors.

Gender-related data challenges cited by MCDGC key informants were the lack of comprehensive data on GBV, health, and education; the difficulty in collecting accurate data on women's participation and decision making; and the lack of a common M&E framework for gender across all ministries, which results in incomparable data. Recommendations to improve the availability and use of gender data were to create an M&E ministry at the highest level to ensure coordination of indicators and tools; train staff at the district level and in policy and planning; and secure additional funds to collect relevant data.

National Bureau of Statistics

The National Bureau of Statistics (NBS) collects nonroutine data across multiple sectors in Tanzania, much of which is sex-disaggregated. The NBS conducts the national census, which includes data by sex, but the report has minimal gender analysis. In addition, the NBS conducts a number of surveys, including the Demographic and Health Survey (DHS), which provides in-depth gender analyses. The DHS, which is implemented about every five years in all countries receiving health-related funding from USAID, is a household-based survey that collects data and analyzes them by age and sex. It has gender-sensitive indicators for numerous domains, including household decision making.

SUMMARY AND CONCLUSIONS

Key informant interviews revealed a variety of viewpoints and levels of experience with regard to sex-disaggregated and gender-sensitive data. There was a range in understanding of the value of collecting and using sex-disaggregated and gender-sensitive data for HIV epidemic control among staff within Tanzania's ministries. Several KIs were unable to give examples of sex-disaggregated data, few KIs were able to offer concrete examples of how one would use sex-disaggregated data for decision making, and one KI felt gender was not important to their work. Several other KIs expressed their belief that gender is an important factor in HIV, and said that more emphasis should be placed on gender in national HIV prevention efforts.

The desk review revealed that most indicators are sex-disaggregated, though a few important ones are not. Notably, ART follow-up data lack disaggregation. For example, the NACP quarterly facility-based HIV care/ART reporting form does not disaggregate "Number of clients no longer receiving services" by sex. This is concerning, because it prevents analyses by sex to examine differences between men and women dropping out of care for various reasons. Other reports, such as the most recent report on Implementation of HIV/AIDS Care and Treatment Services in Tanzania, periodically analyze routine HIV data by sex to understand epidemiological outcomes. The analyses, however, are not fully used to make program or policy decisions.

The Government of Tanzania has been making efforts to address gender in the HIV epidemic. For example, in 2014, TACAIDS updated its forms so more indicators are sex-disaggregated. While changes to the forms are a critical and substantial step toward examining the HIV epidemic from a gender perspective, it will be necessary to train staff to use the disaggregated data accordingly.

In many countries, M&E systems do not have many gender-sensitive indicators; we found this to be the case in Tanzania, as well. However, the DHIS 2 platform has recently begun to incorporate GBV indicators. GBV data collection is being piloted in selected regions, and the government plans to roll this out in all regions. The collection of this data is a result of increased recognition of the link between GBV and HIV risk, and a GBV prevention and response intervention is being piloted in some regions.

Limitations and Lessons Learned

Key informant interviews relied on self-reports, which could be biased due to social desirability or inaccurate recall. It is also possible that the KIs who were available for interviews had different experiences or opinions about gender than those KIs who were unavailable.

The desk review surveyed documents found by MEASURE Evaluation through the Internet, Tanzania associate award contacts, key government websites, and documents shared by key stakeholders. It is possible that important documents were missed, either because they were not available online or were not shared with the research team.

While the original scope of work covered gender analysis of data in the DHIS 2 and TOMSHA databases, the assessment team was unable to access these data. Therefore, we could not conduct quality checks on the portion of data housed within these databases that are disaggregated by sex. However, our review of written reports suggests that many indicators are disaggregated.

During the gender assessment, we discovered that the roles of data producers and data users are not as distinct as expected. Initially, two key informant interview guides were designed: one to collect information from people who analyze data and write reports; the other to collect information from those who use the reports to make programmatic and policy decisions. After we conducted the first few interviews, it became apparent that some job roles are not as clearly differentiated as that, or at least not operationalized that way.

Recommendations

We recommend that the Government of Tanzania promote both the collection and use of sex-disaggregated and gender-sensitive data.

The following recommendations are provided with the aim of increasing collection of sex-disaggregated and gender-sensitive data on HIV and AIDS within Tanzania's RHIS:

- Update NACP's quarterly facility-based HIV care/ART reporting form so all relevant sections, including all indicators under "ART Follow-up," have space to record data by sex.
- Update NACP's National PMTCT Services Referral/Transfer Form, by adding space to record the sex of patients under five years of age.
- Update the TACAIDS quarterly TOMSHA form so that all indicators are disaggregated by sex.
- Update the PMO-RALG's reporting requirements to include data reported to be sex-disaggregated.
- Ensure that data collection forms and national databases collect and maintain sex-disaggregated data.
- Incorporate analysis by sex in guidance documents or data analysis and use plans.

Additionally, in order to increase the use of sex-disaggregated and gender-sensitive data, we recommend capacity building for decision making. Key informant interviews and the review of key documents show a need for increased capacity among HIV data users, producers, and decision makers around the importance of gender in HIV. The majority of documents reviewed had limited discussion of gender,

with the exception of the Gender Operational Plan and the National HIV and AIDS Response Report, which focused on or included significant gender discussion. Moving forward, Tanzania should include substantive discussion of gender in all HIV and AIDS reports, because gender inequality is a key driver of the epidemic and will be critical to the success of epidemic control.

Furthermore, it will be important to discuss gender and HIV in national and subnational technical working groups, M&E meetings, and strategic planning sessions. We recommend including discussion of gender in agendas and in meeting objectives and identifying champions to raise the issue of gender during discussions.

The varied, and at times limited, examples of sex-disaggregated data analysis and use that KIs offered revealed that those working on HIV would benefit from additional training. Data analysis and interpretation and the use of sex-disaggregated data are key steps in understanding and addressing gender-related factors in epidemic control. Thus, it will be crucial to make gender part of future national and subnational M&E training. Offering such training will enable people to analyze and interpret findings according to gender, leading to increased discussion of gender in reports, strategies, and program and policy decision making.

REFERENCES

Cappa, C., Wardlaw, T., & Morgan, R. (2011). Disparities by sex in early childhood and adolescence. *The Lancet*, *378*(9797), 1122–1123. Retrieved from http://doi.org/10.1016/S0140-6736(11)61303-2.

Doss, C., & Kieran, C. (2013). Standards for collecting sex-disaggregated data for gender analysis: A guide for CGIAR researchers. CGIAR Research Program on Policies, Institutions, and Markets. Retrieved from https://library.cgiar.org/handle/10947/3072.

Lin, V., Gruszin, S., Ellickson, C., Glover, J., Silburn, K., Wilson, G. & Poljski, C. (2007). Comparative evaluation of indicators for gender equity and health. *International Journal of Public Health,* 52, S19-S26. Retrieved from http://econpapers.repec.org/article/sprijphth/v_3a52_3ay_3a2007_3ai_3a1_3ap_3as19-s26.htm.

Mahundi, M., Kaasbøll, J., & Twaakyondo, H. (2011). Health information systems integration in Tanzania: Tapping the contextual advantages. *IST-Africa 2011 Conference Proceedings*, 1–11. Retrieved from http://ieeexplore.ieee.org/xpl/login.jsp?tp=&arnumber=6107360&url=http%3A%2F%2Fieeexplore.ieee.org%2Fxpls%2Fabs_all.jsp%3Farnumber%3D6107360.

Ministry of Community Development, Gender, and Children (MCDGC). National strategy for gender development. Dar es Salaam, Tanzania: MCDGC. Retrieved from http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=94117.

Mushi, R. T., & Maharaj, M. (2013). Short communication health information systems in Tanzania. *African Journal of Library, Archives & Information Science*, 23(2), 151–155.

Nutley, T., & Reynolds, H. W. (2013). Improving the use of health data for health system strengthening. *Global Health Action*, 6(1), 1–10. Retrieved from http://doi.org/10.3402/gha.v6i0.20001. http://www.globalhealthaction.net/index.php/gha/article/view/20001.

Nowatzki, N. & Grant, K.R. (2011) Sex is not enough: The need for gender-based analysis in health research. *Healthcare for Women International*, 32:4, 263-277. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/21409661.

Nyamtema, A.S. (2010). Bridging the gaps in the health management information system in the context of a changing health sector. *BMC Medical Informatics and Decision Making*, 10(36). http://bmcmedinformdecismak.biomedcentral.com/articles/10.1186/1472-6947-10-36.

Raban, M. Z., Dandona, R., & Dandona, L. (2012). Availability of data for monitoring noncommunicable disease risk factors in India. *Bulletin of the World Health Organization*, 90(May 2011), 20–9. Retrieved from http://doi.org/10.2471/BLT.11.091041.

Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF International. (2013). Tanzania HIV/AIDS and malaria indicator survey 2011-2012. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and ICF International. http://www.nbs.go.tz/tnada/index.php/catalog/23.

United Nations Children's Fund (UNICEF). (2011). Boys and girls in the life cycle: Sex-disaggregated data on a selection of well-being indicators, from early childhood to young adulthood. Division of Policy and Practice, UNICEF. Retrieved from http://www.unicef.org/lac/boys_and_girls_life_cycle.pdf.

World Health Organization (WHO). (n.d.) The WHO Health Systems Framework. Retrieved from http://www.wpro.who.int/health_services/health_systems_framework/en/.

APPENDIX A. TOOLS AND REPORTS FROM THE DESK REVIEW

National AIDS Control Programme (NACP)

1. National AIDS Control Programme (NACP). (n.d.) National PMTCT Services Referral/Transfer Form
2. The United Republic of Tanzania, Ministry of Health and Social Welfare. (2013). Patient Record Form
3. The United Republic of Tanzania, Ministry of Health and Social Welfare. National Care and Treatment Program. (n.d.). Quarterly Facility-Based HIV Care/ART Reporting Form
4. The United Republic of Tanzania, Ministry of Health and Social Welfare. (2013). National HIV Care and Treatment ART Register
5. The United Republic of Tanzania, Ministry of Health and Social Welfare. National AIDS Control Programme (NACP). (2014). Third Health Sector HIV and AIDS Strategic Plan (HSHSP-III) 2013–2017
6. The United Republic of Tanzania, Ministry of Health and Social Welfare. National AIDS Control Programme (NACP). (2013). Implementation of HIV/AIDS Care and Treatment Services in Tanzania (Report No. 3)
7. National AIDS Control Programme (NACP). (n.d.). Mfumo wa HUWANYUDATA Version 1.3. Manual ya Utumiaji wa Mfumo

Ministry of Community, Development, Gender, and Children (MCDGC)

1. Ministry of Community Development Gender and Children (MCDGC). (n.d.). Monitoring Plan Matrix
2. The United Republic of Tanzania. Ministry of Community Development Gender and Children (MCDGC). (2011). Strategic Plan July 2011–June 2016

President's Office

1. United Republic of Tanzania, Prime Minister's Office. Tanzania Commission for AIDS (TACAIDS). (2010) Gender Operation Plan for the HIV Response in Tanzania Mainland (2010–2012). Dar es Salaam, Tanzania

Tanzania Commission for AIDS (TACAIDS)

1. Tanzania Output Monitoring System for HIV and AIDS (TOMSHA) Daily Register. (n.d.)
2. Tanzania Output Monitoring System for HIV and AIDS Quarterly TOMSHA Form. (n.d.)
3. Tanzania National Multisectoral HIV Monitoring and Evaluation System. (2007). Guidelines for the Tanzania Output Monitoring System for non-medical HIV and AIDS interventions (TOMSHA). Dar es Salaam, Tanzania: Commission for AIDS (TACAIDS)
4. The United Republic of Tanzania. Prime Minister's Office. (2013). Tanzania Third National Multi-sectoral Strategic Framework for HIV and AIDS (2013/14–2017/18). Dar es Salaam, Tanzania
5. The United Republic of Tanzania, Prime Minister's Office. Tanzania Commission for AIDS (TACAIDS). (2014). National HIV and AIDS Response Report 2013, Tanzania Mainland

APPENDIX B. KEY INFORMANTS

Ministry of Community Development, Gender and Children (MCDGC)

Catherine David, MCDGC Director, Women's Information Centre (WIC) Department
Joyce Haule, Assistant Director of Monitoring and Evaluation (M&E)
Judy D Kizaya, Assistant Director for Women's Issues

Ministry of Health and Social Welfare, Health Management Information System (HMIS)

Claud John Kumalija, HMIS Director

National AIDS Control Programme (NACP)

Bernard Rabier, M&E Officer
Robert Josia, Director, Assistant Program Manager

National Bureau of Statistics

Aldegunda Komba, Director of Statistics Operations

Prime Minister's Office-Regional Administration and Local Government

Isaka Jeremiah, Researcher, Policy and Planning Department, M&E Division
Steven Mutambi, Program Coordinator, Health Services Division

Tanzania Commission for AIDS (TACAIDS)

Steven Wandella, Acting Director, M&E Specialist

Tanzania Gender Network Programme (TGNP)

Lilian Liundi, Executive Director
Martha Samwel, Program Officer, Department of Research, Knowledge and Analysis
Gloria Chimabo

UN Women

Fortunata Temu, Senior Advisor
Catherine Sentamu, Programme Management Specialist, M&E

APPENDIX C. KEY INFORMANT INTERVIEW GUIDE FOR DATA PRODUCERS

Assessment of Availability and Use of Sex-Disaggregated Data (TZA-08)

Key Informant Interview Guide: Technical Staff Who Analyze Data and Write Reports

Complete this section before starting the interview

Date and time of interview:

Name of interviewer:

Name of key informant interviewee:

List participant's sex:

Key informant's place of employment:

Key informant's professional title:

Introduction to Interview

Thank you for taking the time to speak with me today. My name is (FILL IN THE BLANK) and I work for a MEASURE Evaluation, a USAID-funded project that strengthens capacity in developing countries to gather, interpret and use data to improve health. Under this project, we are working in Tanzania to increase the availability and use of high quality data to inform community health and social service policy, planning and decision making. I am working with a team to specifically increase the availability and use of gender data. I would like to learn how much you analyze and use sex-disaggregated and gender-sensitive health data in your work, and how much importance it is given in your ministry/agency/organization. I'm also interested in whether gender data are used when making decisions about health programs and policies; and the facilitators and barriers of using sex-disaggregated and gender-sensitive data for decision making.

1. How many years have you worked with this ministry/agency/organization?
2. How many years have you worked in your current professional capacity at this ministry/agency/organization?
3. Describe the type of work you do
    a. PROBE: How much do you work with data?
    b. PROBE: How much of your work involves using data for writing reports?
4. (IF RESPONSE TO QUESTION 3 INDICATES THAT KEY INFORMANT ANALYZE DATA) How do you decide what data to include in your analysis?
5. (IF RESPONSE TO QUESTION 3 INDICATES THAT KEY INFORMANT WRITES REPORTS USING DATA) How do you decide what data to present in the reports you write?
6. Can you describe what your understanding is of sex-disaggregated data?

    IF KEY INFORMANT DOES NOT ADEQUATELY DESCRIBE OR DEFINE SEX-DISAGGREGATED DATA, PROVIDE THE FOLLOWING DEFINTION:

    Sex-disaggregated data is data that is separated for males and females.

a. PROBE: Can you given an example of sex-disaggregated data?

   IF KEY INFORMANT DOES NOT GIVE AN EXAMPLE OF SEX-DISAGGREGATED DATA, PROVIDE THE FOLLOWING EXAMPLE:

   An example of sex-disaggregated data is from the 2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey. The results of the survey showed that among 15-49 year olds, 62% of women and 47% of men received HIV testing and counseling, including receiving the test results. With these statistics, national, district, and community HIV programs can examine why males are less likely to go for HIV testing and counseling, and develop strategies to overcome such gender barriers.

7. Can you describe what your understanding is of gender-sensitive indicators?

   a. PROBE: Can you given an example of sex-disaggregated data?

      IF KEY INFORMANT DOES NOT ADEQUATELY DESCRIBE OR DEFINE GENDER-SENSITIVE INDICATORS, PROVIDE THE FOLLOWING DEFINTION:

      Gender-sensitive indicators are those that directly address gender. They go beyond sex-disaggregated data (though they should be presented separately for men and women).

      IF KEY INFORMANT DOES NOT GIVE AN EXAMPLE OF GENDER-SENSITIVE INDICATOR, PROVIDE THE FOLLOWING EXAMPLE:

      An example is the % of women and men who think wife beating is justifiable; or % of men and women who share in decision making with their spouse.

8. How much do you consider using or analyzing gender-related data or indicators when writing reports?

   a. PROBE: How often do you use sex-disaggregated and/or gender-sensitive data when writing reports? (Every time you write a report? More than half? About half? Less than half? Never?)

   b. PROBE: For what types of health topics or reports do you use sex-disaggregated data?

   c. PROBE: Can you give 1-2 examples of reports that you have analyzed data for or reports you have helped write that highlight sex differences or gender-sensitive information?

9. Are there any instances when you wanted to include sex disaggregation in your analyses or reports, but were unable to because sex-disaggregated data were not available?

10. (IF RESPONSE TO QUESTION 8A. IS "EVERY TIME" OR "MORE THAN HALF"): What has helped or encouraged you to use sex-disaggregated and gender-sensitive data when writing such reports?

11. (IF RESPONSE TO QUESTION 8A. IS "ABOUT HALF", "LESS THAN HALF", OR "NEVER"): What would help you to use sex-disaggregated and gender-sensitive data more often?

12. What are some barriers that prevent you from using sex-disaggregated and gender-sensitive data when writing such reports?

    a. PROBE: What challenges, including policy or logistical challenges, prevent you from using sex-disaggregated data?

13. What could be done to encourage program managers and policy makers to more frequently use sex-disaggregated data for decision making?

Closing of Interview

Thank you again for taking the time to talk with me. My team and I will use the responses you've provided to draft recommendations for increasing the collection and use of gender data within the Tanzanian government.

APPENDIX D. KEY INFORMANT INTERVIEW GUIDE FOR DATA PRODUCERS

Assessment of Availability and Use of Sex-Disaggregated Data (TZA-08)

Key Informant Interview Guide: Decision Makers

Complete this section before starting the interview

Date and time of interview:

Name of interviewer:

Name of key informant interviewee:

List participant's sex:

Key informant's place of employment:

Key informant's professional title:

Introduction to Interview

Thank you for taking the time to speak with me today. My name is (FILL IN THE BLANK) and I work for a MEASURE Evaluation, a USAID-funded project that strengthens capacity in developing countries to gather, interpret and use data to improve health. Under this project we are working in Tanzania to increase the availability and use of high quality data to inform community health and social service policy, planning and decision making. I am working with a team to specifically increase the availability and use of gender data. I would like to learn how much you and your organization use sex-disaggregated data and gender-sensitive data to make decisions for health programs and policies. I'm also interested in the facilitators and barriers of using gender data for decision making.

1. How many years have you worked with this ministry/agency/organization?
2. How many years have you worked in your current professional capacity at this ministry/agency/organization?
3. Describe the type of work you do
    a. PROBE: How much do you work with data?
    b. PROBE: How much of your work involves using data and reports to make recommendations for program and policy decisions?
4. How do you decide what portions of the report to use to make decisions?
5. How often do you use data to make decisions?
6. How do you decide which types of data to use in making decisions?
    a. PROBE: Where do you get this data from?
7. Can you describe what your understanding is of sex-disaggregated data?

    IF KEY INFORMANT DOES NOT ADEQUATELY DESCRIBE OR DEFINE SEX-DISAGGREGATED DATA, PROVIDE THE FOLLOWING DEFINTION:

    Sex-disaggregated data is data that is separated for males and females.

    a. PROBE: Can you given an example of sex-disaggregated data?

IF KEY INFORMANT DOES NOT GIVE AN EXAMPLE OF SEX-DISAGGREGATED DATA, PROVIDE THE FOLLOWING EXAMPLE:

An example of sex-disaggregated data is from the 2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey. The results of the survey showed that among 15-49 years old, 62% of women and 47% of men received HIV testing and counseling, including receiving the test results. With these statistics, national, district, and community HIV programs can examine why males are less likely to go for HIV testing and counseling, and develop strategies to overcome such gender barriers.

8. Can you describe what your understanding is of gender-sensitive indicators?
    a. PROBE: Can you given an example of sex-disaggregated data?

    IF KEY INFORMANT DOES NOT ADEQUATELY DESCRIBE OR DEFINE GENDER-SENSITIVE INDICATORS, PROVIDE THE FOLLOWING DEFINTION:

    Gender-sensitive indicators are those that directly address gender. They go beyond sex-disaggregated data (though they should be presented separately for men and women).

    IF KEY INFORMANT DOES NOT GIVE AN EXAMPLE OF GENDER-SENSITIVE INDICATOR, PROVIDE THE FOLLOWING EXAMPLE:

    An example is the % of women and men who think wife beating is justifiable; or % of men and women who share in decision making with their spouse.

9. How much do you consider gender-related data and information when making programmatic or policy decisions?
    a. PROBE: How often do you use sex-disaggregated data and/or gender-sensitive indicators when making decisions? (In all your decisions? More than half? Half? Less than half? Never?)
    b. PROBE: FOR THOSE WHO HAVE RESPONDED THEY HAVE EVER USED GENDER DATA: Can you describe an example of when you used sex-disaggregated or gender-sensitive indicators?
10. Are there any instances in which you would have preferred to have information that was disaggregated by sex, but found it was not available?
11. What has helped or encouraged you in using sex-disaggregated and gender-sensitive data when making decisions?
12. What are some barrier that prevent you from using sex-disaggregated data and gender-sensitive data when making decisions?
    a. PROBE: What are some barriers including policy, logistics, lack of availability?
13. What would encourage you to use sex-disaggregated data and gender-sensitive data more frequently for decision making?

Closing of Interview

Thank you again for taking the time to talk with me. My team and I will use the responses you provided to help draft recommendations for increased collection and use of gender data within the Tanzanian government.

MEASURE Evaluation/Tanzania
TCRS Building,
1st Floor, Plot No. 436, Mwai Kibaki Road,
Mikocheni B.
Dar es Salaam, TZ
+255 22 277 3023
www.measureevaluation.org/tanzania

This research has been supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation-Tanzania associate award AID-621-LA-14-00001. MEASURE Evaluation-Tanzania is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of PEPFAR, USAID, or the United States government. TR-16-132

USAID FROM THE AMERICAN PEOPLE

PEPFAR

MEASURE Evaluation TZ