2020

Gender and TB

INVESTMENT PACKAGE

COMMUNITY, RIGHTS & GENDER

Stop TB Partnership hosted by UNOPS

Contents

Abbreviations

ACSM: Advocacy, communication and social mobilisation

M&E: Monitoring and evaluation

PWUD: People who use drugs

TB: Tuberculosis

WHO: World Health Organization

[1] The intersectionality between key populations and gender is relevant across all key populations. The inclusion here of people who use drugs serves as one example of how to respond to gender in a key population focused intervention. The forthcoming TB and Prisons CRG Investment Package will also provide specific guidance for prison-based projects.

About

Gender is relevant to all aspects of the TB response. It shapes who is at risk of infection and disease, when and how diagnosis occurs, treatment access, the likelihood of adherence and treatment completion and the social and monetary consequences of TB disease. Two thirds of TB cases globally are in men, indicating that there are significant gender-related barriers for increased risk and/or prevention services. Studies have shown that women, however, face disproportionate barriers in accessing TB care services, as well as greater stigma and psychosocial consequences of TB disease Women also face numerous additional challenges related to TB and maternal health.[2] A gender-based approach to TB acknowledges and responds to the social, legal, cultural and biological issues that underpin gender inequality and contribute to poor health outcomes. Gender-based responses to TB are further built on the acknowledgement that all TB interventions have the capacity to either reinforce or mitigate harmful gender norms. TB Programmes therefore have an ethical responsibility to monitor interventions to ensure broad, positive impact.

The StopTB Partnership supported the implementation of Community Rights and Gender (CRG) Assessments in 13 countries. These qualitative assessments revealed the extent to which gender differences shape TB vulnerabilities and care access in different contexts. They have also revealed some broad commonalities, including a lack of gender sensitisation in healthcare workers, particularly in relation to transgender people. Other commonalities include poor availability and use of detailed gender-disaggregated data, the absence of gender mainstreaming[3] in monitoring and evaluation processes, ongoing gender-bias in the health workforce, gender-blind TB policy, the commonality of TB-related stigma, and a wide array of other gender-related barriers to care access. Together the CRG Assessments highlight the urgent need for TB programmes to put gender front and centre of their programming.

The Global Fund has a clear commitment to promoting the protection of human rights and gender equality in the context of TB as evident in the Global Fund Strategy (2017-2022)[4] and related technical briefs.[5] Their commitment aligns with the Global Plan to End TB[6] and the commitments to "integrated, people-centred, community-based and gender-responsive health services based on

[2] TB in Women, WHO [Available from: https://www.who.int/tb/publications/tb_women_factsheet_251013.pdf]

[3] As outlined by ECOSOC in 1997, gender mainstreaming is "the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres, so that women and men benefit equally, and inequality is not perpetuated. The ultimate goal of mainstreaming is to achieve gender equality."

[4] The Global Fund Strategy 2017-2022: Investing to End Epidemics, The Global Fund [Available from: https://www.theglobalfund.org/media/1176/bm35_02-theglobalfundstrategy2017-2022investingtoendepidemics_report_en.pdf]

[5] Technical Brief: Tuberculosis, Gender and Human Rights, The Global Fund [Available at: https://www.theglobalfund.org/media/5536/core_malariagenderhumanrights_technicalbrief_en.pdf] & Technical Brief, Gender Equity, The Global Fund [Available at: https://www.theglobalfund.org/media/5728/core_gender_infonote_en.pdf]

[6] Global Plan to End TB, Stop TB Partnership. [Available from: http://www.stoptb.org/assets/documents/global/plan/GPR_2018-2022_Digital.pdf]

human rights" as outlined in the UN High Level Meeting on Tuberculosis Political Declaration[7] as well as in the WHO End TB Strategy.[8] The Declaration of Rights of People affected by Tuberculosis further notes various rights related to gender, including the right to freedom from discrimination based on gender and the right to gender-appropriate information.[9] In line with the above blue prints, countries are advised to implement gender-sensitive/responsive policies and programming across all aspects of TB programmes, with particular consideration for both disease prevalence and barriers to accessing services .[10]

Objective and Scope

This investment package is one of the Global Plan to End TB investment packages, committed to by UN member states. This package draws on insights from completed Community, Rights and Gender Assessments to provide guidance on how TB programmes and projects can meet gender equity needs and goals by becoming gender-responsive.[11,12]

The guidance provided here assumes that countries will shape the interventions in accordance with their needs and context. Where gender assessments have not already been conducted they should be implemented to ensure that a programmed is applicable to context. Guidance on the implementation of gender assessment can be found at: http://www.stoptb.org/assets/documents/resources/publications/acsm/Gender_Assessment_Tool_TB_HIV_UNAIDS_FINAL_2016%20ENG.pdf

The table below outlines the areas covered in this document and indicates their priority level. Intervention areas 1, 2 and 3 are essential and subsequent intervention areas described in this document require that these basic steps have been taken. Intervention area 4 is highly recommended. Intervention areas 5 – 8 provide inputs into how countries can approach a focus on being gender-responsive.

Table 1: Document content areas and priority levels for gender responsive programmes (intervention areas are all specific to gender)

Priority level	Intervention area
Essential	1. Service provider sensitisation and capacity building

[7] Political Declaration of the high-level meeting of the General Assembly of the fight against tuberculosis [Available from: https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/3]
[8] The End TB Strategy, WHO [Available from: https://www.who.int/tb/post2015_strategy/en/]
[9] Declaration of the Rights of People Affected by Tuberculosis', Stop TB Partnership and TB People [Available at: http://www.stoptb.org/assets/documents/communities/FINAL%20Declaration%20on%20the%20Right%20of%20People%20Affected%20by%20TB%2013.05.2019.pdf]
[10] See Global Fund Technical Briefs. Ibid.
[11] For information on the gender-integration spectrum, which describes the range of approaches to gender, from gender-blind to gender transformative, see the UNDP 'Gender Integration Spectrum' in Annex 1
[12] The Global Plan to End TB highlights the importance of the gender-responsive programming in Southern and Central African settings where HIV and mining are key drivers of the epidemic; African settings with moderate to high HIV where mining is not a significant issue; settings with severely under-resourced health systems; and country settings with challenging operating environments. The CRG Assessments have further noted the vital importance of a gender responsive approach in Eastern Europe and Asia more broadly.

	2. Data and monitoring and evaluation for gender-responsive programming
	3. Gender equity in the TB workforce
Highly recommended	4. Developing a national TB gender strategy and action plan
Potential project areas	5. Facility-based service quality improvement
	6. TB education and stigma reduction
	7. Community-based case finding
	8. TB services for people who use drugs

For each intervention area covered the document provides a succinct justification, an outline of focus areas, and a summary of key steps, actors and cost considerations for a gender-responsive approach. These are not intended to be exhaustive, or prescriptive, but rather to provide guidance for programme design purposes. Clarifying examples are provided in footnotes throughout the text.

1. Service provider sensitisation and capacity building

Optimal, rights-based care requires that TB programme staff at all levels of programme design, management and implementation understand how gender impacts TB vulnerability, care access and care provision. They also need to understand why a gender-responsive approach is necessary, how not taking one can reinforce stigma and discrimination, especially for transgender people, and what their role is in driving and implementing this approach. This knowledge is essential for a willingness to take a gender-responsive approach. Ensuring that knowledge and attitude changes translate to behaviour change also requires that programme staff are sufficiently skilled. Without a comprehensive training approach programmes risk reinforcing harmful gender norms and discrimination.

1.1. Focus areas

Target population: All current and incoming TB programme staff, gender programme officers, legal aid providers, and healthcare students at all medical training institutions should receive basic gender and TB sensitisation training. Targeted training shaped to specific roles should also be provided to TB programme staff. [13]

Curricula content and structure: Basic gender and TB sensitisation training content can be uniform for all trainees. The content should tackle knowledge, attitudes and practices related to providing gender sensitive and responsive care. It should also incorporate key practices on how to identify and respond to gender-based violence. Advanced knowledge and implementation training for TB programme staff should have separate curricula be targeted to different healthcare roles. All curricula content should be tailored to context by drawing on a local gender assessment.

Training timing: Training should be done during tertiary education (for healthcare professionals) as part of pre-service training (for all relevant ministries and civil society organisations) and/or during

[13] E.g. health managers must be trained to apply knowledge to program design, data use and monitoring and evaluation processes, and facility staff need to understand differences in diagnostic and treatment needs and TB counsellors must be trained to implement gender-responsive counselling processes.

employment, potentially though programme supervisory visits. Training should be reiterated periodically to reinforce learning and ensure that behaviour change is happening.

Training format: Training can be done in person, through an online platform[14] or a combination of these based on resources available and the needs of the target population. Practical exercises need to be included to ensure that knowledge can be applied.[15]

Monitoring and evaluation: Monitoring and evaluation must record the activities implemented (outputs) and assess the effectiveness of the teaching methods (outcomes) and behavioural change(s) of the people trained (impact). Indicators should be quantitative and qualitative.[16]

Sustainability: Sustainability should be ensured by setting up a cohort of gender trainers within the NTP, led by a designated training lead.

[14] See, for example https://www.un.org/gender/file/373

[15] E.g. healthcare workers working directly with people affected by TB must be able to ask gender minorities about preferred pronoun use and be able to use the correct pronoun.

[16] Output indicators can include number of people trained and number of training implemented. Outcomes indicators can include measurement of changes in knowledge, skills and attitudes resulting from training processes. Impact indicators can include changes in the quality of gender-sensitive care provided, for example, by assessing the experience of care provision by different genders, or the use of gender-appropriate pronouns for transgender people.

1.2.Key steps, actors and cost considerations

1. Service provider sensitisation and capacity building			
#	Steps	Key actor/s	Cost considerations
1.1 Goal: Fit-to-purpose training curriculum developed			
1.1.1	Engage civil society process lead	NTP/ government	Process lead contract for intervention duration
1.1.2	Set up representative training task team to guide decisions about training content and structure	Process lead	
1.1.3	Develop curricula for basic and advanced training modules: draft, share with task team, adapt and finalise	Process lead & task team	Task team meetings: travel, venues, refreshments
1.1.4	Publish training curricula in printed or online format	NTP & process lead	Editing, desktop publishing and printing or website design
1.2 Goal: Sensitised and gender-capable TB workforce			
1.2.1	Develop iterative training and M&E plans: draft, share with task team, adapt, finalise	Process lead and task team	Task team meetings: facilitation, travel, venues, refreshments
1.2.2	Integrate gender training into staff orientation package	NTP/ government	Publication of updated materials
1.2.4	Select in-house gender trainers and one gender training lead	NTP/ government	Additional staff capacity
1.2.5	Capacitate in-house gender trainers	Process lead	Training events: training materials, travel, venues, refreshments
1.2.5	Implement basic sensitisation training for all NTP and related government staff	Gender training lead	Training events: training materials, travel, venues, refreshments
1.2.6	Implement advance knowledge and skills training for different healthcare roles	Gender training lead	Training events: training materials, travel, venues, refreshments
1.3 Goal: Future workforce training in place			
1.3.1	Sensitise healthcare training institutions about the need for gender-training	Gender training lead	Sensitisation meetings: travel, venues, refreshments
1.3.2	Train healthcare training institution staff to implement training package for students	Gender training lead	Training events: travel, venues, refreshments or online training costs

2. Monitoring and evaluation for gender-responsive TB programming

Comprehensive collection and use of sex and gender disaggregated data[17] at all stages of the TB care cascade provides insight into the differences between men and women, boys, girls and transgender people in terms of their TB risk, diagnosis, treatment initiation and treatment completion. It is, therefore, a key resource for the design and evaluation of gender-responsive programming.

Beyond the case finding and treatment, all interventions – even those not specifically focused on gender - need to incorporate additional indicators specific to the interventions to address gender-related risks and inequities (intervention areas 1 and 3) in monitoring and evaluation processes. This is because any intervention, whether it intends to or not, will affect the existing gender relationships and roles.[18] All interventions should therefore assess the extent to which they support moves towards gender equity or reinforce gender discrimination.

Implementing gender-responsive data collection and tracking requires that front-line staff are sensitised and capacitated to ask and speak about gender in ways that are respectful, especially towards gender minorities (see intervention area 1). In addition, there should be protections in policy, as well as reporting systems and processes of accountability to ensure appropriate responses to cases of abuse (see intervention area 3).

2.1. Focus areas

Demographic detail: Collecting demographic detail is essential to being able to track the gendered dynamics of inclusion or exclusion of sub-groups from the TB response. Detail on gender must go beyond only recording "male" and "female" and include a category for people who do not conform to gender norms (such as transgender people and intersex people). These people are routinely excluded from TB care or provided with sub-standard care that does not acknowledge their gender identity and dignity.[19] Furthermore, age,[20] occupation and key population affiliation[21] all intersect with gender and play an important role shaping TB risk and care access. These demographic details should therefore all be collected for every TB affected person, engaged by any TB intervention or care process. If key populations have not been defined in the country, guidance for how to do this can be found at:
http://www.stoptb.org/assets/documents/communities/Data%20for%20Action%20for%20Tuberculosis%20Key,%20Vulnerable%20and%20Underserved%20Populations%20Sept%202017.pdf

[17] Throughout this document "sex" is used in reference to biological differences, or to data gathering that only references these differences. "Gender" refers to socially constructed set of norms, roles, behaviours, activities and attributes that a given society considers appropriate or valued for women, men and transgender people.
[18] E.g. A community case finding project that employs a cadre of women to go door-to-door is gendered in that it reinforces the assumption that basic, lower-paid, care roles are the preserve of women. It is also likely to miss more men than women because men are more likely to be working outside of the home.
[19] This means that data on gender should include "Male", Female" and "Other".
[20] Gender differences are not uniform across ages. E.g. In India, the analysis of data from two states showed that while overall TB incidence is twice as high in men as women, in the group of 0-14 years, this trend was reversed.
[21] Key populations may be people of one occupation. They may also be largely one gender (e.g. miners) or there may be different care needs within the population (e.g. women who use drugs generally have additional challenges accessing care).

Comparative data analysis and reporting: The way in which sex, age, occupation, and key population affiliation interact with each other and TB depends on context. A nuanced picture of the TB epidemic and response therefore requires that countries go beyond only reporting sex disaggregated data at a national level. Sex disaggregated TB data must also be analysed and reported in terms of regional and district differences and in terms of other key demographic details.

Gender mainstreaming indicators: At a basic level, projects must have monitoring and evaluation indicators that capture intended changes related to improving gender equity.[22] In addition, interventions must measure their broader effects on the community in which they are implemented. This means that all interventions should include monitoring and evaluation indicators that track who participates in the intervention;[23] who benefits from the intervention; how the intervention impacts on gender inequality in the broader community;[24] and whether the intervention has impacted on tensions or gender-based violence in the community. These indicators should be both quantitative and qualitative.

Qualitative research: Qualitative research is key both to gathering additional information to explain and contextualise the findings revealed by examining gender-disaggregated TB care cascade data (including intersectionality between gender and key populations). It is also an essential means of providing insights into programme impact and gathering community inputs on appropriate programmatic changes or responses. Qualitative research should therefore be integrated into routine data collection and analysis processes.

Appropriate, maximised data utility: Data is only useful if it is available and well used. Data reports must be disseminated and accessible for use by TB managers at district and regional levels. TB managers must also be capacitated to apply gender sensitivity training knowledge to interpreting sex disaggregated TB data and gender indicators (see intervention area 1).

Sustainability: Monitoring and evaluation for gender responsive programming should be sustainably integrated into the TB programme. The suggested intervention therefore includes a gender expert (or consultancy) to support set up and initial review processes after which the NTP should have sufficiently skilled staff to continue.

[22] E.g. Measuring the reduction in barriers to travelling to healthcare facilities for women in a project seeking to achieve this.
[23] E.g. Is this predominantly men or women? How old are participants?
[24] E.g. Does the intervention disrupt standing power dynamics and if so, how?

2.2.Key steps, actors and cost considerations

2. Monitoring and evaluation for gender-responsive TB programming			
#	Steps	Key actor/s	Cost considerations
2.1. Goal: Comprehensive TB case management data collection, analysis and reporting systems in place			
2.1.1	Identify gender expert to support processes led by NTP	NTP	Gender expert contract for intervention set up and review periods
2.1.2	Adapt all TB cascade data collection and input tools to include additional gender minorities, key population affiliation, age and occupation demographic data points	NTP & gender expert	TB case management data collection tool adaption and printing; input system adaptations
2.1.3	Analyse TB cascade data disaggregated by gender, key population affiliation, age and occupation, region and district	NTP & gender expert	Additional capacity for detailed analysis
2.1.4	Develop report on disaggregated data	NTP & gender expert	Additional capacity for reporting detail
2.2. Goal: Qualitative research implemented to explain data trends			
2.2.1	Identify qualitative researcher/s	NTP	Researcher contract for research period
2.2.2	Set up research protocol that responds to unexplained disaggregared data findings: Draft protocol, share with stakeholders for review, revise and submit for ethics approval	Qualitative researcher & stakeholders	Stakeholder feedback meeting: Facilitation, venue, travel, refreshments; Ethics submission
2.2.3	Conduct research and analysis: Implement research, transcribe data, analyse data	Qualitative researcher	Travel; participant reimbursement; refreshements; audio recorders; transcription; translation; qualitative data analysis tool
2.2.4	Develop and disseminate research report	Qualitative researcher, gender expert & NTP	Report printing and distribution
2.3. Goal: Gender mainstreaming in M&E indicators			
2.3.1	Set up gender impact indicators for all TB programme interventions	NTP, partner organisations & gender expert	
2.3.2	Conduct basic data gathering during routine operations	NTP & partner organisations	
2.3.4	Conduct additional data gathering for gender impact indicators	NTP & partner organisations	Research implementation: researchers, travel, participant reimbursment and refreshments
2.3.5	Analyse and report on collated gender-related data indicators	NTP & gender expert	Data input, cleaning, analysis and reporting
2.4. Goal: Data is optimally used			
2.4.1	Implement gender sensitivity and capacity building refresher course for data analysts, report writers and TB managers	Gender expert	Training events: facilitators, travel, venues, refreshments
2.4.2	Disseminate quarterly gender report	NTP	
2.4.3	Implement quarterly gender review meetings	NTP	

3. Gender equity in the TB workforce

The TB workforce is overwhelmingly unbalanced in terms of gender. Senior, decision-making positions are largely filled by men while the vast majority of primary healthcare workers, inclusive of care workers, facility-based staff and laboratory technicians are women. Gender minorities are rarely represented. A lack of representation in the TB workforce disadvantages everyone; women's needs are less taken into account when women are not adequately represented at levels where decisions are taken. Men, on the other hand, may benefit from having other men provide primary care that is currently provided by women. Furthermore, current systems exacerbate standing gender discrimination by failing to provide adequate capacity building and support to lower-tier workers who are predominantly women.[25] Such systems should also include community feedback mechanisms on gender issues.

Building a gender equitable workforce requires that all staff are required to undertake basic gender sensitivity training (see intervention area 1).

3.1. Focus areas

Gender task force: A task force of sensitised TB programme staff should be set up. This task force should be responsible for overseeing and monitoring all activities undertaken towards gender equity in the TB work force. The task force should have more than 50% female representation and should include key population representatives and people who do not conform to gender norms. Equally men from leadership positions should be engaged as allies and champions in the task force.

Gender-representation in the workforce: TB programmes should aim for gender parity within the workforce through setting employment gender equity goals. These goals should aim for representation of people who do not conform to gender norms and key populations; support for skills and leadership training for women; increases in women visibly in leadership roles; and increases in male primary healthcare workers.

Adequate protections for all levels of employment: Ensuring that women in TB are not unduly discriminated against requires that attention is paid to adequate infection control, access to personal protective equipment, and access to leave and compensation for occupationally acquired TB at all tiers of employment, including for community care workers and cleaning staff. Accountability frameworks are further required to ensure that protections are realised in practice.

Gender equity employment policy: An organisational gender equity policy is required to attend to the areas described above as well as to maternity, paternity and family leave; protection from sexual harassment and sexual discrimination; and equal pay and benefits for equal work.

[25] Primary healthcare workers are more likely to work in environments where infection control is limited and less likely to be able to access personal protective equipment. They are therefore at increased risk of acquiring occupational TB. They are also less likely to be able to access compensation for occupational acquired TB, and have higher changes of suffering TB-related stigma.

Sustainability: The mechanisms put in place through the intervention should all form part of long-term institutional vision and practice.

3.2.Key steps, actors and cost considerations

3. Ensuring a gender-equitable TB workforce			
#	Steps	Key actor/s	Cost considerations
3.1. Goal: Gender task force established			
3.1.1	Engage process lead	NTP	Gender equity process lead contract for duration of work
3.1.2	Elect a gender task force of sensitised TB programme staff inclusive of gender minorities and key populations	NTP	
3.1.3	Implement regular gender transformation review meetings	Task team	
3.2. Goal: Gender representation in the workforce			
3.2.1	Review current gender breakdown of all employees	Process lead	
3.2.2	Set gender equity targets: recruitment targets for all levels of employee; target percentage of meetings led by women or gender minorities	Process lead & task team	Task team meetings: facilitation, travel, venue, refreshments
3.2.3	Train and employ men as frontline healthcare workers	NTP & task team	Training events: facilitation, travel, venues, refreshments
3.2.4	Institute skills and leadership training for women and gender minority staff members	Task team	Curriculum development: expert input, publication; Training events: travel, venues, refreshments
3.3. Goal: Adequate protections for all levels of employment			
3.3.1	Review policy to provide protections for healthcare workers at all tiers of employment	Process lead & task team	Task team meeting: travel, venue, refreshments
3.3.2	Adapt procurement and M&E to include new protection needs	Process lead & task team	Task team meeting: travel, venue, refreshments
3.3.3	Set up an accountability frameworks to ensure protections are upheld	Process lead & task team	Task team meeting: travel, venue, refreshments
3.3.4	Train managers and workers on new policy and related practices	Process lead & task team	Training events: travel, venues, refreshments
3.4. Goal: Gender equity policy in place			
3.4.1	Develop equity policy: draft, task team review, revise, finalise, print	Process lead & task team	Task team meeting: travel, venue, refreshments; desktop publishing; printing
3.4.2	Train staff on new policy and related practices	Process lead & task team	Training events: travel, venues, refreshments

4. Development of a national gender strategy and action plan

Taking into account and responding to the ways that gender impacts on TB risks, care access, and treatment needs and quality is an important step towards the realisation of country commitments to end TB. Yet, despite commitments and the positive impact that a gender-responsive approach can have on case detection and treatment outcomes, gender is frequently relegated to the side lines. Ensuring a coherent, gender-responsive approach requires that commitment is solidified by the development of a national gender and TB strategy which is accompanied by a clear, costed action plan. This strategy development must be centrally led and processes must include meaningful participation from key stakeholders, especially gender and key population representatives.

4.1. Focus areas

Leadership and participation: This strategy development must be centrally led by the NTP. Processes must include meaningful participation from key stakeholders, including gender and key population representatives, related government departments, civil society and donor organisations. The strategy content should be generated by a representative technical working groups, supported by a gender expert. A broader stakeholder group should be invited to monitor processes and validate the final document.

Context and information review: The Gender and TB strategy and action plan should be based on the best available evidence. If one has not already been conducted, a gender or CRG assessment is an essential first step. Assessment findings and recommendations may need prioritised for focus by members of an inclusive task team.

Strategy and action plan content: The action plan should provide guidance and steps to develop a rights-based gender-responsive TB programme aligned with the current NSP. The aim should seek to shift the entire TB programme towards being gender-responsive while focusing on concrete steps to meet gender priorities outlined in the gender assessment and by civil society organisations. It is likely that content development will need to be an iterative process requiring multiple rounds of meetings and adaptations before document finalisation.

Sustainability: Sustainability should be ensured by ensuring the strategy is aligned with the National Strategic Plan and all action steps are realistically costed. Buy-in and going implementation in should further be ensured through a strategy launch and training plan and in inclusion of indicators in national reporting processes.

4.2.Key steps, actors and cost considerations

4. Development of a national TB gender equity strategy and action plan			
#	Steps	Key actor/s	Cost considerations
4.1. Goal: Inclusive, evidence informed strategy development process			
4.1.1	Identify a process lead within the NTP	NTP	
4.1.2	Engage gender expert to support process	Process lead	Gender expert contract for duration of intervention
4.1.3	Engage a representative stakeholder group and task team	Process lead & gender expert	
4.1.4	Present gender assessment findings and recommendations to stakeholder group. Adapt and prioritise recommendations.	Process lead, gender expert	Stakeholder meetings: facilitation, travel, venues, refreshments
4.1.5	Set up representative technical working groups for strategy and action plan content development	Process lead	Stakeholder meetings: facilitation, travel, venues, refreshments
4.2. Goal: Gender equity strategy and action plan developed			
4.2.1	Develop draft strategy and action plans: Technical working groups draft, share, and adapt strategy and action plan inputs	Process lead, technical working groups & gender expert	Technical working group meetings: facilitation, travel, venues, refreshments
4.2.2	Inputs collated into single, coherent document with a costed action plan	Process lead & gender expert	
4.2.3	Finalise and validate strategy and action plans: share with stakeholder group, discuss, finalise and validate	Process lead & gender expert	Stakeholder meeting: facilitation, travel, venues, refreshments; Strategy editing, design and publishing
4.3. Goal: Strategy and action plan accepted and put into practice			
4.3.1	Get strategy and action plan endorsed by key national figures	Process lead	
4.3.2	Implement launch event: Invite key delegates and media; organise event materials, venue and programme	Process lead	Venue, refreshments, AV, event material design and printing
4.3.3	Set up dissemination and training plan for partner organisations and TB programme staff	Process lead & gender expert	

5. Facility-based service quality improvement

Implementing an approach that responds to the different care and treatment needs of girls, boys, women, men, gender minorities and key population groups is an essential component of improving facility-based services. The suggested steps below build on the assumption that a gender assessment has been implemented to provide baseline information. If this has not been done, this is a first step. Improving facility-based services requires that sensitised healthcare workers (see intervention area 1), gender responsive data and monitoring and evaluation processes (intervention area 2), and a gender-representative workforce (intervention area 3) are already in place. The focus areas and steps below are intended to be integrated into broader, comprehensive, facility-based service quality improvement intervention plans.

5.1. Focus areas

Health facility infrastructure: Healthcare facilities and waiting areas that are dominated by one gender are frequently experienced as uninviting by the opposite gender, even when gender separation is not common in everyday life. Transgender people experience stigma and discrimination from other TB-affected people and women generally have greater difficulty producing sputum partly due to social sanction on spitting. Setting up gender-friendly infrastructure therefore requires that waiting areas[26] and ablutions are provided for all genders and that sputum production areas are private and safe.

Health facility opening times: Facility opening times can determine access. Hours that clash with traditional working hours may be particularly difficult for men, who are more likely to be formally employed. Facility opening times may need to be adapted to meet the needs of all genders.

Integrated services: In addition to being integrated into HIV services, gender-responsive facility services should integrate TB screening and diagnosis into maternal health services to increase the number of women reached.[27]

Diagnostic and treatment algorithms: Under-diagnosis in women is partly due to challenges in diagnosis in PLHIV, pregnant and post-partum women, and cases of genital TB.[28] Diagnostic and treatment algorithms need to be sufficiently sensitive and tailored to women's needs.

Psychosocial support: Psychosocial support needs differ by gender and context.[29] Psychosocial support processes should be informed by research on local context and shaped to meet specific gendered needs.

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[26] This might include fast track processes for vulnerable people, separate waiting and treatment areas, and/or different treatment times.

[27] For example, maternal health clinics can implement diagnostic procedures and maternal health staff can be trained to identify women who are at risk due to anemia or undernourishment.

[28] Genital TB is frequently missed and estimated to account for approximately a quarter of all female infertility. 'Prevalence of infertility in women with genital tuberculosis: a systematic review and meta-analysis' Kefayat et al [Available at https://www.researchgate.net/publication/319476222_Prevalence_of_infertility_in_women_with_genital_tuberculosis_a_systematic_review_and_meta-analysis].

[29] This should include including differentiated counselling processes, access to endocrinological support for transitioning transgender people, nutritional support for malnourished patients, additional counselling for pregnant

5.2.Key steps, actors and cost considerations

5. Facility-based service quality improvement			
#	Steps	Key actor/s	Cost considerations
5.1 Goal: Gender-responsive facility infrastructure and opening			
5.1.1	Engage process lead	Lead organisation*	Process lead contract for the duration of the intervention
5.1.2	Develop gender and TB infrastructure report: Gather inputs on space and patient flow needs from gender and key population representatives; conducting observational facility infrastructure assessments.	Process lead & gender and key population representatives	Assessment costs: travel, communcations and meetings
5.1.3	Develop costed restructuring plan: Present infrastructure report to key stakeholders, prioritise change requirements; cost restructuring options; finalise facility adaptation plan	Process lead, stakeholder group, architect, quanitity surveyor	Stakeholder meetings: travel, venues, refreshments; architectural input; quantity surveyor costs
5.1.4	Adapt treatment facility structures and opening times to better meet the needs of all genders and priority key populations: Adapt opening time schedule; restructure spaces; acquire additional furniture, materials and signage; adapt SOPs where required	Process lead, facility managers, architect, builders	Staff capacity for adapted opening times; building/space restructuring; additional furniture, equipment and signage
5.2 Goal: Integrated, sensitive and responsive health services set up			
5.2.1	Set up routine TB screening and testing in maternal health and HIV treatment services: train staff; adapt/develop SOPs; provide additional resources; adapt data collection and reporting processes	Lead organisation	Additional staff capacity; additional diagnostic and laboratory resources
5.2.2	Set up appropriate diagnostic algorithms: assess current algorithms; adapt for greater sensitivity; adapt/develop SOPs; provide additional resources; train staff in new algorithms	Lead organisation	Additional diagnostic resources
5.2.3	Sensitise and capacitate staff to provide gender-responsive psychosocial support	Lead organisation & gender training lead	Training events: training materials, facilitation, travel, venues, refreshments

*The lead organisation may be the NTP or a partner organisation

women, and referrals for women facing GBV. Childcare provision at TB facilities can also assist women with children to access TB care.

6. TB education for stigma and discrimination reduction

Lack of knowledge about TB infection and treatment supports ongoing stigma and discrimination related to TB. This is often gendered. In many countries, women face more intense stigma and discrimination and greater psychological distress with a TB diagnosis. Efforts to reduce stigma and discrimination need to take a gendered approach which reduces, rather than reinforces, negative gender norms.

A gender assessment is a key first step for understanding what local gender norms and stereotypes are. A stigma assessment would provide key additional information on the local dynamics of stigma and discrimination. For guidance on how to assess TB stigma see the StopTB Stigma Assessment handbook, accessible at: http://www.stoptb.org/assets/documents/communities/STP%20TB%20Stigma%20Assessment%20Implementation%20Handbook.pdf

Within the TB response, TB counselling, implemented by sensitised staff (area 1) can be used as an opportunity to provide people effected by TB comprehensive TB knowledge and reduce self-stigma. The focus areas and steps below provide input into how to make TB education and stigma reduction processes gender-responsive.

6.1. Focus areas

Advocacy, communication and social mobilisation (ACSM) materials: All ACSM materials should provide education about the gendered dynamics of TB risk and infection, debunk popular myths related to gender and TB and educate people about the right to quality care of all people, including gender minorities and key populations. The way that gender is portrayed should not reinforce common gender norms[30] and should include boys, girls, men, women and transgender people in a variety of roles from TB affected persons to healthcare providers. The development of any ACSM materials should be done with the guidance of gender and key and affected populations representatives.

Key strategic partner engagement and training: Strategic partners should be engaged and sensitised to the dynamics of gender and TB. These strategic partners should be context specific and inclusive of focus key populations. This includes training and capacitating the media to report in gender responsive ways; engaging and training religious and traditional leaders to provide support and appropriate messaging for equal access to TB care; engaging TB champions[31] as gender advocates; and securing the support of high profile women who can serve as gender and TB ambassadors.

[30] For example, they should not only represent women in primary care roles.
[31] TB champions should be people affected by TB and should include people of different genders, ages, education and social and economic standing.

6.2.Key steps, actors and cost considerations

6. TB education and stigma reduction			
#	Steps	Key actor/s	Cost considerations
6.1. Goal: Gender-responsive ACSM materials			
6.1.1	Engage gender and key populations representatives as expert advisors	Lead organisation*	Expert advisors contracts for material development period
6.1.2	Review available information and collate dominant gender myths and stereotypes	Lead organisation	
6.1.3	Develop key messaging to respond dominant gender myths and stereotypes: draft, share with gender and key population reprenstatives, adapt, finalise, and translate	Lead organisation & expert advisors	Key messaging workshop: facilitation, travel, venues, refreshments
6.1.4	Produce or select gender-representative visuals or images: develop/select, review, finalise	Lead organisation, production teams & expert advisors	Production costs
6.2. Goal: Strategic partners engaged and trained			
6.2.1	Engage gender and key populations representatives as expert advisors	Lead organisation	Expert advisors contracts for engagement and training period
6.2.2	Select and engage strategic partners	Lead organisation & expert advisors	
6.2.3	Develop training processes and content: develop curriculum and training materials	Lead organisation & expert advisors	Curriculum development, material design and printing
6.2.4	Engage and train strategic partners in gender and TB messaging	Lead organisation & expert advisors	Training and engagement events: facilitation, travel, venues and refreshments, or online training costs

*The lead organisation may be the NTP or a partner organisation

7. Community-based case finding

Community-based case finding accesses men and women where they spend time.[32] If correctly done, it can decrease gendered barriers to care and effectively increase TB case notification rates especially for women and key population groups in high prevalence settings. Community-based case finding can also provide an optimal opportunity for responding to TB-related stigma and gender-based violence. However, it also runs the risk of reinforcing negative community gender norms if done without taking into account considerations related to confidentiality and privacy.

Community based case finding should take gender into account in data and monitoring and evaluation frameworks (see intervention area 2); be implemented by a sensitised, gender-representative workforce (intervention areas 1 & 3); and have systems in place for appropriate responses to evidence of gender-based violence and discrimination. Any advocacy, communication and social mobilisation (ACSM) materials should further be gender-responsive (see intervention area 6). The focus areas and steps below provide input into how to make TB community-based case finding processes gender-responsive.

7.1. Focus areas

Stakeholder engagement: To be effective community-based case finding needs to be planned, implemented and monitored in partnership with key stakeholders, including government institutions, gender and key population civil society organisations. Civil society expertise and links are essential for community mapping, setting activity timetables, and shaping counselling content, all of which need to be set up with attention gendered differences. Industry leaders of industries which carry a high TB risk[33] should also be engaged, if case finding is going to access these settings.

Community mapping: Door-to-door case finding is likely to predominantly find women, to the exclusion of men and women who spend the majority of their time outside the home. Gender-responsive community-case finding must be implemented in areas where men and women spend their time and congregate, including places of work. This requires community mapping of times, areas and group size estimations of gender-specific and key population congregate settings by civil society organisations who know the area and population well.

Case-finding algorithm: Women tend to have higher rates of HIV positivity, have higher rates of extra-pulmonary TB, suffer from genital TB, which is a significant cause of infertility, and women with TB living with HIV have maternal mortality of almost 400%. Community-based case finding-algorithms therefore need to account for both biological sex and gender differences and needs in screening and diagnostic processes. This includes ensuring that women have safe and confidential places to provide sputum. People who do not conform to gender norms, specifically transgender people, likely have high rates of TB and therefore case finding needs to actively respond to their particular needs (Bridge TB REACH project Pakistan footnote).

Counselling: Community-based case finding presents an opportunity for healthcare workers to undertake in depth TB education and counselling. This should debunk common TB gender

[32] Men tend to congregate more in places of alcohol sale and consumption, and male-dominated work contexts, such as construction or mining, whereas women are more likely to be found in the home, or in female dominated work-spaces such as garment factories.
[33] E.g. factories and mining.

misconceptions and respond to gendered barriers to TB care[34] and consequences of infection and disease.[35] It also provides an opportunity to engage all genders about the health and care needs of the family.

7.2.Key steps, actors and cost considerations

7. Community-based case finding			
#	Steps	Key actor/s	Cost considerations
7.1.Goal: Key stakeholders engaged			
7.1.1	Engage key stakeholders, including gender and key population CSOs, government departments and industry and labour leaders	Lead organisation*	
7.1.2	Set up inclusive task team to guide gender aspects of planning, implementation and M&E	Lead organisation	
7.2. Inclusive community mapping			
7.2.1	Assign and contract CSOs to lead regional mapping of congregate areas and TB risk spots	Lead organisation & task team	CSO contract for duration of mapping
7.2.3	Conduct preliminary area fieldwork: Collate current knowledge on TB risk areas; check and augment current knowledge with field research	CSOs	CSO costs: time, travel, communication
7.2.4	Implement regional planning workshops: Map and prioritise high risk settings; collate and prioritise implementation scheduling needs	Lead organisation & CSOs	Regional workshops: facilitation, travel, venues, refreshments
7.3. Goal: Gender-responsive engagement			
7.3.1	Train implementing teams to recognise and respond appropriately to signs of gender-based violence and implement gender-sensitive case-finding: engage trainer, set curriculum, implement training	Lead organisation & gender trainer	Training events: trainer contract, travel, venues, refreshments or online training costs
7.3.2	Set up appropriate diagnostic algorithms: assess current algorithms; adapt for greater sensitivity; adapt/develop SOPs; provide additional resources; train staff in new algorithms	Lead organisation	Additional diagnostic resources

*The lead organisation may be the NTP or a partner organisation

[34] E.g. Cultural restrictions on women's movement to healthcare facilities.
[35] E.g. The greater care burden experienced by women and TB-related stigma.

8. TB services for people who use drugs

People who use drugs often struggle to access health services due to experiences of stigma and discrimination, economic instability, and fears of withdrawal while waiting for services. People who use drugs face additional challenges to access TB treatment and care services. This includes an absence of a harm reduction approach to drug use.[36]Accessible, quick, non-judgemental and integrated services are key to retaining people who use drugs in TB services.

Gender dynamics for people who use drugs are often particularly acute. Women who use drugs tend to have greater exposure to HIV and other blood-borne infections, due to sex work, challenges negotiating sterile injecting equipment use within partnerships and social groups, and exposure to sexual violence. They also often face additional barriers to care, including family planning and other sexual and reproductive health services. Women tend to suffer more severe stigma and social sanction and may fear accessing health services due to concerns that revealing their drug use may result in their children will be taken from them. Women who use drugs who are in intimate partnerships with men may also have their movements, contacts and spending controlled by male partners, limiting their capacity to access services. Transgender communities frequently have high levels of drug use and tend to face even greater barriers to care access due to stigma and discrimination.

Gender-responsive services for people who use drugs require sensitised staff delivering services at community and facility levels (intervention area 1), gender-responsive data and monitoring and evaluation systems (intervention area 2) and a gender-representative workforce (intervention area 3). The focus areas and steps below assume the design and implementation of a rights-based and gender-sensitive harm reduction approach to drug use and TB.[37]

8.1. Focus areas

Inclusive, gender-specific planning and implementation: The design and implementation of any services for people who use drugs must involve people who use drugs at all levels of programme design, implementation and monitoring. Gender-responsive services require that men, women and gender non-conforming people are all engaged and offered opportunities to provide input in gender-separated groups to ensure that everyone is able to voice their needs.

Discrete, low threshold services: The additional stigma and care access barriers faced by women and gender non-conforming people mean that special service times and/or locations should be set up to allow them to access services discretely. Services for all should also be "low-threshold" (easy to access and use) through not requiring appointments, long waiting periods, or official identity documents or fixed contact details. Addition of women-specific items to basic harm reduction kits (women's hygiene materials and female condoms along with syringes, male condoms, wipes and lubricants) can be provided as part of low threshold services.

[36] E.g. Healthcare providers insisting on abstinence, which is generally not a requirement for treatment of infectious diseases, discourages care access.

[37] See "Harm reduction for people who use drugs" The Global Fund [Available from https://www.theglobalfund.org/media/1279/core_harmreduction_infonote_en.pdf]

Staff training and sensitisation: TB programme staff involved in providing services to people who use drugs need to be knowledgeable about the particular challenges faced by women and gender non-conforming people. This should, for example, include the knowledge and skills to recognise and respond appropriately to gender-based violence or gender-based barriers to TB care. TB Programme staff should also be sensitized to provide rights-based responses to people who do sex work as the practices of sex work and drug use frequently overlap.

Psychosocial support for service providers and PWUD affected by TB: Mental health support is a key requirement for comprehensive services for people who use drugs. This should be provided by gender-sensitised healthcare providers. Service providers who are inexperienced at working with the specific, gendered needs and requirements of PWUD are likely to need mentoring and support. People who use drugs and have TB benefit from gender-specific, peer-led support groups where they are able to raise and discuss the particular issues they face. Women who use drugs may benefit from TB counselling that includes their intimate partners.

Case-finding algorithms: In addition to the standard challenges in diagnosing TB in women (see intervention area 5) women who use drugs are more likely to interpret TB signs and symptoms as related to drug use or their psychosocial circumstances. Suitably sensitive screening and diagnostic algorithms are therefore required.

8.2.Key steps, actors and cost considerations

7. TB services for people who use drugs			
#	Steps	Key actor/s	Cost considerations
7.1.Goal: Inclusive, gender-specific planning and implementation			
7.1.1	Engage process lead	Lead organisation*	Process lead contract for intervention period
7.1.2	Set up gender-inclusive PWUD service user advisory teams	Process lead	
7.1.3	Implement regular gender-specific PWUD programme oversight meetings	Process lead & PWUD advisory teams	Meetings: venues, travel, refreshments, participant reimbursement
7.1.4	Develop low-threshold, gender-responsive programme plan: review available information on gender and PWUD, draft intervention plan, present to PWUD advisory teams, adapt and finalise	Process lead & PWUD advisory teams	Review workshop: venues, travel, refreshments, participant reimbursement
7.1.5	Set and meet recruitment targets for PWUD of all genders	Lead organisation	
7.2. Goal: Gender-appropriate, rights-based service provisions			
7.2.1	Sensitise and capacitate staff: Develop curriculum, train staff	Process lead & PWUD advisory teams	Training events: training material development, facilitation, venues, travel, refreshments
7.2.2	Set up appropriate diagnostic algorithms: assess and adapt for sensitivity, adapt/develop SOPs, provide additional resources, train staff in new algorithms	Process lead	Staff training; additional diagnostic resources
7.3 Goal: Psychosocial support for staff and service users			
7.3.1	Set up and implement a mentoring system for TB programme staff: Identify mentors, link staff to mentors, set mentoring terms of reference, implement regular mentoring	Process lead & staff mentors	
7.3.2	Set up and implement gender-specific peer-led support groups for PWUD affected by TB: Identify peer support group leads, train support group leads, develop support group process and schedule; recruit PWUD affeected by TB, implement support groups	Process lead & PWUD peer mentors	Peer training: training material development, facilitation, venues, travel, refreshments, reimbursement; Support group implementation: venues, travel, refreshments

*The lead organisation may be the NTP or a partner organisation

Annex 1

UNDP Gender Integration Spectrum, UNDP (2014)

Type of intervention	Impact	Example
Gender-negative or gender-blind	Fails to acknowledge the different needs or realities of women and men and transgender people Aggravates or reinforces existing gender inequalities and norms.	Lack of disaggregated data because of a failure to acknowledge that programmes and policies have different effects on women, men and transgender people
Gender-sensitive or gender-responsive	Recognizes the distinct roles and contributions of different people based on their gender; takes these differences into account and attempts to ensure that women, men and transgender people equitably benefit from the intervention.	Cash transfer programme provides funds to families to keep girls in school as one element to reduce girls' vulnerability to HIV. Clinic operational hours are changed to early mornings and late evenings to reflect the needs of men and women who work. Outreach workers trained under Project Ashya of The Union have managed to convince 140 HIV positive women to get tested for TB and have counseled and guided these women to being cured for TB thereby improving health seeking behavior of women or girls[11]
Gender-transformative	Explicitly seeks to redefine and transform gender norms and relationships to redress existing inequalities.	Challenges and changes both sexuality norms and uneven access to resources in order to strengthen men and women's ability to insist on condom use by their sexual partners.