

ADDRESSING GENDER DISPARITIES IN ANTIMICROBIAL RESISTANCE (AMR)

Empowering Women and Engaging Men in Shinyanga Region, Tanzania

Dr. Gloria E. Swilla (M.D)

Supervised by: Krístrun Fríðsemd Sveinsdóttir

GRÓ GEST, University of Iceland

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Dedication

This work is dedicated to all the patients I have lost to resistant infections during my career.
Your lives and stories will always be in my heart. You are a constant reminder of why this
work matters.

Table of Contents

Dedication.....	III
List of Tables	VI
List of Figures.....	VI
List of Acronyms	VII
Acknowledgement	VIII
Key Definitions	IX
Preface: Why AMR and Gender?	X
Executive Summary	XII
1.0 Introduction.....	1
1.1 Overview of AMR (Antimicrobial Resistance).....	1
1.2 Global and Regional Context	3
1.3 National Context	6
2.0 Project Justification	8
2.1 Problem Statement.....	8
2.2 Problem Analysis.....	8
2.3 Situational Analysis	11
2.4 Proposed Intervention.	12
2.5 Introduction to One Health Society (OHS).....	13
2.6 Individual Capacity and Technical Expertise.....	15
2.7 Theoretical framework	17
2.8 Theory of Change	23
3.0 Proposed Technical Approach	25
3.1 Capacity Strengthening.....	25
3.2 Training of Trainers (ToT) Model	25
3.3 Community Engagement	27
3.4 Stakeholder Engagement.....	29
3.5 Household Hygiene Assessment for Infection Prevention	30
3.6 Gender Responsive Approach.....	30
4.0 Project framework	33
4.1 Project Goal.....	33
4.2 Project Objectives	33
4.3 Project Impact.....	34
4.4 Project Outcomes	34
4.5 Project Outputs.....	34
5.0 Target Group	36
5.1 Description of Project Site	36
5.2 Target Beneficiaries	37
6.0 Project Implementation	39
6.1 Project Stages and Activities	39

6.2 Project Administration	43
6.3 Cost Saving Measures on the Project	46
6.4 Risk Analysis and Mitigation	47
6.5 Stakeholders Analysis	49
6.6 Ethical Considerations in Implementation.....	52
7.0 Budget.....	54
7.1 Personnel and Technical Support	54
7.2 Training and Capacity Strengthening.....	54
7.3 Community Engagement	54
7.4 WASH Demonstration Support	55
7.5 Monitoring and Evaluation	55
7.6 Stakeholder Engagement and Policy Influence	55
7.7 Logistics and Operations	56
7.9 Budget Summary.....	57
8.0 Monitoring, Evaluation, Accountability, Learning and Research (MEALR) Plan.	59
9.0 Project Sustainability Analysis	62
10.0 Reporting	64
11. Conclusion	66
References	67
Annex 1. Problem Tree.....	73
Annex 2: Washington Group Disability Questions.....	74
Annex 3: Logical Framework.....	75
Annex 4: Project Activities Schedule	83

List of Tables

Table 1 : Risk Analysis Phase 1	48
Table 2 : Risk Analysis Phase 2	48
Table 3 : Risk Analysis Phase 3	49
Table 4 : Risk Analysis Phase 4	49
Table 5 : Local Level Actors and Stakeholders	51
Table 6 : National Level Actors and Stakeholders	51
Table 7 : Global and Regional Level Actors and Stakeholders	52
Table 8 : Overall Budget Summary	58
Table 9 : Shows the Project's MEAL Plan	61
Table 10 : Highlights the Project's Reporting Schedule	65

List of Figures¹

Figure 1 : Illustrates the key SDGs related to AMR.....	5
Figure 2 : Summarizes the drivers of AMR in the study context	11
Figure 3 : Represents the One Health Triad.....	22
Figure 4 : Illustrates the ToT cascade model as used in this project	26
Figure 5 : The Gender Integration Continuum (GIC) Levels.....	31
Figure 6: Adapted GIC Decision Tree from UNICEF GIC to social protection	32
Figure 7 : Shows the project's administration structure	44
Figure 8 : Project's Budget Pie Chart	56

¹ The figures used in this work have been created using the Canvas App or obtained from referenced sources

List of Acronyms

AMR - Antimicrobial Resistance

AU - African Union

COHESA - Capacitating One Health in Eastern and Southern Africa

DBF - Ducit Blue Foundation

FAO - Food and Agriculture Organization

GBV - Gender Based Violence

GDP - Gross Domestic Product

GIC - Gender Integration Continuum

HDA - Health Diplomacy Alliance

HIV - Human Immunodeficiency Virus

KAP - Knowledge, Attitudes, and Practices

LMICs - Low and Middle Income Countries

MEALR - Monitoring, Evaluation, Accountability, Learning and Research

MUHAS - Muhimbili University of Health and Allied Sciences

NAP - National Action Plan

OHS - One Health Society

RBA - Roll Back Antimicrobial Resistance Initiative

SACCOS - Savings and Credit Cooperative Societies

SDG / SDGs - Sustainable Development Goal / Sustainable Development Goals

STI / STIs - Sexually Transmitted Infection / Sexually Transmitted Infections

ToT - Training of Trainers

TPA - Tanzania Parliamentarians Alliance

UNEP - United Nations Environment Programme

UTI / UTIs - Urinary Tract Infection / Urinary Tract Infections

VICOBA - Village Community Banks

WAAW - World Antimicrobial Awareness Week

WASH - Water, Sanitation and Hygiene

WHO - World Health Organization

WHO AFRO - World Health Organization Regional Office for Africa

WOAH - World Organization for Animal Health

Acknowledgement

I want to start by thanking God for giving me life and for giving me the desire to make a difference in my community. This desire has been what motivates me to keep going.

I also want to thank the GRÓ GEST Team for letting me be part of the 2026 Cohort. As I write this in April, I can see that being part of this group has been a big learning experience for me. I have learned a lot about gender and how it relates to my work. I am very grateful to Margrét Ann, who has been an inspiration to me and has motivated me throughout this process.

My supervisor Krístrún, I feel lucky and blessed to walk this path with you. Thank you for being patient with me and for supporting me even when I doubted myself. Your guidance has helped shape this work. I look forward to the day we celebrate the impact of this work together.

I am here today because of the faith that the One Health Society team had in me. While I am grateful for the recommendation that opened this opportunity, I am more thankful for the support the One Health Society team has given me behind the scenes. The One Health Society team has guided me through learning about AMR, encouraged me during my interview preparations, celebrated this milestone with me, sent me off at the airport and has continuously checked in on both my wellbeing and academic progress. The One Health Society team has truly been a family to me. I cannot wait to return and implement this work with you.

My family, my mama, my baba and my brother Samwel you are why I try my best every day. Thank you for praying for me, loving me, supporting me and encouraging me. I hope to make you proud.

I also want to thank my gym buddies, Norah and Evelyne who also became my writing accountability partners. All the hours we spent in the library, the writing centre and after class working on this assignment meant so much. Thank you for standing by me and making this process enjoyable.

Lastly, I want to thank my mentor Prof. Martin and my friends Dr. Marynas, Dr. Christine, Dr. Biubwa, Dr. Eva and Mr. Bruno for their support and for being part of my journey. You are always in my heart and in my prayers.

Key Definitions

Antimicrobial Resistance - is a process that occurs when bacteria, viruses, fungi and parasites no longer respond to antimicrobial medicines. As a result of drug resistance, antibiotics and other antimicrobial medicines become ineffective and infections become difficult or impossible to treat, increasing the risk of disease spread, severe illness, disability and death (World Health Organization, 2023).

Antimicrobial agents - these include antibiotics, antivirals, antifungals and antiparasitics, medicines used to prevent and treat infectious diseases in humans, animals and plants (World Health Organization, 2023).

Antibiotics - are a type of antimicrobial agent that fight bacterial infections in people and animals. They work by killing the bacteria or by making it hard for the bacteria to grow and multiply (National Library of Medicine, n.d.).

Sepsis - is a life threatening condition that happens when the body's immune system has an extreme response to an infection, causing organ dysfunction (Singer et al., 2016).

Household - refers to a group of individuals living together and dwelling under the same roof (Cambridge University Press, n.d.). For the sake of this study, these individuals share daily resources and responsibilities where caregiving practices and health related decisions take place.

Preface: Why AMR and Gender?

This is one of the questions I have been asked the most in 2026. Each time, I find myself giving a different answer. I thought by now I would have the perfect response, something clearer and more confident. The truth is, my answer is still changing, just like my journey is changing. I became a doctor when I was 23 years old, which is a very young age in Tanzania. People expected me to work in a hospital and follow the traditional clinical path.

But that has never been who I am.

Throughout my five years at the university, I was always passionate about my community. During my studies, I worked part time with the community in areas such as sexual and reproductive health, mental health, non-communicable diseases and neglected tropical diseases. I have always believed that if we want to make people healthier, we need to focus on preventing illnesses.

And that has been a great part of my work, prevention through community awareness, screening, early diagnosis and promoting sustainable behavioral change by translating medical knowledge into practical, easy to understand information for the community.

After graduating, I did what was expected. I worked in the hospital. I treated patients. I prescribed medications. But something was missing. I witnessed the lives of newborns, toddlers, teenage girls and boys, young adults, pregnant women and the elderly being lost. Some who survived had to live with lifelong impairments. Many of these illnesses were caused by infections that did not respond to medicine.

What can we do when an infection does not respond to any of the available medications?

At the time, I did not fully understand antimicrobial resistance. To me, it was a really complex concept, full of pharmacology and microbiology, areas I did not naturally gravitate towards. But what I did understand was this, we were dealing with problems that could have been prevented.

Joining One Health Society was a huge change for me. The organization works on areas such as antimicrobial resistance, neglected tropical diseases and climate change. I felt confident in some of these areas, but AMR was not one of them.

I was working with AMR experts and sometimes I felt like I did not know enough. There were moments when I wanted to go back and stay in my comfort zone. But I was encouraged to learn and grow. I found myself in high-level AMR meetings with global stakeholders, presenting and learning in the process, sometimes simply

trying to keep up. Over time, I started to understand the systems, the policies, the National Action Plans and the gaps in implementation.

There was one moment that changed everything.

We came across global evidence highlighting the link between gender and antimicrobial resistance. As we explored this research, we saw that the problem was also relevant in our context. Despite the strong focus on biomedical and AMR governance approaches, there was little attention given to how gender roles and power dynamics influence antibiotic use at the household level.

That realization led to the development of this project.

With support from stakeholders and political leaders in Shinyanga, we started working on the idea. Before I knew it, I was on my way to Iceland to build my understanding of gender and further develop this work, with the hope of bringing it back home.

This project is very personal to me.

Because AMR does not begin in laboratories or policy rooms, it begins in our homes. In the everyday decisions we make. Decisions about when to seek care, who makes that decision, how medications are used and whether instructions are followed.

Many people are not aware of this. And when they do become aware, it is sadly too late. This work is the beginning of having a different kind of conversation. A conversation that allows us to reflect on our everyday realities in relation to AMR.

What role do we play in the way antibiotics are used?

How do the relationships in our homes affect the way we make health decisions?

Does gender affect who makes decisions, who takes action and who is heard?

What can we do to change these existing practices?

For me, the answer is simple.

"I am working on AMR and gender because I care about my community. I am working on AMR and gender because I want to help people understand the existing sociocultural gendered norms and make informed health decisions. I am working on AMR and gender because these issues have been normalized for too long and we need to talk more about them."

Executive Summary

AMR is a rising global and national health challenge that affects millions of people. It alters our ability to treat common infections and sets back the health advancements we have made by decades, as our current drugs become ineffective. This leads to increased morbidity, mortality and underdevelopment in countries. The majority of efforts to respond to AMR in Tanzania are top down and focus on biomedical and technical solutions, such as AMR governance, improved surveillance, diagnostics and AMR stewardship. While these efforts are important, they do not take into consideration the sociocultural gendered norms that shape our everyday realities and affect access and decisions to use medications. As a result, key drivers of AMR such as self medication, inappropriate use of medications and poor sanitation and hygiene practices continue to prevail.

In many communities in Tanzania, gendered power relations within households influence health decision making, access to health care services and the use of antibiotics. Women who are considered caregivers and managers of families' and communities' health often have limited decision making power, which leads to inappropriate use of antibiotics and increases the risk of AMR. This project aims to address this gap by co-creating and implementing a gender responsive, community centered AMR intervention in Shinyanga Region, so as to promote equitable household health decision making and responsible use of antibiotics.

Over a 12 month period, the project will train 50 AMR champions and reach about 1,000 community members. The project centers women and girls as AMR champions while actively engaging boys and men as partners and allies in transforming household health decision making dynamics. Using the capacity strengthening and Training of Trainers (ToT) models, the selected AMR champions will be equipped with the knowledge and skills to facilitate peer-led, creative, gender responsive AMR sessions within their existing community social groups, such as Savings and Credit Cooperative Societies (SACCOS) and Village Community Banks (VICOBA). This will create a ripple effect in which knowledge is passed down and sustained within the community. At the same time, structured community dialogue

sessions will be conducted with boys and men to reflect and challenge harmful gender norms that affect access to health care and antibiotic use practices. The project also integrates household assessments and infection prevention practices to reduce the need for antibiotics in the first place.

This project is guided by the principles of community engagement, equity and sustainability and is grounded in the One Health approach, gender and power theory and co-creation of locally acceptable behavioral change practices. These frameworks ensure that the proposed intervention addresses individual knowledge gaps as well as the structural and social factors that drive AMR.

This project recommends the integration of gender responsive strategies into AMR policies and interventions for key AMR stakeholders at both sub-national and national levels. The proposed approach is beneficial because it leads to more equitable household health decision making, responsible antibiotic use and reduced infections through better hygiene practices. The project calls for a shift in how we design and implement AMR interventions to recognize that long-term, sustainable change begins at the household level, where everyday health decisions are made.

1.0 Introduction

1.1 Overview of AMR (Antimicrobial Resistance)

Antimicrobial resistance (AMR) is a complex and growing global health challenge often misunderstood (WHO, 2023). In simple terms, it is the ability of microorganisms such as bacteria, viruses or parasites to develop resistance against antimicrobial agents or ‘medications’ that were previously effective in treating them.

When an individual is infected by microorganisms that have developed resistance, this results in what is referred to as “drug resistant infection.” These infections become difficult to treat and often do not respond to standard medications. This is considered an evolutionary response of the microbes, but it becomes accelerated with improper use of antimicrobial agents (Irfan et al., 2022) which has detrimental effects on the health of humans, animals and plants.

Antimicrobial resistance as stated earlier, cuts across a range of microorganisms but for the sake of this paper, the focus will be on antibiotic resistance as it is the most common in low and middle income countries.²

To further understand this, it is important to look at the “drivers³” of antimicrobial resistance. According to Holmes et al. (2016), misuse and overuse of antibiotics are the leading causes of resistant infections. This entails the use of antibiotics for viral infections, not completing medications, not using medications as prescribed, in some cases the use of herbal medications (due to lack of standardized dosage and quality control), self medication using over the counter drugs and this translates when dealing with human, animal and plant health as per the One Health Approach. Antimicrobial agents are also used in plants and in livestock keeping to treat infections and misused to promote growth and increase production, making the people working in these fields also vulnerable to resistant infections (ReAct – Action on Antibiotic Resistance & IDS, 2020). In addition to this, other drivers to take into consideration include poor water, sanitation and hygiene practices and environmental

² This reflects the most prevalent and contextually relevant form of AMR in the study setting (Shinyanga Region, Tanzania).

³ Drivers of AMR are factors that accelerate the development and spread of AMR.

pollution, all of which create suitable conditions for resistant infections to be transmitted from one host to the other.

The consequences of AMR are devastating, as they would lead to what we now consider treatable infections incurable, leading to prolonged illness, recurring infection, severe sepsis and death. Some of these consequences are not as direct or immediate, for example in reproductive health, recurrent sexually transmitted infections (STIs) and Urinary Tract Infections (UTIs) may lead to pelvic inflammatory disease, hence infertility. Depending on the affected part of the body, it may lead to tissue or organ damage that may also cause lifelong impairments and disability (ReAct – Action on Antibiotic Resistance & IDS, 2020). These are just physical health related effects of antimicrobial resistance.

Beyond health, AMR also has socio-economic impacts caused by factors like prolonged hospital stays that burden the family financially, reduced productivity and income within the household. The economy of the nation is similarly affected through heavy financing of medications, diagnostic tools, new drug discovery and skilled personnel to address AMR.

The victims of AMR and their families are not usually immediately aware of their condition. The experience that comes with multiple hospital visits, use of various medication alternatives, long hospital stays, being subjected to multiple invasive diagnostic procedures, not being able to lead a normal day to day life can be psychologically and emotionally overwhelming and draining. In severe cases, the loss of a beloved one due to preventable and treatable infections raises difficult questions around prevention and health decision making, what could have been done better?

Due to its complicated nature, more often than not AMR is treated as a biomedical concept and majority efforts to address it are focused on getting better medications and better diagnostic tools to detect resistance (WHO, 2018) . But it is important to look behind every decision to use antibiotics and determine what factors affect access, uses of antibiotics and infection prevention measures at the household and community level.

For example, in many low income settings, a caregiver with a sick child may resort to using previously obtained medications without proper guidance. This reflects

underlying systemic challenges that influence the isolated individual's behavior or decision.

Factors that lead to misuse of antibiotics include the inability to afford medication (lack of financial power), lack of knowledge of repercussions of improper use of antibiotics, decision making power that affects health seeking behaviour and one important factor is hygiene, which affects the need to use medications in the first place (Batheja et al., 2025).

AMR is not gender ⁴ neutral. The socio-economic drivers of AMR within many communities especially in developing countries, are often shaped by gender. Women bear the burden of the caregiving role and the unspoken responsibility of managing the family's and community's health in addition to their own. These responsibilities increases their exposure to antibiotics and places them at a much higher risk of getting resistant infections. At the same time, limited decision making power and restricted access to resources influence how and when antibiotics are used. Therefore, women are unevenly affected by AMR and also play a key role in antibiotics usage within households.

1.2 Global and Regional Context

AMR ranks top 10 in the leading global health threats (WHO 2022) and has led to over 4.71 million deaths directly attributed to resistant infections with over 1.14 million associated deaths (Naghavi et al., 2024). This is an overwhelming number of people affected globally and it shows just how severe the problem is. In this context, attributed deaths are those that would not have occurred without the resistance, associated deaths are those where resistance is not a primary cause but a contributory one. O'Neill (2016) predicted that if nothing is done to address AMR from both a health, policy and equity angle, then we will lose over 10 million lives a year by 2050. This surpasses many leading causes of death globally today.

AMR has impact on health and causes life long impairments and death. In addition to that, it has devastating economic costs globally. According to World Bank

⁴ In this project the term 'gender' is used to refer to binary gender dynamics (men and women) due to the sociocultural context of the target area while acknowledging the fact that 'gender' is diverse and socially constructed.

(2016), AMR could result in US\$1 trillion additional health care costs by 2050 and US\$1 trillion to US\$3.4 trillion gross domestic product (GDP) losses per year by 2030. If this happens, it is predicted to push over 28 million people into extreme poverty. The global economic crisis as a result of AMR is predicted to be similar to the financial crisis in 2008 and the chances of recovering from this are minimal (WHO,2018; World Bank, 2016).

As AMR disproportionately affects most of the middle and low income countries due to drivers such as poverty, poor water, hygiene and sanitation measures, limited medicines regulations, informal drug markets and inequitable access to health care services. Most of the economic and health impacts of AMR, are and will be faced in these regions.

To address this health challenge and prevent the predicted damage that AMR will cause, the World Health Assembly adopted the Global AMR Action Plan. This was later endorsed by the quadripartite (WHO, WOA, FAO and UNEP) showing the commitment of the global One Health actors in addressing AMR (WHO, 2018). These efforts require close collaboration of the animal, human and environment sectors and all the important professions within the finance, political and even the gender equality experts to come together and tackle AMR at all important levels. The Global AMR action plan laid down 5 specific objectives that have been adopted by member state countries at the national level to support efforts to tackle AMR (WHO 2015).

At a regional level, in Africa it is estimated that by 2050 AMR would have caused a projection of over 4.1 million deaths. This is almost 41% of the deaths that would happen globally per year. The leading resistant infections are considered to be tuberculosis (TB), typhoid, cholera, meningitis, gonorrhoea and dysentery most of which are STI, Respiratory tract infections and GI infections (World Health Organization Regional Office for Africa, n.d.). The burden of AMR is particularly higher in Africa region leading to increased morbidity and mortality across the region (Naghavi et al., 2024).

To respond to this, the African Union formulated a task force in 2018 that developed AU Framework to address AMR (Africa Centres for Disease Control and Prevention, 2018). The framework sets tone to strengthen control measures for AMR and prioritizes action within member states. The focus was on improving surveillance,

delaying emergence, limiting spread and mitigating harm caused by AMR. The surveillance network was put in place to help measure, prevent and mitigate the harm caused by AMR in both human and animal health (Africa Centres for Disease Control and Prevention, 2018). In 2026 April, it is expected that the AU will launch the second framework that will focus more on the One Health approach to addressing AMR and promoting equity towards access to health care services (Africa Centres for Disease Control and Prevention, 2025).

All the efforts undertaken by the global agencies and at the regional level to address AMR align with global commitments towards attaining the sustainable development goals, specifically SDG 1 (No Poverty), SDG 3 (Good Health and Wellbeing), SDG 5 (Gender Equality) and SDG 10 (Reduce Inequality) (United Nations, 2015).

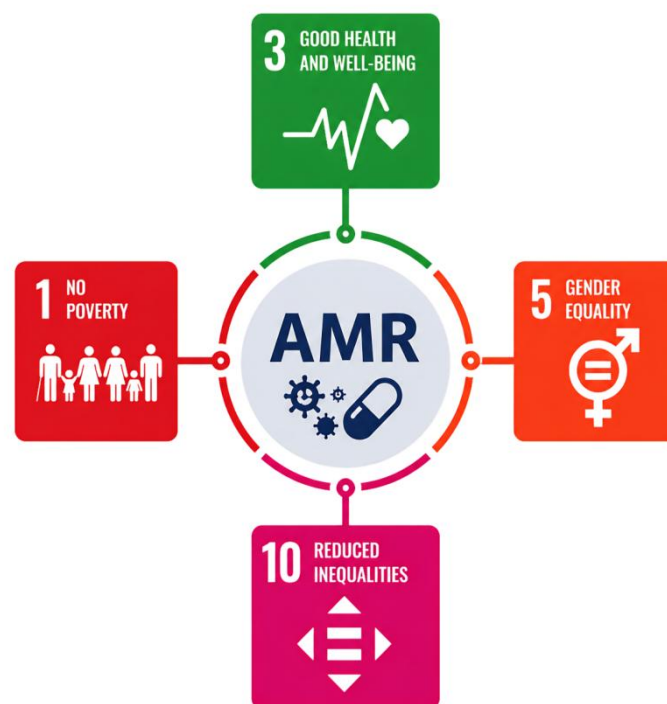


Figure 1: Illustrates the key SDGs related to AMR

Low and middle income countries are more susceptible to infections and the likelihood of getting resistant infections is higher as a result of misuse or overuse of antibiotics and poor sanitation and hygiene. If no effort is made to tackle this health challenge, most people from LMICs will be pushed to extreme poverty and this will further the existing inequalities, as majority of people will not be able to access proper

health care services (WHO, 2018). In agriculture and livestock systems, crops and animals will die due to infections leading to insufficient food production affecting food security and livelihood (FAO, 2020). Poverty increases vulnerability to AMR but also, AMR pushes people and households to extreme poverty, creating a vicious cycle that is difficult to break through (ReAct – Action on Antibiotic Resistance & IDS, 2020). This is why the fight against AMR is also a fight against poverty and inequalities, pushing us closer to attaining SDG 1 and 10.

AMR contributes to morbidity and mortality that affect the attainment of targets for sustainable development goals. AMR has been observed to directly and indirectly affect at least eight targets of SDG 3 (Aslam et.al., 2024). This highlights the importance of collaborative global and regional efforts to address AMR through policies and proper implementation practices through the One Health approach.

With relation to SDG 5, gender dynamics play an important role in shaping access to health care services and equitable health decision making within households. These factors directly influence patterns of antibiotic use, misuse or overuse hence contributing to the development and spread of AMR (ReAct – Action on Antibiotic Resistance & IDS, 2020). Addressing gendered sociocultural norms is therefore essential in tackling AMR and advancing regional and global progress toward the SDGs.

1.3 National Context

In 2021, there were an estimated 9,230 deaths attributable to AMR and an additional 42,200 deaths associated with AMR in Tanzania, making it a major public health concern of our time (Institute for Health Metrics and Evaluation [IHME], 2024). However, there is limited availability of sex disaggregated data that highlights how this national burden is distributed across different sexes. The available age disaggregated data shows that, the most of the affected group is that of under five children, who have the highest mortality and morbidity (Institute for Health Metrics and Evaluation [IHME], 2024).

The United Republic of Tanzania developed its first draft of AMR NAP in 2017, showing its commitment to supporting national and global efforts to address AMR through the One Health approach. This NAP set the tone for the adoption of AMR into

the governance system and a specific national multisectoral coordinating committee for AMR was established, responsible for coordinating all national AMR programs and strategies through the One Health approach (Frumence et al., 2021). In addition, the AMR surveillance strategy and implementation have improved significantly over time (Camara et al., 2023).

Despite this major success like many other countries in the LMIC settings, the implementation of the NAP is underfunded, has gaps in implementation of a multisectoral approach and lacks the integration of gender perspectives. Currently, Tanzania is in the implementation phase of the second AMR NAP (2023 - 2028) this is an improvement from the first NAP and addresses key issues like costing of the implementation strategies, improved governance, surveillance and AMR stewardship (United Republic of Tanzania, 2022).

It is still important to note that gender perspectives have not yet been integrated in the second NAP, despite the 20 recommendations provided by WHO on how countries can design, implement and monitor their NAPs from a gender responsive lens (World Health Organization, 2024a). Addressing this gap is important if we ever want to make inclusive and holistic advancements in the fight against AMR.

2.0 Project Justification

2.1 Problem Statement

In many Tanzanian communities, women play a central role in managing their own, their families' and their communities' health, including the use of antibiotics. Even with this huge responsibility, they often have limited decision making power within the household because of the existing traditional patriarchal norms. This imbalance affects how families access health care services, how and when antibiotics are accessed and used, often leading to inappropriate use at the household level, which contributes to antimicrobial resistance (AMR).

On top of that, most AMR interventions, policies and even the AMR NAP focus on biomedical and technical AMR solutions, with limited attention to everyday social realities. This creates a gap in addressing the deep root causes of antibiotic misuse, especially those shaped by gender and power dynamics.

2.2 Problem Analysis

At first glance, AMR and gender may not seem directly connected, yet gender is deeply rooted and influences our everyday health practices. Many people coming from the LMICs like Tanzania can easily recall the days when, as young children, we got sick and our mothers would be our first “physicians” to give us either hospital based or traditional regimen before even visiting the hospital. Women are often the first point of care before the formal health care is pursued within households and even the wider community. These practices are shaped by the sociocultural, gendered norms that position women as primary caregivers without corresponding decision making power to make health related decisions for their own, their families' or their communities' health. As a result, women play a crucial role in determining how and when antibiotics are accessed and used, making gender an important but often overlooked driver of AMR.

In 2024, WHO released a report that stated, “Women are 27% more likely to receive antibiotics in their lifetime ” (Schröder et al., 2016, p. 1803). This report not only reflects on the extent to which women interact with health systems and

medications, it also supports the existing inequalities within the household that contribute to patterns of misuse and overuse of antibiotics. This emerging evidence became a pivotal moment to deeply analyze the gendered norms and practices that affect access to antimicrobial agents in the community. Evidence from a study conducted in Tanzania among pastoralist communities shows that gender plays a critical role in influencing exposure and use of antibiotics, men were seen to purchase more unprescribed antibiotics, but women were the ones who used or administered these drugs at the household level (Barasa, 2024).

The increased exposure of women to antibiotics is shaped by various factors throughout a woman's lifetime such as biological, social and structural factors. For instance, women may use antibiotics for reproductive health conditions especially in settings where poor water, hygiene and sanitation (WASH) increase their risk of infections such as Urinary Tract Infections (UTIs). UTIs are eight times more common in women and result in increased consumption of antibiotics and hence the development of resistance (UNICEF, 2023; ReAct – Action on Antibiotic Resistance & IDS, 2020; Aika & Enato, 2022). Studies also show that women use antibiotics during their menstrual periods to alleviate pain (Sapkota et.al., 2010). This is mostly due to misinformation and lack of access to appropriate health care services. On top of that, 1 in 3 women worldwide have experienced some form of violence (WHO, 2024 b). While men also experience violence, women are disproportionately affected. Due to unequal power relations, women are more likely to experience intimate partner violence and sexual violence. All this also puts them at risk of sexually transmitted infections (STIs) and hence, improper use of antibiotics through informal channels to be able to counteract the effects (Batheja et al., 2025). This self medication practice is also in response to the existing societal bias, judgments and shame that come with STIs and GBV. All these factors in their totality, increase the use and misuse of antibiotics and hence the risk of AMR for women.

Beyond their own individual health care needs, women have a caregiving role that makes them at further risk of exposure to antibiotics and acquiring resistant infections. As primary caregivers, women are responsible for administering medications to sick family members, preparing food and maintaining household hygiene. In circumstances where there is indoor air pollution, poor sanitation and

hygiene practices, due to the caregiving role, women become at an increased risk of infections (ReAct – Action on Antibiotic Resistance & IDS, 2020). Also their caregiving role automatically gives them a responsibility to handle all medications in the family, thus their knowledge and access to proper information on the use of antibiotics is of crucial importance.

However, despite the role that women play in caregiving and health management at household level, the patriarchal society practices rob women the ability to participate in household health decision making processes. Patriarchal norms promote male dominance, male authority, male power, male leadership and control over financial resources. This affects the ability of women to seek timely health care services because of lack of autonomy. It also restricts access to proper diagnostics and treatment as these services are usually expensive and due to financial dependency, majority of women in this setting are unable to afford them (ReAct – Action on Antibiotic Resistance & IDS, 2020). As a result, women end up utilizing treatment options from informal channels or self medication. These structural inequalities affect the access to health care services and make women more vulnerable to AMR.

Shifting the focus to policies and programs set as national efforts to deal with the burden of AMR, it is undeniable that the focus has been more on diagnostics, stewardship and surveillance. While all these efforts are essential, they overlook the sociocultural drivers of AMR which are gendered (Batheja et al., 2025). In Tanzania, both the first and second NAP editions do not set clear frameworks for the integration of gender in the national AMR program design and implementation processes. This reflects a very crucial gap, addressing AMR requires not only technical biomedical solutions but also interventions at both local and national levels that respond to our day to day lived experiences and realities (ReAct – Action on Antibiotic Resistance & IDS, 2020).

Overall, gender shapes health seeking behaviour, access to health care services and antibiotic use practices. Women are positioned uniquely in this as caregivers, victims of gender based violence, affected by poor water, sanitation and hygiene facilities and bearers of the burden of a patriarchal system that limits their access to proper health care services including medications, reliable information, diagnostics and hence, face the highest risk of AMR. Addressing AMR through a gender responsive

lens will ensure that our strategies to fight against AMR are more effective and inclusive for all members of the community. The broader drivers of AMR are explained in the figure below:



Figure 2: Summarizes the drivers of AMR in the study context

2.3 Situational Analysis

Tanzania has successfully developed and implemented the first NAP (2017 to 2022) and currently implementing the second five year AMR NAP (2023 to 2028). Significant progress has been made in addressing AMR by strengthening AMR governance to ensure proper coordination, accountability and implementation of the frameworks and guidelines (United Republic of Tanzania, 2022). While these efforts have set a good foundation, it is now important to give attention to key gaps at the community level, particularly in creating context-specific evidence from communities to inform existing AMR policies and interventions. It is also equally important to integrate more gender sensitive and responsive approaches at grassroots levels, where the burden of AMR is most severe.

Despite the growing global evidence on the social drivers of AMR, the current strategies overlook the sociocultural norms and how gender dynamics shape access to health care services, household health decision making, hygiene practices and antibiotics use and misuse. The current Tanzania AMR NAP does not operationalise

gender or take into account the sociocultural norms that affect AMR. “While the Action Plan is grounded in a whole system approach using the One Health Approach, gender is not incorporated into the plan nor is there a focal point for gender considerations”(Barasa, 2024, p.3-4). This study emphasizes that Tanzania has a technically strong system, a system that is considered “whole” but whose approach is gender blind and this makes the entire system socially incomplete as it overlooks the structures that shape access and use of antibiotics in the community.

It is essential to look not only at gender, but at how gender intersects with other social identities such as age, religion, ethnicity, education level, geographical location and economic status that determine the availability, use and misuse of antibiotics (Gautron et al., 2023). The focus of most of the existing AMR policies and interventions has been on surveillance, governance and stewardship, as important as these AMR aspects are. We also need to take special consideration of gender and an intersectional lens, since it determines who benefits from the AMR interventions and who continues to be further marginalized.

In order to address these gaps and generate community driven evidence that can inform existing AMR policies and national plans, this project proposes a community based gender responsive AMR program. This project is important right now because for so long our AMR efforts in Tanzania have been focused on biomedical and system level approaches without looking at the deep sociocultural and gendered drivers that shape the use of antimicrobial agents and even the resistance patterns.

2.4 Proposed Intervention.

This project utilizes a community based, gender responsive AMR approach that centres women and girls as AMR champions and agents of change in their communities. Understanding that women are disproportionately affected by sociocultural norms that shape health care access, caregiving roles, antibiotic use and misuse, the project focuses on building their capacity through gender responsive AMR education and infection prevention practices. By empowering women and girls they will be knowledgeable, become more aware of the gender norms that affect them, make informed decisions and choices on the use of antibiotics for their own health and the entire household.

The trained AMR Champions will further disseminate this knowledge to other women in their social capital community groups and networks and together they will reach an even larger community creating a ripple effect. This model makes the intervention community owned, sustainable and more effective in creating long lasting behavioral change.

The project also recognizes that men play a huge role in shaping and maintaining the patriarchal norms that influence household health decision making. To address this, the project also engages men through structured community dialogues that provide a safe platform for men to reflect on gender norms and their effect on shaping health behaviors and antibiotic use at the household level. The aim of these dialogues is not to blame but to shed light and understanding of existing norms, encourage men to be supportive of women as they seek to improve their health behaviors and practices and promote equitable household health decision making. These discussions also create a room for men to look at ways in which they are also uniquely affected by drivers of AMR in their community.

Local community leaders will be engaged in every step of the project cycle, from co-creating and implementation to evidence dissemination. The goal is to strengthen understanding, promote easy uptake, acceptability and sustainability of the project in the community.

The evidence generated from this project will help inform the existing sub-national and national AMR interventions by integrating gender responsive and intersectional lens in AMR policies and practices. The approach used in this project is suitable since it is community led, driven, sustainable and addresses the unique contextualized needs, social and behavioral drivers of AMR in the target community which are often overlooked. By doing so, the project complements the existing biomedical and system level interventions in Tanzania contributing to a more comprehensive and truly “whole” system response, as highlighted by Barasa (2024).

2.5 Introduction to One Health Society (OHS)

This project will be implemented by One Health Society (OHS) in collaboration with key AMR partners in Tanzania. One Health Society is a registered non-governmental organization that works to address local and global health challenges using the One Health Approach (One Health Society, n.d.).

The organization was established in 2019 and works closely with the Prime Minister's Office under the One Health section. OHS has focused its work in four main areas which are AMR, Neglected Tropical Diseases (NTDs), climate change and pandemic preparedness and response. The organization also utilizes four approaches which include capacity development and training, research and innovation, policy advocacy and community engagement that promotes social and behavioral change at the grassroots level (One Health Society, 2025).

With relation to AMR, One Health Society is a member of the AMR Technical Working Group in Tanzania that helps with coordination, advocacy and implementation of AMR initiatives. OHS is also part of the global AMR Multi-Stakeholder Partnership Platform that is coordinated by the Quadripartite organizations. These include Food and Agriculture Organization (FAO), United Nations Environment Programme (UNEP), World Health Organization (WHO) and World Organization for Animal Health (WOAH). Through this platform, the organization has contributed to AMR advocacy efforts, shared technical expertise and engaged policymakers and stakeholders in shaping AMR responses. In addition to that the organization is part of the WHO Civil Society Task Force on AMR (Health Diplomacy Alliance, 2025). This platform was launched to amplify community voices and strengthen the role of civil society in advancing global AMR strategies.

To be able to successfully implement AMR programs, One Health Society has collaborated with various national and global stakeholders. These stakeholders include American Society for Microbiology (ASM), Capacitating One Health in Eastern and Southern Africa (COHESA), The Fleming Fund, Africa Centres for Disease Control and Prevention (Africa CDC), World Health Organization Africa Region (WHO AFRO), ReAct Africa, Health Diplomacy Alliance (HDA), Ducit Blue Foundation (DBF), WaterAid Tanzania, Roll Back Antimicrobial Resistance Initiative (RBA) and Muhimbili University of Health and Allied Sciences (MUHAS). Through these partnerships, One Health Society has implemented grassroots AMR initiatives. One of these is the Maasai Health

Initiative that promoted AMR awareness and WASH practices in rural communities, reaching over 10,000 people (One Health Society, 2024).

One Health Society made significant progress in AMR policy advocacy in 2024 by establishing the first and the third Parliamentarians Alliance on AMR in Africa and globally respectively (One Health Society, 2025). The alliance brought together 15 influential members of parliament in Tanzania who advocate for AMR financing, policy development and improved WASH infrastructure. In 2025, One Health Society co-hosted the 7th Africa Continental World AMR Awareness Week (WAAW) (Ministry of Health Tanzania, 2025), where it was recognized by the Vice President of the United Republic of Tanzania as the first civil society organization in Africa to establish a Tanzania Parliamentarians Alliance (TPA) on AMR. These achievements position One Health Society as an important stakeholder in Tanzania's AMR landscape, with the capacity to design and implement community based interventions and influence AMR policies and strategies.

This project builds on that experience, as it addresses a gap observed through previous AMR community engagement activities. While these initiatives have contributed to awareness and behavior change, they have often been male dominated and they have not addressed the gendered and sociocultural factors influencing antibiotic use. The evidence generated will inform interventions and policies at both national and global levels. The goal is to contribute to a holistic, gender sensitive and responsive One Health approach to addressing AMR in Tanzania. One Health Society works to ensure that gender is at the center of all AMR interventions, policies and strategies.

2.6 Individual Capacity and Technical Expertise

As a public health advocate, a big part of my work has been directly linked to the community. With experience implementing community based health programs, I worked with TAMIDA for 4 years, a partnership project between Tanzania and the International Medical Cooperation Committee (IMCC) Denmark. As the project lead in 2022, I coordinated the implementation of a Sexual and Reproductive Health (SRH) intervention that reached about 3,000 secondary school students in 5 schools. This

experience strengthened my capacity to design and implement community based health education programs in rural regions of Tanzania.

I started working with One Health Society (OHS) in 2023 as an intern and later directly promoted to the Head of Programs and Partnerships, where I supervise a team of 4 interns. In my current role as the Head of Programs and Partnerships, I have engaged with various AMR stakeholders locally and globally, securing long term partnerships and collaborations. I have also overseen the implementation of several AMR projects, one that was particularly impactful targeted underserved Maasai communities 293.2 km from the city. In this project, we raised awareness about AMR through interactive means like community dances and dramas reaching approximately 10,000 people and promoting the responsible use of antibiotics. This project helped me build the ability to translate complex health concepts like AMR into community friendly initiatives. I also have experience working with vulnerable groups. In 2025, I led the implementation of a short WASH sensitization project that reached 100 primary school students with hearing impairments. Working through this project allowed me to learn how to be sensitive and responsive to the unique needs of various groups in the community, an approach that is important when implementing community based interventions.

In addition to this, I have worked in hospital or clinical settings in both national and private hospitals. Working in the wards allowed me to interact closely with patients and observe gaps in our health system. I have attended newborns, toddlers, young children, adults, men, women and the elderly in various departments and sub-specialties. In all these, AMR is a common health problem that cuts across from surgical to medical specialties. This enabled me to see the clinical burden of AMR and understand the social drivers of AMR. This also supports why we need a holistic approach in understanding and addressing AMR.

The International Gender Equality Training at the University of Iceland has opened my eyes to see health in a different perspective beyond the technicalities and focus more on the social realities. Through this training, I have gained skills and knowledge in gender analysis, power dynamics, intersectionality and engaging with men and boys, concepts that are closely linked to this project. The combination of the training, clinical experience and experience from the community engagement work,

positions me to effectively lead the implementation of this project and achieve the desired outcomes.

2.7 Theoretical framework

2.7.1 Gender and Power Relations Theory

Like many countries in Sub-Saharan Africa, Tanzania is considered mainly a patriarchal society, where men are seen as dominant within social and household structures (Ceasay, 2013; Dillip et al., 2018). With over 120 ethnic tribes, less than 10% are matrilineal, meaning that the majority of the communities follow systems that position men at the center of authority (Emilie, 2023). The Shinyanga region is also mainly occupied by patriarchal tribes, hence these unequal power dynamics are visible within the project setting.

In these communities, gender norms shape how men and women are expected to behave from a very young age all the way through adulthood. Men are usually seen as heads of households, providers, breadwinners, leaders and decision makers. Women, on the other hand, are expected to be subordinate, respectful, followers and obedient (Ceasay, 2013; UN Women, 2019). These expectations put men in positions of power over women within the household and in the community.

These norms translate into gender roles within households. Men are typically responsible for making key decisions related to finances, health and socially while women take on caregiving roles that include caring for children and the sick, cooking, cleaning and maintaining household hygiene. Even in cases where women engage in paid work, they continue to carry this unpaid domestic responsibility, also known as the “double burden” (Dillip et al., 2018).

Drawing on Connell’s Gender and Power Theory, Maharaj (1995) explains that gender relations are not simply a result of individual behavior but are shaped by social structures that organize power. In the Tanzanian context, these social structures can be evidenced within household dynamics, where men often have decision making power over health care, while women remain responsible for the unpaid carework. This creates a huge gap between responsibility and power, where women have the central role in infection prevention and caregiving but have limited or no influence over decisions regarding treatment and antibiotic use.

In relation to AMR, these gendered norms and power relations place women in a disadvantaged position that limits their autonomy and agency in making health related decisions (Sen et al., 2007). While women are often the primary users of health services and the ones administering medications within households, they may not have the authority to decide when or where to seek health care, whether to access formal health services or how antibiotics should be used. In many cases, these decisions are influenced by men who control financial resources and have corresponding decision making power (Ceesay, 2013; World Bank, 2022). This results in delays to seek health care, incomplete treatment, self medication or inappropriate antibiotic use which increases the risk of antimicrobial resistance.

On the other hand, Connell also states that gender roles and power relations are not fixed, they are socially constructed and can be reshaped over time through practice and interaction (Maharaj, 1995). Building on this concept, this project addresses these health inequalities by promoting more equitable participation in household health decision making. By providing women with gender responsive AMR knowledge, the project focuses on strengthening their ability to make informed decisions. Meanwhile, also engaging men through community dialogues to reflect on existing norms and explore more supportive roles they can play. This will redistribute decision making power within households, improve antibiotic use practices and reduce the risk of AMR.

2.7.2 Intersectionality Perspective

Health is not a gender neutral subject (Gautron, 2023). While the gender and power relations concept has allowed us to understand the inequalities that exist in the community, it does not fully explain the differences within the experienced inequalities. The intersectional lens complements this by allowing us to understand and appreciate that these inequalities are experienced differently across groups and individuals. Women are not a homogeneous group, their realities are also not the same, they are shaped not only by gender but also by other important factors like religion, socioeconomic status, education, occupation, geographical location and ethnicity.

The concept of intersectionality was first described by Kimberly Crenshaw, who explains that individuals can experience overlapping forms of discrimination that cannot be understood through a single category such as gender or race alone (Crenshaw, 1989). This supports the fact that inequalities do not occur in a single axis or dimension but they appear in so many other diverse forms. Similarly, in the Tanzanian context where women are generally subjected to gendered norms, their experiences vary. For instance, women in rural areas face more inequalities in terms of access to education, financial resources and employment opportunities that make them more vulnerable compared to women in urban areas. These overlapping multidimensional realities shape household power dynamics and access to health care services.

In relation to AMR, intersectionality factors determine the risk of exposure to resistant infections, access to appropriate health care services and how antibiotics are used within households. For example, age plays a significant role, studies have shown that youth aged 18 to 24 are more likely to consume antibiotics in Tanzania (Barasa, 2024). This could be as a result of low level of awareness, low health literacy and engaging in risky sexual behaviours that lead to STIs. Economic status determines the ability of the family to afford standard health care services, which are expensive diagnostic tests and treatment regimens. People from low economic status end up resorting to self medication or incomplete treatment that put them at higher risk of AMR. Education level further influences the ability to understand prescriptions and adhere to the treatment guides. Evidence shows that women with low education levels have the tendency to stop antibiotic use for children when symptoms disappear rather than completing the prescribed course (Bosley et al., 2018). In addition to that, environmental factors such as limited access to safe water also affect women, as they are the ones who go to fetch water and are at risk of being exposed to contaminated water sources (WHO, FAO & OIE, 2020) and also infections due to poor hygiene and sanitation. Geographical location also affects access to health care facilities, where majority of rural areas facilities are far, a factor that acts as a barrier towards access to health care (Gautron, 2023). All these factors demonstrate that patterns of use of antibiotics and the risk of AMR are not evenly distributed across populations, but are shaped by multiple intersecting realities.

Intersectionality in this project is not treated as an inclusion checklist, rather an approach towards understanding that no single solution fits all realities. Thus the project's context in the Shinyanga region reflects an understanding that people are affected by multiple layers of vulnerability. The project uses community led and context specific solutions such as co-creation with community members and needs assessment at both individual and household levels. This makes the interventions adaptable according to the unique realities and needs of the community in relation to AMR.

2.7.3 Behaviour Change Theory

Many diseases and health conditions are closely related to everyday life choices and practices, which is why behaviour change is important as it improves health outcomes and reduces risks of health conditions. In terms of antimicrobial resistance, health related behaviours such as hygiene practices, health seeking behaviours and use of antibiotics are not random but shaped by beliefs, sociocultural norms and contexts. To change these behaviours goes beyond just providing information to the community especially if this change is to be long term (Elder et al., 1999). This is because behaviours are sustained as a result of social, economic and contextual barriers. Therefore, it is important to adapt behaviour change approaches that move beyond creating awareness to influencing how people think and act within their environments.

In the context of AMR, behaviour shapes the access, use and misuse of antibiotics. Inappropriate use of antibiotics practices such as not adhering to prescription, sharing antibiotics among family members, self medication and access to antibiotics through informal channels are all shaped by a combination of sociocultural norms, past experiences and household power dynamics. As much as some of these practices may be individual choices, those choices are reinforced by the community.

Bandura (1993) explained the social learning theory, one of many theories that explain why individuals adopt or resist certain health related practices. This theory is relevant as it helps us understand behaviour within communities. According to

Bandura (1993) behaviour is built as a result of interaction between individuals, their immediate environment and their actions, a concept known as reciprocal determinism. This theory explains that people learn not only through experience but by observing others. Behaviour is also influenced by the belief on the consequence of an action (outcome), confidence in one's ability to perform the behaviour (self efficacy) and reinforcement.

The social learning theory allows us to look at behaviours that lead to AMR differently. If behaviours that lead to inappropriate use of antibiotics such as taking unprescribed medications are normalized within communities, then they are more likely to be adopted by others close to them regardless of their level of knowledge or awareness of AMR. The project applies this theory using the community based, peer led model that uses AMR champions as advocates towards behaviours that encourage proper use of antibiotics and infection prevention. Through community learning, observation and regular interactions other community members are more likely to learn and adopt similar behaviours. The learning sessions and community dialogues are ways to reinforce these positive behaviours and practices while also addressing the misconceptions and gendered norms that contribute to AMR. The practical hygiene demonstrations are aimed to promote self efficacy and confidence to adopt and sustain behaviour change over time.

Behaviour change is a social process and this project utilizes the existing social networks, relationships and community structures to create a suitable environment where positive behaviours are learned, practiced and reinforced together as a community. It is important to know that while the behaviour change theory creates a strong foundation for influencing practices, it does not fully address structural barriers like economic constraints and limited access to health care services. This highlights the importance of having a more integrated approach, a combination of structural, social and behavioral interventions when addressing AMR. Recognizing this, the project engages with stakeholders with the capacity of influencing change at the structural levels such as improving access to affordable health care services in the community. By linking community level interventions with system level actors, the project creates an enabling environment for sustained behaviour change in the community.

2.7.4 One Health Approach

The most fascinating idea about the One Health approach is that it recognizes that health is not singular and rather human health, animal health and the environmental health are interconnected. What affects human health can also affect animals and the environment, similarly the origin of most human infections is from the environment and animals and vice versa is true. The use of antibiotics in human, animal and plants contributes to the emergence and spread of resistant microorganisms. This interaction forces us to look beyond individual health outcomes and consider how all related domains (human, animal and environment) shape disease patterns (Robinson et al., 2016). Below is the One Health Triad.



Figure 3: Represents the One Health Triad⁵

One Health acknowledges that the health of humans, animals and the environment or plant health are interconnected and must be addressed through coordinated and interdisciplinary action (Destoumieux-Garzón et al., 2018). In this project, we look at how AMR affects human health, but also take into consideration the important roles played by the animal health and environment. These include household use of antibiotics for small scale farming that influence the spread of AMR. Also, an unhygienic environment with poor WASH facilities contributes to the spread

⁵ Source: SiouxFalls.Business (2018), One Health: The future of biotech and a fit for South Dakota.

of infections (WHO, FAO & OIE, 2020), creating a demand for antibiotics and increasing the risk of developing resistance. This shows that AMR is not just a consequence of inappropriate use of antibiotics but also of unhygienic conditions that increase the likelihood of infections in the first place.

The project takes this into account and integrates education on infection prevention measures and provides demonstration tools that will support households towards maintaining proper hygiene practices that will reduce the need to use antibiotics and risk of AMR. Tackling this addresses one of the key pathways that lead to AMR. By understanding the One Health approach, the project shifts its focus from treatment to prevention which is important for sustainability purposes.

One Health approach also operates through an interdisciplinary and trans-disciplinary manner. In addressing AMR, perspectives from human health, environment and animal health often come together to create solutions. In addition to engaging these professions, this project also shifts the focus towards integrating gender perspectives and gender experts in the community based initiative as a way of tackling sociocultural factors that drive AMR. By doing so, the project bridges an important gap between technical and social aspects of AMR through the One Health approach.

2.8 Theory of Change

This theory of change outlines how the proposed gender responsive AMR approach used in the project will contribute to improved use of antibiotics and infection prevention measures at the household and community levels in Shinyanga Region, Tanzania. It highlights the pathway that links the project's inputs, activities, outputs, outcomes and long term impact, taking into consideration key assumptions that may affect the achievement of the target project's outcomes.

If we develop and pilot gender responsive AMR and infection prevention training materials, assess household WASH conditions, conduct community education sessions for women and men, facilitate open community dialogues that address gender norms influencing antibiotic use, provide practical hygiene demonstrations and document community evidence to engage policymakers and key stakeholders.

Then households in participating communities in Shinyanga Region will practice more equitable health decision making, adopt responsible antibiotic use behaviors and strengthen infection prevention practices. In the long run, the gender responsive approaches will also be increasingly integrated into AMR plans and programs at both sub-national and national levels. Because knowledge alone is not enough to change antibiotic use behaviors.

In many households, women are primary caregivers but do not always have decision making power regarding when and where to seek care or information on how medicines are used. By combining gender responsive AMR education with structured community dialogues, we not only increase community awareness about AMR, we also begin to challenge and shift the unequal power dynamics that influence household health decisions. When men understand the risks of inappropriate antibiotic use, are engaged as partners in responsible decision making and when women feel more confident and supported to participate in health decisions, households are more likely to make informed health choices. At the same time, strengthening WASH and immunization practices reduces preventable infections, which lowers the need for antibiotics in the first place. Documenting community level evidence and engaging stakeholders ensures that these approaches inform broader AMR programs and policies, making the change more sustainable beyond the project period.

This approach assumes that men and women are willing to participate in education sessions and dialogues, that community leaders are supportive of discussions around gender norms and that policymakers are open to integrating gender responsive approaches into AMR strategies. Nevertheless, the project also acknowledges that this approach will face some degree of resistance since it targets sociocultural norms and power dynamics. The project will therefore adapt strategies such as early engagement with community leaders and men, building trust, non-accusatory discussions and culturally relevant messaging. The aim is to build community acceptance over time.

3.0 Proposed Technical Approach

This section provides an overview of the technical approaches in which the project operates and how these approaches lead to sustainable outcomes.

3.1 Capacity Strengthening

Capacity strengthening often used interchangeably with “capacity building” refers to the process of enhancing the skills, resources and abilities of individuals or communities to achieve a certain goal or attain certain outcomes (United Nations, n.d). In the context of gender responsive AMR, capacity strengthening of the community and individuals means enabling them to understand how the sociocultural and gendered norms influence access to health care services, affect the use of antibiotics and co-create solutions that they can adapt to prevent antimicrobial resistance.

For women and girls, who are often considered as primary caregivers and gatekeepers of antibiotic use within households, capacity strengthening means improving their ability to make equitable, timely and informed decisions that improve their own health outcomes and that of their families and communities. It also involves addressing the structural barriers such as unequal gender power relations and sociocultural norms that limit women’s participation in health decision making.

For men and boys, capacity strengthening means creating spaces for them to reflect on how the existing gender norms within the patriarchal system shape health decisions and how they can be transformed to support more equitable decision making, promote access to health care services and responsible use of antibiotics.

At the community level, capacity strengthening encourages equitable decision making, empowers women, supports women’s leadership and promotes collective action in addressing AMR. This approach is suitable since it creates local ownership of the solutions, skills, knowledge and capacities which are then sustained for generations and generations to come.

3.2 Training of Trainers (ToT) Model

The Training of Trainers (ToT) model is an effective technical approach that allows for a “domino effect” in the process of sharing knowledge within the community. It involves training a small group of individuals for a period of time, who in turn transfer the knowledge and skills to a larger group, creating a cascade chain of events where knowledge is dynamically shared between groups. It is important to appreciate the fact that even the trainers continue to learn as they train others.

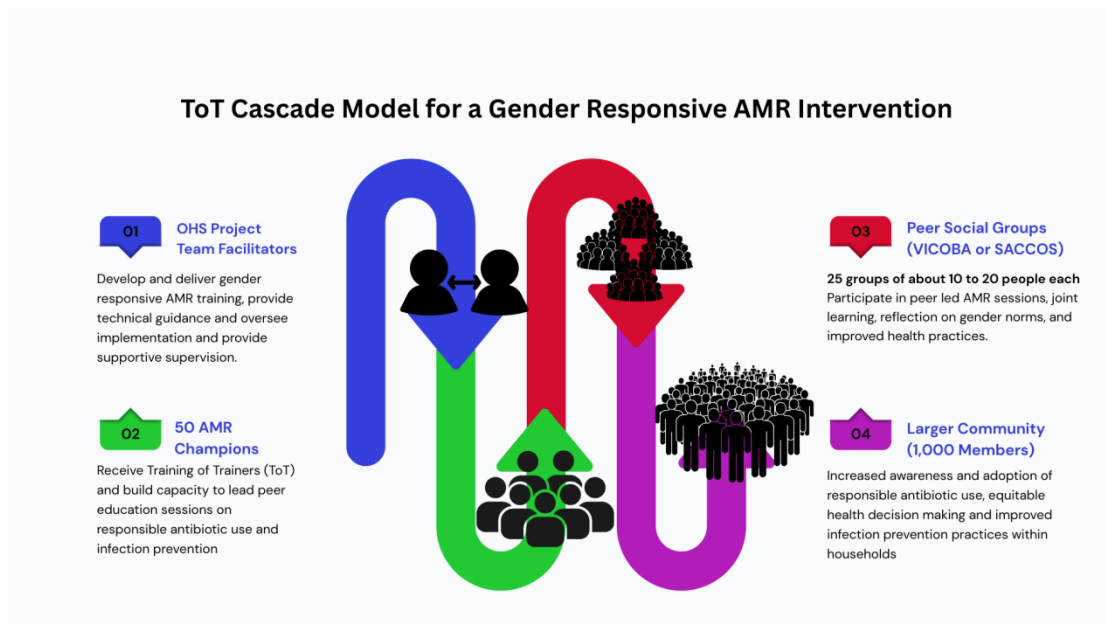


Figure 4: Illustrates the ToT cascade model as used in this project

In this project, a team of facilitators will train a group of selected women as AMR champions. These AMR champions will then go into their existing community groups (such as VICOBAs and SACCOS groups) and share the knowledge and promote improved antibiotics and hygiene practices using creative and locally relevant ways, such as storytelling, songs, role playing and community theatre. Through the existing social groups, the intervention will reach a broader community in the Shinyanga region, creating a sustainable flow of information between community members.

This model is less dependent on external facilitators, who are mostly available during the sessions to provide technical support to the AMR Champions. It allows the community to take charge of knowledge dissemination, promotes the scalability potential of the project, builds trust in the community, compliance and local ownership of the movement. It allows for the localization of the training to the

realities of the community. Furthermore, what is unique is the fact that these AMR Champions are peers in the community and hence they understand how these social norms operate and how they can be easily navigated.

To ensure effectiveness, the project will adapt structured training materials, provide supportive supervision during the training sessions and provide continuous mentorship to AMR Champions so that the quality of the training is maintained and that there's consistency in the information shared.

3.3 Community Engagement

“Nothing for us without us” (Charlton, 1998, p. 3). This phrase captures the core purpose of community engagement in this project. United Nations Children’s Fund (n.d.) describes community engagement as a spirit that seeks to improve the involvement, participation, collaboration and voices of communities in taking action to bring change. At the heart of every humanitarian work lies community engagement which creates room for the community members to drive their own change.

For long, efforts to tackle AMR have been a top down approach that focuses mainly on governance and improving diagnostics, it is high time that we shift that focus to the community. To engage the community in AMR may be particularly challenging due to the complex nature of the subject and bio-medical aspect that lies behind it (Mitchell et al., 2019). This project therefore adopts a co-creation approach that allows for the community to actively participate in designing AMR solutions that are locally acceptable, relevant and implementable in their own setting.

The project has adapted the seven principles of community engagement proposed by Mitchell et al. (2019), which are particularly applicable to addressing antimicrobial resistance in the context of Shinyanga, Tanzania. These principles include:

Clarity: This principle ensures that the work we do in the community is easily understandable to people. In the project, we use simple, locally translated materials to bring awareness about household norms, antibiotic usage and AMR.

Evidence Led: This principle highlights the importance of using community evidence for interventions. In this case, the project conducts baseline

assessments to understand the unique needs of the community this is not just limited to awareness, knowledge and practices, but also includes an assessment of households to determine the gaps in WASH and provide appropriate tailored measures.

Equity: In the process of addressing the gender norms that affect household health decision making, the project works to address inequalities in the community. It also takes into consideration of intersectionality where people's experiences are not homogeneous and are shaped by multiple intersecting factors that influence access to health care services, reliable health information, health decision making power and use of antibiotics. The project therefore takes measures to ensure that its interventions are inclusive and respond to unique community needs as a way of promoting equity for all.

Interdisciplinary: Addressing AMR requires an interdisciplinary approach that recognizes the important role of expertise from human, animal and environment sectors, as well as from the gender experts, a unique angle that the project brings on board.

Creativity: Community engagement requires creative and innovative methods. The project implements the social innovation aspect of using the Training of Trainers model, the community based cascade model and the structured community dialogues with men, so as to tackle the norms that lead to AMR. In addition to that, the trained AMR champions are empowered to communicate the knowledge and information acquired through creative ways such as storytelling, community theatre, poems, songs and any other interactive means relevant to their context.

Sustainability: Community engagement initiatives need to have a sustainable approach. The community engagement model for the project utilizes the existing community groups that will carry the initiative long after the project has ended.

Flexibility: Community engagement needs to adapt to the community context. Throughout, the project will remain flexible and take into consideration the community feedback and adapt in accordance to the context of Shinyanga Region.

These principles are particularly important in this project because behaviour change, trust and community ownership are critical for achieving the targeted sustainable outcomes.

3.4 Stakeholder Engagement

Stakeholders are individuals or groups who have an interest in and are impacted by the actions or outcomes of a certain initiative. Engagement of stakeholders is crucial as it influences and determines the acceptability of the project and whether or not the project faces potential backlash, especially from the community.

In this AMR project, we engage stakeholders at various levels starting with those in the household level. We have highlighted that women are important actors, not only due their roles, but also because their meaningful and active participation is needed to achieve the intended project outcomes. At the same time, men often hold the household decision making power and thus, if we want a more equitable health decision making process, we need to actively engage them fully from the beginning of the project.

The next level is the community level, where we look at the community leaders whose support is important in mobilizing, engaging the community, building trust, ensuring the sustainability of the proposed actions and adoption of gender responsive AMR approaches in community programs and local policies. These include leaders from community social groups such as SACCOS and VICOBA, local government leaders, religious leaders, community health workers, traditional leaders, traditional healers, community based health care providers and leaders of men and youth local groups.

At the health facility level, this is where the end result occurs, thus having them on board smoothens the process. The health facilities are the main points where community members especially women will go to seek health care services and the main channel this project is proposing for them to get prescribed medications. These health facilities therefore need to also play their role in strengthening AMR stewardship and ensuring appropriate prescription practices among health care workers.

The next level is the policy or national level, where the project aims to engage with policymakers and key stakeholders who can influence the development and

implementation of policies and programs. Through the multi-level stakeholders engagement process, change that starts within the household level, to the community level and builds momentum up until the national stage and leads to policy level transformations.

3.5 Household Hygiene Assessment for Infection Prevention

The One Health approach discussed in the theoretical framework works to integrate the human health aspect with that of the environment and animal health. This means that the environment we live in plays an important role in determining whether we get infections or not. Poor sanitation and unhygienic conditions increase the risk of infections, create a path for using antibiotics and hence increase the risk of drug resistance if the medication is not consumed properly as prescribed.

The household assessment is a preventive strategy that is intended to understand the household conditions and how they contribute to the spread of infections in the community. The assessment will look at the current household hygiene practices, which include menstrual hygiene, water storage and safety, waste disposal practices, hand hygiene at all critical points⁶ and the overall environmental cleanliness that puts members of the household at risk of infections.

The identified gaps will be addressed by promoting appropriate infection prevention measures at the household level and provision of initial WASH demonstration tools to support sustainable behavioral change. These insights will also be used to inform the AMR education sessions and training materials. This intervention is designed to reduce the spread of preventable infections, the need for antibiotics and eventually reduce the risk of AMR in Shinyanga Region, Tanzania.

3.6 Gender Responsive Approach

The Gender Integration Continuum (GIC) is a practical tool used by policies and programs to assess the extent and level at which they consider and address gender

⁶ Critical points refer to key moments when hand hygiene is essential to prevent infection transmission, such as before preparing food, before eating, after using the toilet, after cleaning a child and after handling waste.

inequalities from the design stage towards the implementation process (UNICEF, 2024). The continuum has five levels that range from Gender Discriminatory to Gender Transformative, as shown below.

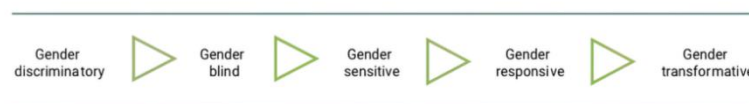


Figure 5: The Gender Integration Continuum (GIC) Levels⁷

The GIC decision logic has been used to determine the level of gender integration in this project by considering the project's outcomes, objectives, methodology and implementation features and how they respond to the unique gender needs and inequalities in the community (as shown in the below figure)

Unlike gender neutral approaches, gender responsive health approaches acknowledge that gender affects how men and women experience health, recognize these differences and design interventions that take this into consideration. Gender responsive approaches in AMR take into account that gender roles shape caregiving responsibilities, vulnerability to infections, health seeking behaviour, access to medications all of which can affect how antibiotics are used at the household level and community at large. Women play a central role in this as caregivers and handlers of medications within the household while men are mostly positioned as decision makers, often controlling financial resources and influencing health seeking behaviour in the family.

The project integrates all these considerations while addressing AMR, positioning women as AMR champions, so that they can create a ripple effect of change across households and in the community. At the same time, men are engaged to support more equitable access to health care services. This gender responsive approach ensures that these inequities are not just highlighted but are also actively addressed through practical community based actions that support the proper use of medications and improved health outcomes. In the long term, this project has the potential to transform sociocultural norms and gender power relations within households and in the community at large.

⁷ The figure has been obtained from UNICEF (2024)

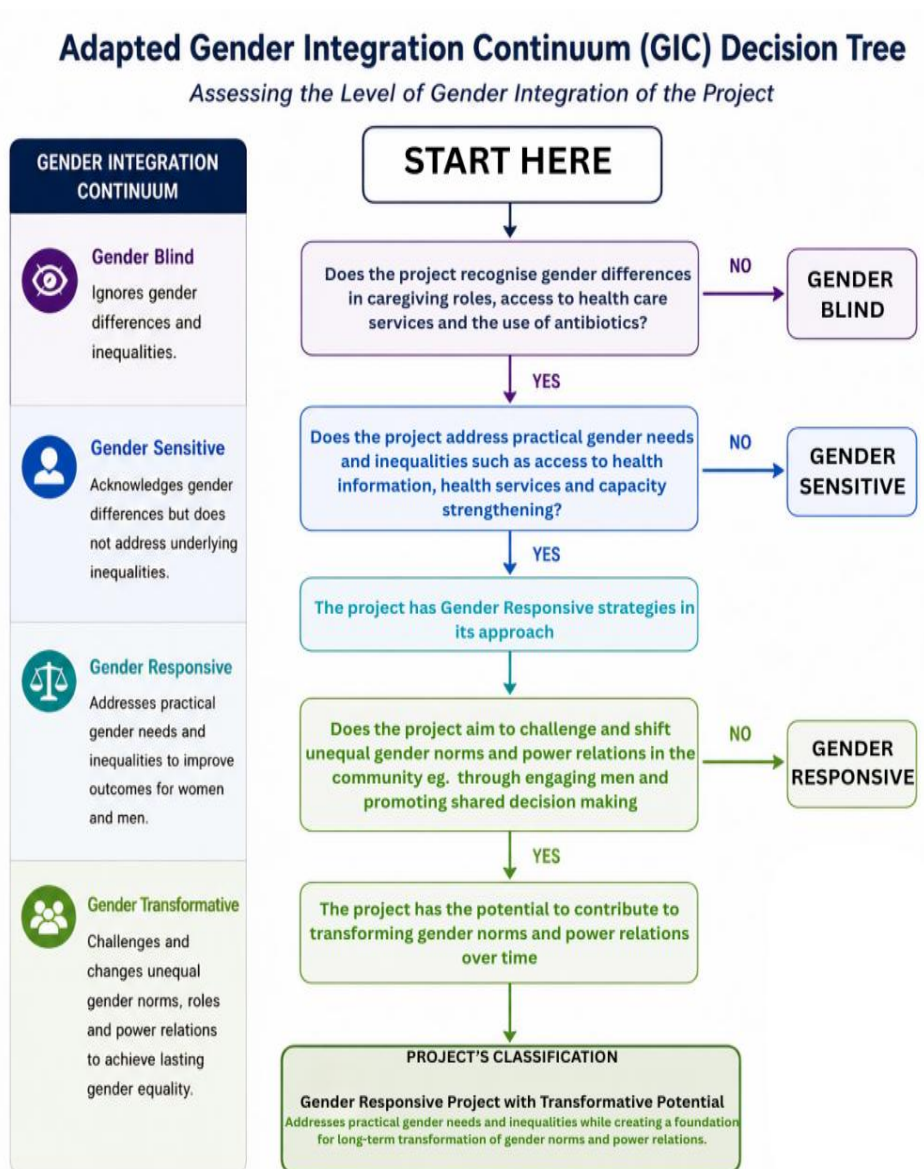


Figure 6: Adapted GIC Decision Tree from UNICEF GIC to social protection (UNICEF, 2024)

4.0 Project framework

This section highlights the project's purpose, objectives, impact, overarching goal and outcomes in relation to the project. It clearly outlines how the proposed interventions will promote equitable household health decision making and support a responsible use of antibiotics through a gender responsive approach.

4.1 Project Goal

To promote equitable household health decision making and responsible antibiotic use among targeted community members in Shinyanga Region

4.2 Project Objectives

4.2.1 General Objective

To improve equitable household health decision making and responsible antibiotics use practices among 1,000 community members of Shinyanga Region through a gender responsive AMR approach.

4.2.2 Specific Objectives

- To strengthen the capacity of 50 girls and women in Shinyanga Region with knowledge and skills to conduct peer-led, gender responsive AMR education sessions that promote responsible antibiotic use and infection prevention within the first 4 months of the project.
- To increase knowledge and adoption of responsible antibiotic use practices among 1,000 community members in Shinyanga Region within 12 months through a peer-led cascade AMR education approach.
- To promote shared household health decision making and responsible antibiotic use by engaging at least 300 men and boys in community dialogue sessions in Shinyanga Region within 12 months.
- To improve household infection prevention practices among at least 300 households in Shinyanga Region through WASH

education and hygiene demonstrations integrated into AMR community sessions within 12 months.

- To generate and disseminate community level evidence through at least two policy briefs and stakeholder engagement meetings to inform gender responsive AMR programs and policy at sub-national and national levels within 12 months.

4.3 Project Impact

To contribute to the reduction of antimicrobial resistance in Shinyanga Region, Tanzania.

4.4 Project Outcomes

4.4.1 Improved equitable household health decision making and responsible antibiotics use practices in participating communities in Shinyanga Region.

4.4.2 Improved household infection prevention practices through adoption of appropriate WASH behaviors in Shinyanga Region.

4.4.3 Increased integration of gender responsive approaches in AMR policies and programming at sub-national and national levels.

4.5 Project Outputs

- A Gender responsive AMR training curriculum developed, tested and disseminated.
- Household WASH conditions assessed using a standardized hygiene assessment among 300 households.
- Fifty (50) women trained as AMR Champions to facilitate peer led sessions.
- Eight (8) Peer-led AMR and infection prevention education sessions conducted per community social group.
- Five (5) community dialogue sessions conducted engaging 300 men and boys to address gender norms influencing household health decision making and antibiotic use.

- Practical hygiene demonstration tools distributed to support infection prevention behavior change.
- Community level evidence on gender responsive AMR interventions documented and analyzed.
- Two (2) policy briefs developed and disseminated to relevant stakeholders.
- Three (3) stakeholder engagement meetings conducted to promote integration of gender responsive approaches in AMR programming and policies.

5.0 Target Group

5.1 Description of Project Site

Shinyanga Region is located in the northwestern part of Tanzania, with a population of over 2 million people according to the national 2022 census (City Population, n.d.; United Republic of Tanzania & National Bureau of Statistics, 2025). It belongs to one of the 31 administrative regions in Tanzania, covering an area of 18,555 km². It has a total of six districts, with Kahama District (the targeted area) being the most populated one (URT & NBS, 2025). Mining, agriculture and animal keeping are the top three economic drivers of the region.

With reference to health care services, the region still to a great extent relies on traditional healers and informal health channels, despite there being 14 government owned health centers (World Agroforestry Centre, n.d). There's also a high prevalence of infectious diseases like water-borne diseases in the area increasing the risk of antibiotic use and AMR.

The region is very patriarchally rooted, with cultural norms that determine the roles played by men and women in the community. The region ranks one of the highest in harmful gender practices, particularly child marriage with rates up to 59% (UNFPA, 2014; Girls Not Brides, n.d). These practices are linked to gender inequality, leading to limited autonomy and decision making power among women and increased risks of gender based violence (GBV). According to the UNFPA (n.d.) report, 25% of the women aged 15 to 49 experienced physical violence, only 5% report the violence and more than half of the population in the region believe in justifying the wife beating. This shows how deeply these harmful gendered norms are rooted among people in the community. With the patriarchal system in operation, women in many cases require permission to access health care facilities. Women are the primary caretakers in the family and due to the economic dependence, they are often unable to afford appropriate health care services, thus end up utilizing left over medications, traditional medications and informal channels to access medication.

The prominence of gendered norms in this region is one of the main reasons it was selected for this project. Women often bear the burden of these sociocultural

norms and practises, while men are more likely to be on the benefiting end. A balanced approach is needed to address this, one that involves women and actively engages men in the process. This allows for both groups to understand how these norms affect them and the role they each play in sustaining or transforming norms within their communities.

5.2 Target Beneficiaries

5.2.1 Primary Beneficiaries

The project aims to directly benefit women and girls from the age of 15 to 49 in Shinyanga Region. This is representative of two key populations that are the most vulnerable and play an important role in household health practices.

The first group is that of girls aged 15 to 18 who are at their critical stage of puberty and in this setting, they may already be young mothers or future caregivers within households. Empowering them at this early stage creates an opportunity for long term change that can be passed for generations to come. The second group is that of women aged 19 to 49, majority of these women are within households performing roles as primary caregivers. This places them at high risk of exposure to infections and their role influences how antibiotics are accessed and used at household levels.

These women are the center of the project and represent diverse religious backgrounds, minority ethnic groups, economically vulnerable and marginalized populations. They are affected most by the cultural norms leading to improper use of antibiotics and hence AMR. Through this project, women aged 19 to 49 will be selected as AMR Champions, trained and empowered to cascade the knowledge to their socioeconomic groups i.e., SACCOS and VICOBA who together will reach the larger community in the Shinyanga region.

5.2.2 Secondary Beneficiaries

Men and boys aged 15 to 49 are the secondary beneficiaries of this project. They are also further categorized into two groups of boys aged 15 to 18 and adults aged 19 to 49.

The involvement of men is crucial, as they play an important role in shaping and sustaining the sociocultural norms that affect health decision making within the households. Promoting equitable health decision making requires engaging men as partners and creating a safe space for them to understand the impact of these norms and the role they can play in transforming them.

Engaging boys at an early stage is also important. As they grow, building their awareness on existing sociocultural norms within households can make them more supportive in the development of more equitable household health decision making. Participating in community dialogues therefore, allows men and boys to openly discuss their roles, shared responsibilities and practical ways to support women and households in the fight against AMR.

5.2.3 Tertiary Beneficiaries

The tertiary beneficiaries of this project are the key stakeholders, they play a dual role as both influencers of change within the community and also as indirect beneficiaries of the community generated evidence.

These stakeholders include community leaders, local government authorities, district health facilities, non-governmental organizations (NGOs) and policymakers. Through the project, they will gain access to context-specific evidence on gender, health decision making and AMR from the community level. This evidence can be used to inform policies, strengthen the implementation of AMR National Action Plan (NAP) and even guide the design of more gender responsive AMR programs that benefit the community at both local and national levels.

6.0 Project Implementation

This section describes how the project operates from planning to completion, including management structures, implementation phases, coordination mechanisms, financial oversight and risk mitigation strategies. It also demonstrates feasibility, accountability and sustainability.

6.1 Project Stages and Activities

To ensure easy coordination of activities, the project will be implemented in four phases over a period of 12 months. Each phase has a set of activities and aims to achieve set goals to ensure maximum impact in the target community ⁸.

Phase 1: Inception and Baseline (Month 1 and 2)

The first phase of the project is the Inception and Baseline phase. This phase will take place in a total of 2 months and aims at setting the foundation for the implementation of the rest of the project. It involves mapping and engaging with important stakeholders in the community, establishing rapport, introducing the project, co-creating, promoting local ownership and setting initial agreements and expectations from all involved parties. The stakeholders include local government leaders at the district and village level, religious leaders, existing community based social groups such as SACCOS, VICOBA, men's social groups and representatives from the district health facilities.

Concurrent with this, efforts will be made to get ethical clearance from the responsible authorities. This will allow the project's baseline assessment through the KAP surveys, initial household hygiene assessment and gender and power analysis to be conducted ethically. The aim of these initial assessments is to get an understanding of the current situation in terms of the household health decision making, power dynamics, sanitation and hygiene assessments and knowledge, attitudes and practices towards antibiotics usage and AMR. The household hygiene assessments and KAP

⁸ Annex 4 Below summarizes the key project activities in a tabular form

surveys will be conducted in 300 households using checklists, observation and questionnaires. Understanding that the presence of men and women during gender power analysis might limit the authentic contributions of women, the analysis will be conducted in separate Focus Group Discussions (FGD) with 2 groups of 10 men and women, respectively.

The final activity will be the selection of the AMR Champions from the existing social groups. A total of 50 women will be selected, with at least 2 representatives from each social group. The selection criteria will consider the following: A female member of the target community belonging to the social groups, within the age range of 19 to 49 years, willing to commit and participate in the project activities. The process will ensure equal representation of AMR Champions across various age groups, ethnicity, religion and socioeconomic backgrounds.

Phase 2: Curriculum Adaptation and Training (Month 3 to 5)

The second phase of the project takes place over a total duration of 3 months and it will involve the processes of curriculum adaptation and training of the AMR Champions.

Currently, the Ministry of Health through the AMR coordination section, has training materials that have been used to raise community awareness on Antimicrobial resistance. In addition, One Health Society has been utilizing these resources and adapting them accordingly, depending on the target community. For this project, these materials, together with the WHO content, will be adapted to the context of Kahama district, after the initial assessment and engagement with the local stakeholders to address the unique needs and sociocultural practices of the target community. In collaboration with consulted experts (One Health, AMR, Gender and WASH experts) these materials will be adapted and translated to create gender sensitive, cultural relevant and quality materials fit for the context. The translated materials will then be tested with a small group of women and one on one feedback sessions will be done, followed by the final refinement of the content to create gender responsive AMR training materials. These will be printed, summarized and creatively designed, ready for dissemination to the AMR Champions and community at large.

The final activity in this phase is the training of the AMR champions (training of trainers). The One Health Society project implementation team will be responsible for facilitating the sessions. These training sessions will be conducted in a period of 1 month (2 sessions per week) and for the trainees to be considered as ToTs they need to attend at least 80% of the training. To assess their readiness to deliver peer led sessions, the participants will undergo pre and post training assessment. Based on the assessment, AMR champions will be paired during the implementation phase, allowing strong facilitators to work together with those who may require additional support. The aim here is to ensure effective and consistent delivery of community based AMR sessions. The mode of the training sessions will be a “learning by doing” (experiential learning) approach, where participants get to practice facilitation in the process. They will also translate the knowledge into creative, context-specific outputs, such as songs, storytelling or plays so as to communicate the AMR messages in ways that are relatable to the community.

Understanding that women have a double burden of unpaid carework and work to earn a daily living, the project will provide compensation for AMR champions attending the sessions. The participants will decide a suitable time and date for the sessions. Safeguarding officers will be present to ensure that the sessions are safe for women to attend and caretakers will be available to ensure that women with children are still able to attend the sessions. Depending on the needs, the project will also take special consideration for participants who are differently abled.

Phase 3: Community Engagement and Continuous Monitoring (Month 6 to 9)

The third phase of the project is based on engaging with the larger community group and continuous monitoring of the project as it progresses. This phase will take place in the time frame of 4 months, where trained peer educators in phase 2 return to their social groups and conduct the AMR and WASH sessions. On average, these social groups consist of 10 to 20 members and they are usually girls and women (aged 15 to 49). These sessions will be conducted once weekly for 2 months on the already designated days. Towards the end of the sessions, the 300 assessed households will receive feedback from the household assessments and will be provided with WASH demonstration tools that include handwashing guide, soaps, water storage

containers, low cost handwashing buckets with taps, cleaning kits, safe disposal guides and menstrual hygiene materials according to their households needs. These tools are expected to help support hygiene and sanitation behaviour change within the households. The month after the training is dedicated for the social groups to engage with the larger community, impart their gender responsive AMR knowledge and share best practices to improve the general community wellbeing. A total of 1,000 members of the community are expected to be reached through the community engagement activities. One Health Society team will attend all these sessions to support the movement and also for monitoring purposes. Reflections and adjustments to the project will be made accordingly.

Simultaneously, the One Health Society team with the support of local stakeholders, will conduct community dialogues with men. The main aim of these dialogues is to create a safe space for men to open up, but also to share and discuss about the harmful sociocultural practices that affect health seeking behaviours of women and children, hence contributing to improper use of antibiotics and AMR. By the end of the dialogue men should understand the role they play in this and how best they can support equitable health decision making at the household level. In addition to that men are also affected by AMR uniquely through the roles they engage in such as livestock keeping and agriculture, where antibiotics are used to promote the growth of animals and crops. This will be an opportunity to have discussions around the subject and propose best practices for the community. A total of five series of structured community dialogues is expected to be carried out, reaching to about 300 men.

Phase 4: Evaluation, Learning and Policy Engagement (Month 10 to 12)

The final phase of the project will take place in the last 3 months and is themed around evaluation, learning and policy engagement. Endline surveys will be administered so as to measure change, starting with the KAP surveys, household hygiene assessments and focal group discussions. The team will analyze the data, compare with the baseline data, provide community evidence and recommendations that can then be used to inform policies, programs and even the AMR NAP on the importance of taking gender considerations in AMR in both sub-national and national levels. Stakeholder

engagement meetings will be conducted with all the key stakeholders. With the Tanzania Parliamentarians Alliance (TPA) on board through One Health Society (OHS), follow up will be made to see how the evidence produced and recommendations have actually influenced any change (either on policies, designing of AMR interventions or implementation of NAP) in the country.

The team will also produce the final report, highlighting the impact, challenges and where possible the expansion of this community driven initiative beyond Kahama District into other districts and regions beyond Shinyanga.

6.2 Project Administration

This sub-section describes the project's governance and management. It features aspects such as: the project leadership structure, roles and responsibilities. Also important is the decision making process through weekly meetings, monthly reviews and financial chain of approval.

6.2.1 Project's Administration Structure.

The project will be managed by the One Health Society Team members. All the project staff (with the exception of the field officers) are part of the OHS team. The field officers will be engaged on a part time basis to support the project implementation phase. This project will be lead by the Project Team Lead (Dr. Gloria E. Swilla), who will be responsible for the overall project support, coordination, strategic leadership and ensuring effective implementation. Below is the entire project's administration and management structure.

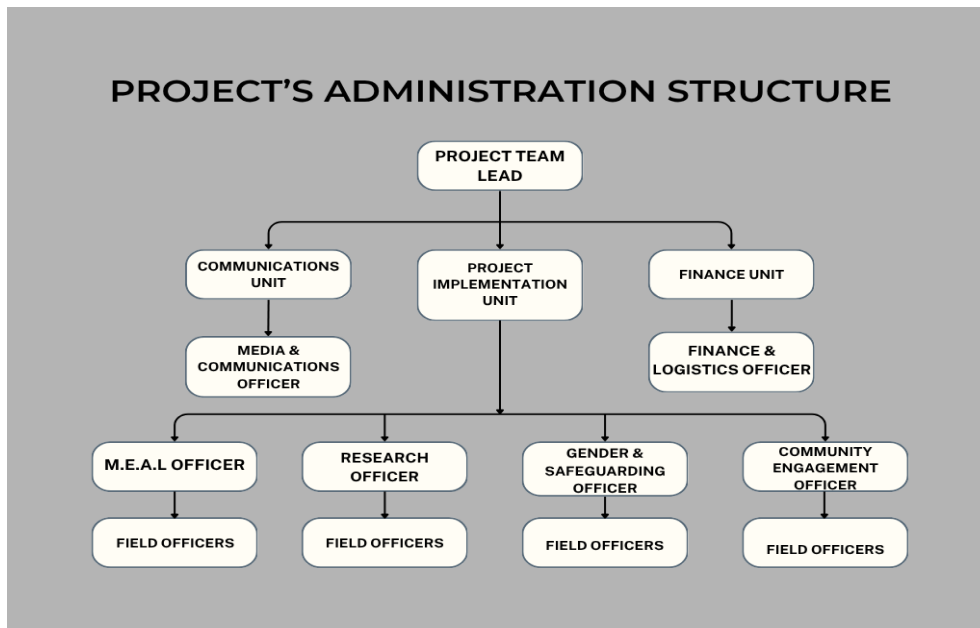


Figure 7: Shows the project's administration structure

6.2.2 Roles and Responsibilities of the Project Team Members

6.2.2.1 Project Team Lead

- To provide overall strategic leadership for the project and ensure that the project runs in accordance with the timeline and objectives.
- To ensure integration of gender, One Health approach, AMR and WASH in all project components.
- To coordinate strategic meetings and engagements with stakeholders and partners at all levels (national and sub-national).

6.2.2.2 Monitoring, Evaluation, Accountability and Learning (M.E.A.L) Officer

- To lead the monitoring, evaluation, accountability and learning processes, ensuring that the developed frameworks are implemented and ensure that quality data is collected.
- To analyze the data and create reports that will provide evidence, promote learning and accountability.

6.2.2.3 Finance Officer and Logistics

- To ensure proper management of finances from budgeting, expenditure tracking up until the reporting stage.
- To coordinate the procurement and arrange the logistics of all project activities and resources.

- To ensure financial compliance, transparency and operate with high integrity.

6.2.2.4 Research Officer

- To design and adapt research tools for the project such as the KAP surveys, household hygiene assessment and gender and power analysis.
- Support data collection, analysis, reporting and development of evidence informed outputs such as policy briefs.

6.2.2.5 Gender and Safeguarding Officer

- Lead the integration of gender responsive approaches across all project activities and budgeting.
- Ensure the project creates a safe environment for all and that everyone involved in the project is aware of GBV referral pathways and Do No Harm policies.

6.2.2.6 Media and Communications Officer

- Develop and implement the media communication and engagement strategies.
- Document the project activities through consented photos, videos and stories.
- Support the dissemination of the project report and findings.

6.2.2.7 Community Engagement Officer

- Coordinate the community engagement activities such as the trainings, engagement with local leaders and community dialogues to ensure that they operate smoothly and create feedback mechanisms from the community throughout the project cycle.
- Supervise all field officers to ensure that all activities in the community are conducted effectively from data collection to final follow up stage.

6.2.2.8 Field Officers (12):

Distributed into 3 sub-groups working to support the project implementation unit.

- The first group is responsible for data collection and supports the continuous monitoring stages, working closely with research and M.E.A.L Officer

- The second group is responsible for conducting the training sessions, supporting and supervising the peer educators during their sessions and as they reach to the larger community
- The third group is responsible for working closely with the finance team to ensure timely procurement of resources needed during project activities.

6.3 Cost Saving Measures on the Project

Some of the financial efficiency strategies include:

- **The use of existing community structures (social groups)**

The project utilizes the existing community structures (VICOBA and SACCOS groups), which are already self-operational in majority of Tanzanian communities. They will act as the initial entry point to the larger community. The AMR champions will conduct sessions within these groups on days when they usually conduct their regular meetings (at least once per week). This is effective because the project does not create a new modality but utilizes the existing model to make impact. This reduces the cost that would have been incurred for venue, transport to the venue, community mobilization cost and recruitment processes. As an added advantage, this format offers sustainability, encourages higher participation and trust, as health information is provided by their own peers.

- **Leveraging partnerships for venue support**

Collaboration with local community leaders and health facilities offers a cost saving approach as they can provide community halls and rooms where the ToTs are conducted, the initial stakeholder meetings are held and community dialogues are conducted. This saves venue costs and reduces the venue setup costs and processes. It will also promote local ownership among the members of the community and provide room for easy coordination of the activities.

- **Volunteer based peer leadership model with incentives**

The AMR Champions are a volunteer based role that operates mainly by the drive to lead and make changes in the community. The project utilizes the AMR

Champions instead of external facilitators mainly to promote local ownership, trust, sustainability and peer influence. In the process of achieving all that, the model saves the staffing costs as the volunteers' contributions are recognized by incentives such as certificates of recognition and transport. In the end of the project, the AMR champions will have gained the capacity and experience to lead and influence change in the community.

6.4 Risk Analysis and Mitigation

This section provides a risk analysis for all the four project phases and proposes mitigation strategies to reduce the likelihood of the risks and the impact that might affect attainment of the project outcomes.

6.4.1 Phase 1: Inception and Baseline

	RISK	LIKELIHOOD	IMPACT	MITIGATION PLAN
A.	Delays in ethical clearance	Medium	High	Early submission of the application, follow up with the regulatory bodies and gather all necessary documents early in advance.
B.	Stakeholders not supportive	Medium	High	Involve stakeholders from the beginning of the project and provide them with regular updates and co-create with them.
C.	Low turnout of AMR champions	Medium	High	Involve community leaders and use trusted community groups and structures for more sensitization. Participants suggest preferred session times that align with

				their availability.
D.	Social desirability bias during data collection	High	High	Train enumerators on neutral questioning, maintain confidentiality and use mixed methods.

Table 1: Risk Analysis Phase 1

6.4.2 Phase 2: Curriculum Development and Training

	RISK	LIKELIHOOD	IMPACT	MITIGATION PLAN
A.	Poorly translated materials and not culturally relevant	Medium	High	Have professional translators, pilot test and validate the training materials with community members
B.	AMR Champions not fully understanding the concept of AMR	Low	High	Use participatory training method, practical and relatable day to day examples
C.	Misinterpretation of the incentives provided to AMR Champions as income (may lead to an increase household burden)	Medium	High	Clear communication of the role as volunteer based and that the incentive is not income, but support for transport (to community stakeholders and champions). Prepare AMR Champions to communicate this clearly in their households.

Table 2: Risk Analysis Phase 2

6.4.3 Phase 3: Community Engagement and Continuous Monitoring

	RISK	LIKELIHOOD	IMPACT	MITIGATION PLAN
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A.	Low attendance and participation in community sessions	High	Very High	Use existing gatherings, set convenient times for sessions, use of community leaders and AMR Champions to sensitize
B.	Resistance to engage in gender discussions (men)	High	Very High	Engage community leaders, use gender sensitive facilitation of discussions, focus on the benefits of equitable health decision making
C.	Hygiene materials provided are not used for their intended purpose	Medium	High	Demonstrate how to use them, make follow up visits, encourage joint accountability strategies and ensure the tools are simple and contextually easy to use.

Table 3: Risk Analysis Phase 3

6.4.4 Phase 4: Evaluation, Learning and Policy Engagement

	RISK	LIKELIHOOD	IMPACT	MITIGATION PLAN
A.	Limited policy uptake by stakeholders	Medium	High	Align the findings with the national priorities and engage stakeholders early
B.	Low participation in endline survey	Medium	High	Communicate clearly early, maintain good rapport with the community and use the same households.

Table 4: Risk Analysis Phase 4

6.5 Stakeholders Analysis

This project utilizes the multi-stakeholder engagement strategy that recognizes the important roles of stakeholders at the local level in promoting project acceptability and behavioral change. The role of national level stakeholders is to ensure long term sustainability of the project's approach and relevant policy changes. Below is the list of stakeholders, their roles, interests, influence and how they will be engaged throughout the project.

6.5.1 Local Level Actors and Stakeholders

Stakeholder	Role	Interest	Influence	Engagement Strategy
Community members (women, girls, men and boys)	Actors of behavioral change	High	Medium	Continuous engagement, training and maintaining feedback loops
Community social groups such as SACCOS and VICOBA	Entry point for mobilization and community sensitization	High	Medium	Integrate sessions into meetings and maintain continuous engagement
Local government leaders	Support the entire implementation process and adoption of a gender responsive approach in local AMR plans and programs	High	High	Formal meetings, reporting, regular updates and co-creation.
Religious Leaders	Shape norms & beliefs	Low	High	Early engagement
District Health Officers	Technical guidance & referrals	High	Medium	Formal meetings
Local level NGOs and CSOs	Support community mobilization and	High	Medium	Partnership in community engagement and joint outreach activities

	implementation of activities			
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Table 5: Local Level Actors and Stakeholders

6.5.2 National Level Actors and Stakeholders

Stakeholder	Role	Interest	Influence	Engagement Strategy
Ministry of Health (MoH)	AMR Action National Plan Alignment. Technical Input Training materials and resources provision	High	High	Continuous collaboration, reporting and participation in the community evidence dissemination process
Tanzania Parliamentarians Alliance (TPA) on AMR	Support advocacy and policy influence on AMR	High	High	Stakeholders policy dialogue, dissemination of evidence and policy briefs
Research institutions (MUHAS, Ifakara Institute)	Evidence validation	High	High	Research partnerships and community evidence dissemination
National Level NGOs and CSOs	Advocacy, technical support and knowledge sharing on AMR and gender	High	Medium	Collaboration and dissemination of findings

Table 6: National Level Actors and Stakeholders

6.5.3 Global and Regional Level Actors and Stakeholders

Stakeholder	Role	Interest	Influence	Engagement Strategy
WHO AFRO and Africa CDC	Guidance, frameworks and regional AMR strategy	High	High	Knowledge alignment Regional strategies alignment
AMREF and ReACT Africa	Technical and advocacy support	High	Medium	Collaboration

Table 7: Global and Regional Level Actors and Stakeholders

6.6 Ethical Considerations in Implementation

The project operates under the following ethical principles guiding the implementation and ensuring protection of the dignity and rights of all participants. These include informed consent (for all participants), confidentiality measures, data protection and privacy measures, referral pathways for GBV cases, the Do No Harm Principle and safe facilitation of discussions. The goal here is to create a safe and trustworthy environment where everyone involved in the project can fully participate with autonomy and without fear.

- Informed consent:** All participants in the project will be required to give their signed consent to participate and provide information that will aid in achieving the project's goals, objectives and outcomes. Understanding that the project engages with participants under the age of 18, special considerations will be made to obtain parental or guardian consent, in addition to the minor's assent. For participants who are unable to read or write, verbal consent will be obtained and documentation of this will be done using a thumbprint. Participation in this project remains voluntary and the consent provided can be withdrawn at any point when the participant decides so, without any retaliation.
- Confidentiality and Privacy:** Understanding the sensitive nature of the topic, i.e., gender and power relations within households, the project will maintain the information provided by participants to the highest degree of confidentiality. The data collection tools will also have unique

identifier numbers to ensure privacy. Breach of the privacy and confidentiality agreement will be only to the legal authorities in circumstances where withholding the information will do more harm than good.

- **Data Protection and Management:** The collected data during the project will be stored and carefully protected, with access limited only to authorized project team personnel. Data will be handled according to the Tanzania Data Protection Act, 2022 (United Republic of Tanzania, 2022) ensuring that individuals' privacy and data protection rights are observed.
- **Do No Harm:** The project will operate to ensure that all activities at various stages of project's life cycle do not promote or exacerbate any form of harm or inequalities.
- **Safeguarding and GBV Referral Pathways:** The One Health Society (OHS) safeguarding policies will be used to ensure that all participants in the project are protected from any form of harm, including sexual harassment. Safeguarding measures will be integrated throughout the project to protect participants from harm, including potential risks related to gender based violence (GBV). In addition to that, all members of the project team will be trained to recognize and respond appropriately to safeguarding concerns and referral pathways so as to ensure that participants can access assistance when needed.
- **Ethical Approval:** Prior to data collection, ethical clearance will be obtained from the National Institute for Medical Research (NIMR). In this context, permissions will also be obtained from the local government authorities to facilitate implementation of the project in the community. These efforts will ensure that all the assessments and activities conducted in this project protect participants' rights, dignity and safety.

7.0 Budget

The proposed budget of **USD 24,000** is designed to support a community driven, gender responsive approach to addressing antimicrobial resistance (AMR) in Shinyanga Region. The budget prioritizes efficiency, local ownership, and sustainability while ensuring that key gender related barriers to participation and behavior change are addressed. The key Budget lines include the following.

7.1 Personnel and Technical Support

A project team structure is adopted, building on the existing capacity of the One Health Society. The allocation for personnel focuses on essential roles such as the M&E Officer, Gender and Safeguarding Officer, Community Engagement Officer and Field Officers, who are critical in ensuring quality implementation. Particular emphasis is placed on the Gender and Safeguarding Officer, whose role ensures that all activities are conducted in a safe, inclusive and gender responsive manner. This includes safeguarding participants, integrating gender considerations across activities and ensuring that women's voices are not only included but actively shape the project.

7.2 Training and Capacity Strengthening

This component focuses on strengthening the capacity of 50 women as AMR Champions using the Training of Trainers model. The budget covers for the development and adaptation of gender responsive training materials, facilitation of training sessions and support for participants. Recognizing the double burden of unpaid care work and economic responsibilities among women, the budget includes support for transport and participation. This is done intentionally, as it reduces barriers to participation and ensures that women who are often excluded are able to fully engage.

7.3 Community Engagement

Community engagement forms the heart of this project. The budget supports the peer-led education sessions, community dialogues with men and boys, continuous follow-up and monitoring.

The inclusion of men's dialogue sessions is particularly important. These sessions create space to reflect on and challenge harmful gender norms that influence health seeking behavior and antibiotic use. By engaging men as partners, the project moves beyond awareness to addressing the root causes of inequality.

7.4 WASH Demonstration Support

This allocation supports practical hygiene tools such as soap, hand washing facilities, and water storage containers for selected households. This is a critical investment because poor hygiene increases the risk of infection, increased infections lead to higher antibiotic use and women bear the burden of maintaining household hygiene. By improving WASH practices, the project directly reduces the need for antibiotics within households.

7.5 Monitoring and Evaluation

The Monitoring, Evaluation, Accountability and Learning (MEAL) budget supports both quantitative and qualitative data collection, including baseline and endline KAP surveys, household hygiene assessments and focus group discussions. Importantly, the MEAL approach is gender sensitive since it captures decision making dynamics within households, women's agency and participation and men's engagement in shared responsibility. This ensures that the project not only measures outputs, but also tracks meaningful social change.

7.6 Stakeholder Engagement and Policy Influence

Funds are allocated for stakeholder meetings and the development of policy briefs. These activities are essential for translating community level evidence into action. Through these engagements, the project aims to influence the integration of gender in AMR planning and interventions, contribute to more inclusive policies and strengthen accountability at both national and sub-national levels.

7.7 Logistics and Operations

The budget for logistics and administration reflects the project's commitment to cost efficiency. By utilizing the existing community structures (VICOBA, SACCOS), locally available community venues and volunteer based peer leadership. The project minimizes operational costs and maximizes reach and sustainability.

Below is a figure summarizing the distribution of the project's cost across all the key budget lines.

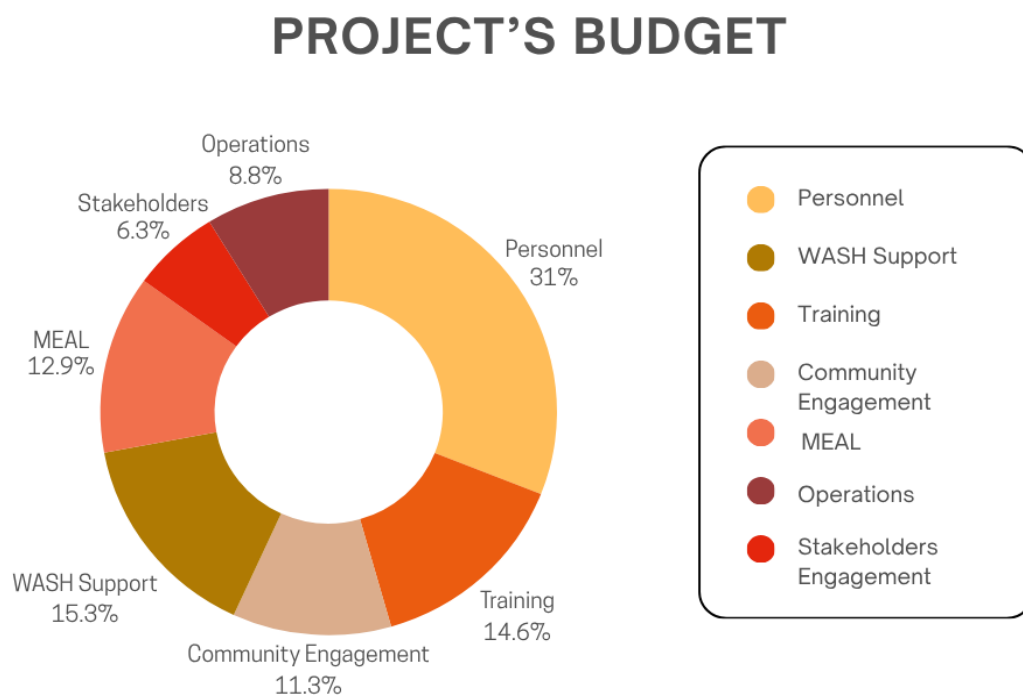


Figure 8: Project's Budget Pie Chart

7.9 Budget Summary

Budget Line (Category)	Sub - Item	Unit Cost (USD)	Quantity	Total Cost (USD)	Available (USD)	Required (USD)	Gender Responsiveness
Personnel	Project Lead	80	12 months	960	0	960	Ensures gender integration across all components
	MEAL Officer	80	12 months	960	0	960	Tracks gender disaggregated data
	Gender and Safeguarding Officer	80	12 months	960	0	960	Ensures safe participation of women
	Community Engagement Officer	80	12 months	960	0	960	Ensures operationalization of the gender responsive community approach
	Field Officers (12)	360	10 stipends	3,600	0	3,600	Supports inclusive field engagement
Training	Training materials (printing and adaptation)	250	4 material types	1,000	500	500	Materials adapted to gender context
	ToT sessions (caregiving and refreshments)	150	8 sessions	1,200	700	500	Safe learning spaces for women
	AMR Champions support	26	50 women	1,300	0	1,300	Reduces participation barriers for women
Community Engagement	Peer-led sessions (incentives and support)	75	20 social groups	1,500	0	1,500	Women Led knowledge dissemination

	Men dialogue sessions (incentives, support and refreshments)	240	5 sessions	1,200	0	1,200	Engages men in shifting norms
WASH Support	Soaps and Menstrual Hygiene Support general hygiene kits	-	300 households	1,660	1,200	460	Reduces women's hygiene burden
	Handwashing facilities	4.3	300 households	1,300	0	1,300	Supports infection prevention
	Water storage containers	2.3	300 households	700	0	700	Improves household health
MEAL	Baseline and Endline surveys	600	2 rounds	1,200	0	1,200	Includes gender and power analysis
	Data analysis and reporting	600	1	600	0	600	Evidence on gender responsive AMR
	Monitoring visits	65	20 visits	1,300	0	1,300	Captures gender dynamics in practice
Stakeholder Engagement	Stakeholder meetings	300	3	900	0	900	Influences gender sensitive policy
	Policy briefs	300	2	600	0	600	Promotes gender integration in AMR
Operations	Transport and logistics	75	12 months	900	0	900	Supports outreach
	Communication and documentation	100	12 months	1,200	0	1,200	Supports outreach
TOTAL				24,000	2,400	21,600	

Table 8: Overall Budget Summary

8.0 Monitoring, Evaluation, Accountability, Learning and Research (MEALR) Plan

The MEALR plan shows how the project will track progress, measure change, learn during the implementation process and create community based evidence. We look at these results in five main levels: The Goal ,Outcome, Output, Process and Learning levels. The main tools that will be used to collect data include the baseline and endline KAP, FGDs and household assessments,training attendance sheets, session logs, observation checklists, feedback forms and meeting notes. All the project data will be analyzed through a gender and intersectional lens including sex, age, education and religion ensuring that the information obtained is in accordance with the do no harm principle. The findings will be reviewed to guide the project's adaptation and community feedback will be provided to improve implementation and so that the project meets the community needs.

Results Level	Indicator	Definition	Baseline	Target	Data Source	Frequency	Responsible	Gender Lens
Goal	Percentage reduction in inappropriate antibiotic use	Proportion of households reporting reduction in improper antibiotic ⁹ use	To be established	30% reduction	KAP Survey	Baseline & Endline	M&E Officer	Disaggregated by sex, caregiver role, disability status ¹⁰ and intersectional factors

⁹ Improper use of antibiotics practices include: self-medication, stopping treatment early, sharing antibiotics or using antibiotics without prescription.

¹⁰ Disability status data will be collected using the Washington Group Short Set of Questions (included in Annex 2), which will be translated into the local language to ensure it is clear and easy to understand.

Outcome	Percentage households with joint health decision making	Households where both men and women participate in making health decisions like seek health care and use of medications	To be established	30%	KAP Survey + FGDs	Baseline & Endline	MEAL Officer	Captures gender and power dynamics
	Percentage household demonstrating improved household infection prevention practices	Households adopting recommended WASH practices	To be established	30% increase	Household observation checklist + KAP Survey	Baseline & Endline	MEAL Officer	Tracks whether hygiene practices are gendered
	Number of AMR interventions incorporating gender responsive approaches	Number of AMR related plans, policies or programs that adopt or integrate gender responsive components influenced by project evidence or engagement	0	At least 2	Documents, meeting reports, stakeholder engagement records, official documents	At the end of project implementation and ongoing tracking	Project Lead and Research Officer	Tracks institutional level adoption of gender responsive approaches

Output	Number of women trained as AMR Champions	Number completing ToT training	0	50	Training attendance sheets and pre & post training assessments	End of training	Community Engagement and Field Officers	Women empowerment
	Number of community members reached	Participants attending AMR sessions	0	1000	Session logs and attendance sheets	Monthly	Field Officers	Sex and age disaggregated, consideration of intersectional factors
	Number of men engaged in dialogues	Men participating in gender dialogues	0	300	Dialogue attendance sheets	Monthly	Community Engagement Officer	Male engagement
Process	Percentage training satisfaction, relevance and understanding	Participants satisfied with training, who consider the trainings relevant and understandable	N/A	80%	Feedback forms	Per training	MEAL Officer	Safe participation
Learning	Number of adaptations ¹¹ made	Adjustments made based on feedback	0	At least 3	Meeting notes	Quarterly	Project Lead	Responsive to gender needs

Table 9: Shows the Project's MEAL Plan

¹¹ Adaptations here refer to any intentional modification made to project design or implementation as a result of monitoring data, participants' feedback or realities.

9.0 Project Sustainability Analysis

The project aims to ensure that the attained outcomes continue to prevail even after the official timeline has ended. Sustainability in this project revolves around the targeted community maintaining behavior changes, the practices around health decision making are more equitable and gender sensitive and responsive approaches are taken into consideration in the AMR research, programs, plans and policies.

The following are the key sustainability pathways:

- **Integration into existing community structures such as VICOPA & SACCOS**

The project utilizes the existing community social groups, which have been operating even before the project started. The fact that we are not creating new systems or structures creates room for the project's outcomes to continue even beyond the project. The members of these social groups will continue to meet, engage with each other, hold each other accountable and sustain the behavior changes long after the project has ended. This will not only last among group members but also the community around them without requiring additional external resources.

- **Local champion model**

The local champions are empowered to be leaders and drivers of change beyond the project. Their new knowledge, skills and practices gained from the project will help them become AMR ambassadors and advocates within their own communities and households. Through mentorship and continuous support they will be able to stand up for themselves and other women in the community and ensure that the misuse of antibiotics is reduced, people are practicing proper hygiene and sanitation practices and men understand the importance of equitable health decision making in the fight against AMR.

- **District health collaboration**

The collaboration with the District health facilities is one very strategic, long term and impactful partnership. By educating the community about AMR and advocating for proper use of antibiotics, we are in a way directly advocating for them to seek formal health care services. So the health facilities also need to be prepared and equipped to deal with the increased demand for health care services. The facilities need to have

more reliable diagnostic tools, appropriate medications and health personnel who are aware of the burden of AMR and the role of gender in driving AMR and how they can educate the community on how to properly use and dispose medications. The collaboration with the district health facilities will make this pathway more sustainable, ensuring that the community receives quality health care services.

- **Local government collaboration**

The local government is crucial in the planning and implementation phase of the project. It acts as a key entry point to reach to the larger community. Beyond that, the local government supports in ensuring the sustainability of the approach beyond the project duration. The local government can act as advocated for a more gender responsive approach when planning for AMR initiatives within the community. They can allocate funds to support initiatives that address AMR through the gender lens. In addition to that they can provide recommendations for the government once the impact of this movement has come to fruition. To the community, the local government can also act as ambassadors to remind the community on the importance of equitable health decision making in reducing the risks of AMR.

- **Policy advocacy pathway**

The project aims at creating community evidence that will be used to create policy outputs that can provide recommendations to policy makers to have more gender sensitive AMR policies, to take into consideration of gender when budgeting for AMR (gender responsive budgeting). Having supportive policies is the first step towards AMR advocacy. Usually, people use policies to justify their actions and initiatives and so not having supportive policies creates an accountability loophole. The Tanzania Parliamentarians Alliance for AMR will help advocate for gender sensitive policies and this will create long term impact in terms of AMR programs and initiatives in Tanzania in both national and sub-national levels.

10.0 Reporting

Reporting is an important part of the project that ensures accountability, allows us to track the progress of the project, see gaps and be able to address them during or even for future expansion processes of the project. This section outlines the types of project reports expected throughout, the frequency, the responsible party and the targeted audience including reporting to the GRÓ GEST Team as part of the academic program supporting this project.

Report Type	Purpose	Key Content	Frequency	Responsible Person(s)	Target Audience
Monthly Progress Report (Internal)	Track routine implementation and identify challenges early	Activities conducted, participation data, field observations, challenges, immediate actions	Monthly	Project Lead And Field officers	Internal project team
Quarterly Progress Report	Assess progress against outputs and indicators	Summary of activities, progress indicators, challenges, lessons learned, next steps	Quarterly	MEAL Officer and Project Lead	Donor, stakeholders and GRÓ GEST
Financial Report	Ensure financial accountability and transparency	Budget vs actual expenditure	Monthly (internal)	Finance Officer	Internal

			Quarterly (external)		Donor
Baseline Assessment Report	Establish starting point for indicators	KAP, Household assessments, gender analysis findings	Month 2	Research Officer and MEAL Officer	Stakeholders
Endline / Final Impact Report	Assess outcomes and impact	Baseline vs endline comparison, behavior change, lessons	Month 12	MEAL Officer, Research Officer, Project Lead	Donor and stakeholders
Policy Briefs	Influence policy	Key findings and recommendations	Month 12	Research Officer and Project Lead	Policymakers
Stakeholder Dissemination Reports	Demonstrate stakeholders engagement and commitments	Meeting summaries and feedback	Final phase	Project Lead and Communications Officer	Stakeholders
Final Project Report	Comprehensive summary	Full achievements and lessons	End of project	Project Lead	Donor and GRÓ GEST

Table 10: Highlights the Project's Reporting Schedule

11. Conclusion

This project looks at how gendered power relations that begin within households influence decision making and increase the risk of AMR. It highlights a simple normalized and overlooked reality that while women carry the caregiving role they are not always positioned to make decisions regarding their own, their family's or their communities' health. This has direct consequences on access to health care services and contributes to the inappropriate use of antibiotics. At the same time, most AMR policies and interventions in Tanzania focus on technical, governance, top down approaches that do not take into consideration the day to day social realities.

The project emphasizes that AMR is not just a biomedical issue but a social and gendered problem. This is why the proposed solution is a community based, gender responsive approach that focuses on addressing AMR by looking at the sociocultural norms in Shinyanga region, Tanzania. This approach creates a space for the community to learn, reflect and co-create behaviour change and practices that drive AMR. In this project, women are not just seen as caregivers, they are recognized for their roles as educators, leaders, advocates and trusted members of the community. Through peer learning, shared experiences and practical demonstrations around AMR and infection prevention, knowledge becomes actionable and promotes locally acceptable and implementable collective behaviour change. The purposeful engagement of men and boys through structured community dialogues also creates an important room for equitable household health decision making.

The bigger picture for this project is to shed light on the importance of rethinking how AMR interventions are designed and implemented at local, national and global levels. Our approaches need to go beyond diagnostics, medications and hospitals to the community with their existing social structures and power imbalances that affect our everyday access to standard health care. Moving forward, in AMR research, programs, policies or any intervention, we need adopt gender sensitive, responsive and transformative models that reflect our local contexts and realities. This is important because the fight against AMR is beyond how we treat infections or use medications, it is about who is marginalized, who makes decisions and under what conditions are these decisions made. If we begin to answer these questions together with local communities, then we move closer to solutions that are effective, fair, inclusive and sustainable.

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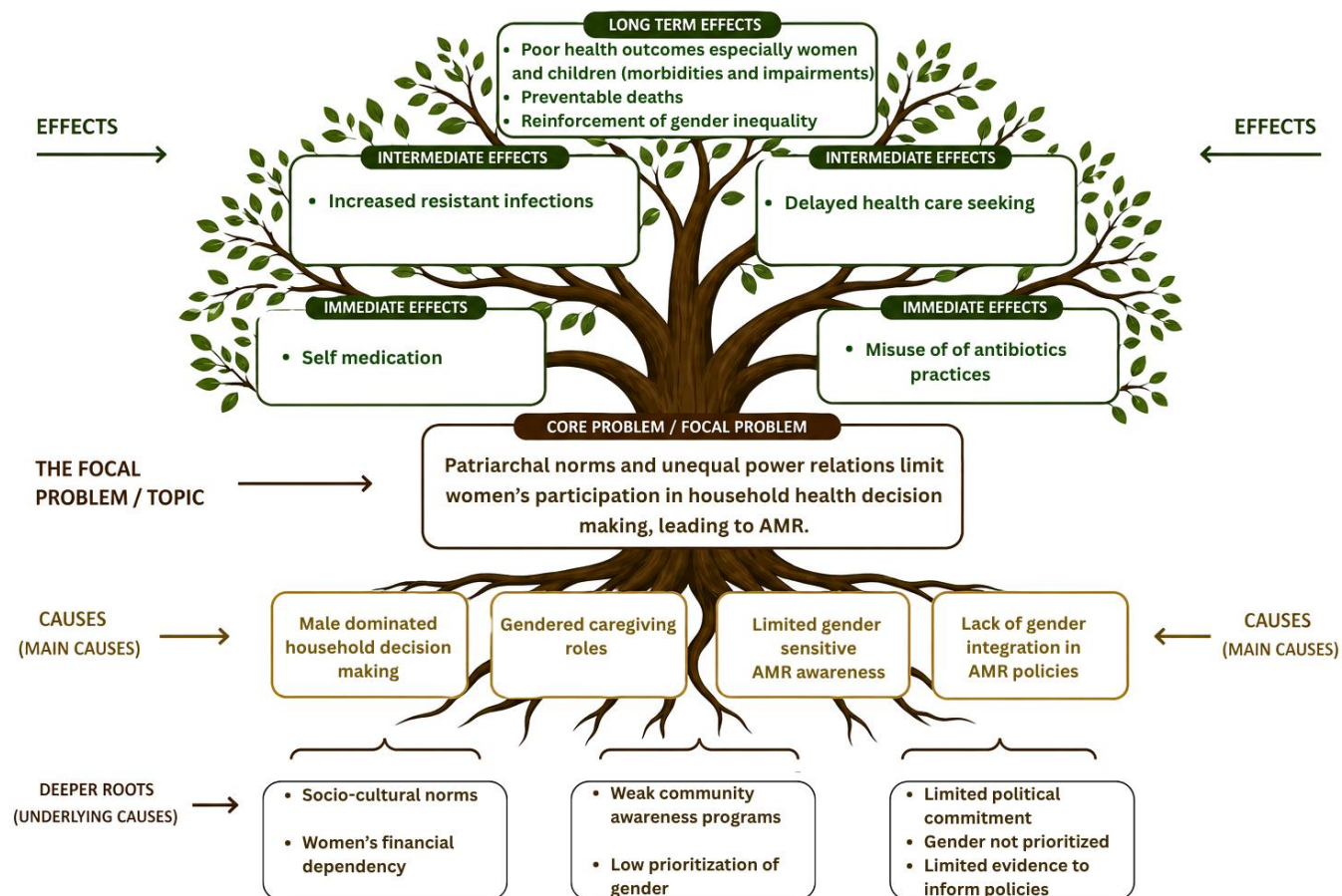
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Annex 1. Problem Tree



Annex 2: Washington Group Disability Questions¹²

1		2		3		4		5		6	
Do you have difficulty seeing, even if wearing glasses?		Do you have difficulty hearing, even if using a hearing aid?		Do you have difficulty walking or climbing steps?		Do you have difficulty remembering or concentrating?		Do you have difficulty (with self-care such as) washing all over or dressing?		Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?	

a. No – no difficulty b. Yes – some difficulty c. Yes – a lot of difficulty d. Cannot do at all

¹² Obtained from UNFPA Asia - Pacific Regional Office, 2022, it is a standardized tool that supports disaggregation of data to identify inequalities across populations. It will be translated to fit the project's context.

Annex 3: Logical Framework

LOGICAL FRAMEWORK			
OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
Project's Overarching goal To contribute to reduced antimicrobial resistance in selected communities of Shinyanga Region	a. Percentage reduction in reported inappropriate antibiotic use in participating communities compared to baseline data b. Number of sub-national AMR planning documents revised to include gender responsive approaches	Baseline and endline KAP survey reports Revised AMR planning documents Written institutional endorsement or commitment	No major external shocks significantly distort antibiotic use patterns Political environment remains conducive to gender responsive AMR integration
Outcome 1 Improved equitable household health decision making and responsible	1a. Percentage of households reporting joint decision making regarding antibiotic use, with at least 30% increase from baseline	Structured baseline, endline KAP survey reports and focus group discussion summaries	No major health crises distort antibiotic demand patterns

antibiotics use practices in participating communities in Shinyanga Region	1b. Percentage reduction in self medication with antibiotics among participating households, with at least 20% decrease from baseline 1c. Percentage of participants correctly using and completing prescribed antibiotic courses, with at least 30% increase from baseline	(qualitative validation of behavior change) Household follow up monitoring reports Structured decision making assessment tools	Household power dynamics allow gradual behavior change Economic constraints do not force reliance on informal antibiotic access
Output 1.1 Gender responsive AMR training materials (1 comprehensive curriculum and 3 supporting materials) developed, pilot tested and disseminated	1.1a. Number of training materials developed, tested and validated (Target: at least 4 materials) 1.1b. Number of participants involved in pilot testing (disaggregated by sex) with at least 30 participants engaged.	1.1a Final approved training curriculum and validation meetings minutes and reports 1.1b Pilot testing attendance and report 1.1c Dissemination log, report	Community stakeholders accept the adapted training materials. Participants are willing to provide honest feedback and the feedback reflects broader community

	1.1c. Number of Training materials disseminated (Target: 300 materials) 1.1d. Percentage of materials reviewed to ensure integration of gender considerations, with at least 100% of materials developed reviewed	and signed recipient forms 1.1d Gender review checklist, feedback report from consulted gender experts	perspectives Qualified gender experts are available to review and validate materials
Output 1.2 Gender responsive AMR education sessions conducted in the community	1.2a. Number of AMR sessions conducted (Target: 160 sessions conducted across 20 community groups and AMR champions) 1.2b. Number of participants who have attended the session (Target: at least 250 participants)	1.2a Session schedule and reports 1.2b Session attendance sheets	Community members are willing to attend sessions. No major disruptions (such as political instability and health

	1.2c. Percentage of participants completing the training sessions (Target: at least 80% completion rate) 1.2d. Percentage of participants who score higher on AMR knowledge assessments post training	1.2c Attendance logs 1.2d Baseline and Endline surveys	emergencies) prevent sessions
Output 1.3 Five Community dialogue sessions conducted to address gender norms influencing antibiotics use	1.3a. Number of community dialogue sessions conducted (Target: at least 5) 1.3b. Number of men engaged in community dialogues (Target: at least 300 men in total) 1.3c. Percentage of dialogue participants (men) reporting increased confidence to engage in shared health decision making with at least 25% increase from baseline	1.3a. Dialogue sessions schedules and reports 1.3b Dialogue sessions attendance and consented photos 1.3c Baseline and Endline surveys	No major push back from community leaders on open discussions of gender norms Participants feel safe expressing views in dialogue forums Cultural resistance does not significantly limit engagement in the discussions

Outcome 2 Improved household infection prevention practices through appropriate WASH in Shinyanga Region	2a. Percentage of households observed with functional hand washing facilities at critical points (Target: at least a 30% increase from baseline levels) 2b. Percentage of households practicing safe water storage (Target: at least a 30% increase from baseline levels)	Structured baseline and endline household WASH observation checklist Household follow up monitoring reports	Water availability remains sufficient to support hygiene practices
Output 2.1 Household WASH conditions assessed and tailored recommendations provided to address identified infection risks	2.1a. Number of households assessed using a standardized WASH assessment checklist (Target: 300 households) 2.1b. Percentage of assessed households receiving feedback on identified infection risks (Target: 100% of assessed households)	2.1a. Completed household WASH assessment forms and field visit reports 2.1b. Household feedback documentation forms	Households consent to assessment visits and allow observation of WASH facilities No major access or safety barriers prevent household visits

Output 2.2 Infection prevention education sessions on WASH and immunization delivered to the selected communities in Shinyanga Region	2.2a. Number of infection prevention education sessions conducted (Target: at least 160 sessions, across 20 community groups) 2.2b. Number of participants attending sessions (disaggregated by sex) (Target: at least 250 participants) 2.2c. Percentage of participants correctly demonstrating key WASH practices post session (Target: at least 50 percent)	2.2a. Session schedules and reports 2.2b. Session attendance sheets 2.2c. Post session observation checklist	Community members are willing to attend the education sessions No major disruptions (such as political instability and health emergencies) prevent sessions
Output 2.3 Practical hygiene demonstration tools provided to support behavior change	2.3a. Number of hygiene demonstration tools distributed to households 2.3b. Percentage of households reporting use of demonstration tools during follow up visits (Target: at least 70% report using)	2.3a. Distribution logs, signed receipt forms and field reports 2.3b. Household follow up checklist and monitoring visits	Households are willing to use the demonstration tools provided Water access and basic infrastructure allow hygiene practices to be implemented

Outcome 3 Increased integration of gender responsive approaches in AMR planning and programming at sub-national and national levels	3a. Number of AMR planning or program documents referencing gender responsive approaches following project engagement (Target: at least 2 documents) 3b. Percentage of engaged stakeholders reporting intention to incorporate gender considerations in AMR planning processes (Target: at least 50% of stakeholders engaged)	Revised AMR planning documents Written stakeholder commitments Stakeholder feedback forms Project policy engagement report	AMR remains a policy priority during the project period No major political push back on discussions of gender integration in AMR
Output 3.1 Community level evidence on gender responsive AMR interventions documented	3.1a. Number of analytical reports produced summarizing intervention outcomes and relevant findings (Target: 1 comprehensive analytical report) 3.1b. Number of evidence briefs developed, with at least 2 briefs produced	3.1a. Final analytical report (approved and ready for dissemination) 3.1b. Published or printed evidence briefs	Findings are relevant to AMR stakeholders The political environment allows room for discussion of gender in AMR

Output 3.2 Policy Briefs Developed & Disseminated	3.2a. Number of policy briefs developed and finalized, with at least 2 policy briefs produced 3.2b. Number of stakeholders receiving briefs (district & national), with at least 20 relevant stakeholders	3.2a. Final policy brief documents 3.2b. Dissemination plan, email dissemination records and stakeholder acknowledgment receipts	Policy briefs are aligned with national AMR priorities Stakeholders are willing to receive and review materials
Output 3.3 Stakeholder Engagement Conducted	3.3a. Number of stakeholder engagement meetings conducted (Target: at least 3 stakeholders meetings) 3.3b. Number of policymakers and parliamentarians participating (Target: at least 10 policymakers) 3.3c. Percentage of stakeholders expressing commitment to consider gender integration in AMR planning (Target: at least 50% of engaged stakeholders)	3.3a. Meeting minutes and reports 3.3b. Meeting attendance sheets and photos (consented) 3.3c. Stakeholder feedback forms	Policymakers and parliamentarians are available and willing to engage AMR remains a priority during the project period and political context allows discussion of gender issues

Annex 4: Project Activities Schedule

PROJECT ACTIVITIES (JULY 2026 TO JUNE 2027)												
ACTIVITIES	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
PHASE 1: SETTING PROJECT'S FOUNDATION AND BASELINE ASSESSMENT												
Stakeholder mapping and meetings	✓											
Ethical clearance	✓	✓										
Baseline KAP survey	✓	✓										
Household WASH baseline assessment	✓	✓										
Gender and power analysis	✓											
Selection of AMR Champions		✓										
PHASE 2: CURRICULUM DEVELOPMENT AND CAPACITY STRENGTHENING OF ToT												
Curriculum adaptation and translation			✓									
Pilot testing and validation of materials				✓								

Finalization of curriculum				✓								
Training of 50 Women AMR Champions					✓							
Partnership formalization					✓							
PHASE 3: COMMUNITY ENGAGEMENT AND CONTINUOUS MONITORING												
Peer led AMR education sessions						✓	✓	✓	✓			
Community gender dialogue sessions						✓	✓	✓	✓			
Household WASH feedback visits						✓	✓	✓				
Distribution of hygiene demonstration tools							✓	✓				
Continuous monitoring visits and session tracking						✓	✓	✓	✓	✓		
Project reflection and adjustments								✓				
PHASE 4: EVALUATION, LEARNING AND POLICY ENGAGEMENTS												
Endline KAP survey										✓		
Endline household WASH observation										✓		

Focus group discussions										✓		
Data analysis and analytical report drafting											✓	
Evidence and policy brief development											✓	
Stakeholder dissemination meetings												✓
Final reporting and project close out												✓