

A young Black woman with her hair pulled back, smiling warmly at the camera. She is wearing a white t-shirt and holding a bright red garment. The background is a plain, light-colored wall. The image is overlaid with a dark semi-transparent rectangle containing white text. There are also decorative orange and red lines crossing the image.

Canada

Stop TB Partnership
TB REACH

hosted by
UNOPS

WOMEN'S EMPOWERMENT THROUGH TB PROGRAMMING:

LESSONS FROM
TB REACH WAVE 7 PROJECTS

**TRAINING HEALTHCARE PROVIDERS
ON GENDER-BASED TB CARE PROVISION**



What are the side effects of treatment?



Objective:
To explain the side effects of treatment to the patient.

Learning Objectives:
After this session, the patient should be able to:

- List the side effects of treatment.
- Explain the side effects of treatment.
- Describe the side effects of treatment.

Key Points:
The side effects of treatment are:

- Nausea
- Vomiting
- Diarrhea
- Fatigue
- Hair loss
- Weight loss
- Loss of appetite
- Mouth sores
- Skin rash
- Joint pain
- Headache
- Dizziness
- Blurred vision
- Constipation
- Dry mouth
- Increased thirst
- Increased urination
- Decreased urination
- Decreased blood pressure
- Increased blood pressure
- Decreased heart rate
- Increased heart rate
- Decreased respiratory rate
- Increased respiratory rate
- Decreased oxygen saturation
- Increased oxygen saturation
- Decreased temperature
- Increased temperature
- Decreased pulse
- Increased pulse
- Decreased blood sugar
- Increased blood sugar
- Decreased electrolyte levels
- Increased electrolyte levels
- Decreased kidney function
- Increased kidney function
- Decreased liver function
- Increased liver function
- Decreased lung function
- Increased lung function
- Decreased bone density
- Increased bone density
- Decreased immune system
- Increased immune system
- Decreased mental health
- Increased mental health
- Decreased physical health
- Increased physical health

Key Questions:
What are the side effects of treatment?

Key Answers:
The side effects of treatment are:

Key Messages:
The side effects of treatment are:

Key Takeaways:
The side effects of treatment are:

Key Conclusions:
The side effects of treatment are:

Key Recommendations:
The side effects of treatment are:

Key References:
The side effects of treatment are:

Key Sources:
The side effects of treatment are:



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Document series

This document is part of the series,
**Women's Empowerment through TB
programming: Lessons from
TB REACH Wave 7 Projects.**

- Describes the purpose of the Wave 7 TB REACH funding
 - Sets out key definitions employed
- Outlines and provides direct links to related documents
- Acknowledges key role players in the development of the series

Collectively, this series sets out the experiences and lessons of the Wave 7 TB REACH projects, supported by Global Affairs Canada.

Acknowledgements

Special thanks to Friends for International TB Relief (Vietnam), Icddr,b (Bangladesh), and REACH, Innovators in Health and ZMQ development (all in India), who all shared examples profiled in this document.





1. Introduction

Men, women and gender diverse communities have different TB care and treatment needs. Quality service delivery recognizes and responds to these varied needs. For this to happen all people providing the services – from community health workers to specialist service providers and health managers – must be trained and supported to provide care that is, at minimum, gender-sensitive (it responds to gender inequities) and ideally, gender-responsive (it seeks to rectify gender inequalities).

Supported by Global Affairs Canada, nine TB REACH Wave 7 projects included training for their program’s TB care providers on gender and women’s empowerment and TB care provision.¹ Because of a lack of available TB-specific information related to gender-based care provision training, many of the Wave 7 projects developed new training and support systems and processes for TB care providers.

In a webinar implemented by the TB REACH Wave 7 women’s empowerment team on 5 March 2021, TB REACH grantees shared their activities and experiences. This document draws on grantee inputs to share the lessons and insights gained during the Wave 7 TB REACH work on training healthcare providers on gender-based care provision. The specific examples presented here happen to be from India, but the broad approaches outlined are from over 30 projects implemented round the world.



¹ <http://www.stoptb.org/global/awards/tbreach/wave7cfp.asp>

2. Scope and purpose

This document is intended to serve as a resource and inspiration for others wanting to take a women's empowerment and gender equity approach to health programming. It covers who should be included in training and TB and gender (4) along with key training thematic and content areas (5). It also outlines suggested training methods (6) inclusive of examples provided by Wave 7 grantees and potential learning outcomes for trainees.

This document is a starting point for ideas, rather than an exhaustive or authoritative outline of possible approaches. Here TB is an example, but many of the interventions and approaches could be applied to other health provision areas. Women's empowerment broadly refers to the empowerment of both women and girls; where approaches specifically target girls this is explicitly mentioned.

3. Audience

The document provides insights for any institution, organization or individual wanting to train healthcare providers on gender-sensitive TB care provision.



4. Training participants

The provision of gender-sensitive care requires that all the people planning, implementing, supporting and assessing TB programmes understand why a gender-based approach is necessary and what their role is in the provision of gender-based care. Groups of people to include in the training therefore include:

- All healthcare providers, inclusive of community health workers
- All organizational staff
- Civil society organizations and women's networks, especially those who can serve as partners in developing a gender-based TB response
- National Tuberculosis Program (NTP) representatives

5. Training content areas

Training content for gender sensitive TB care delivery can be grouped into five thematic areas with suggested learning outcomes for trainees after they complete the training:

- 1. How gender affects us all**
- 2. Gender related barriers and facilitators to TB care**
- 3. Biological sex differences and TB care**
- 4. Sex disaggregated data collection, analysis and use for optimal TB care**
- 5. Gender-based counselling and support**

5.1 Everyday life: How gender affects us all

A solid understanding of how gender impacts on everyone, even if they do not realize it, is a baseline requirement for the provision of gender-based care. At a minimum, trainees need to understand that gender is a social construct (i.e. it is a learned, cultural concept) that is different from biological sex. Trainees also need to understand that globally women and girls experience harmful gender discrimination and that the empowerment of women and girls is an ethical approach that benefits everyone.

Healthcare providers also need to know about the ways that gender manifests in their own life and work contexts and how to respond to this.

LEARNING OUTCOMES

5.1 Everyday Life

After the training, trainees should be able to describe how gender can influence:

- Ability to participate in public life
- Access to and control over resources, including health resources
- Access to education and skill development opportunities
- Bodily autonomy or making decisions about one's physical self
- Opportunities to work and equal pay
- Ability to make and act on decisions
- Freedom of movement
- Stigma and discrimination
- Access to information
- Exposure to harmful socio-cultural practices

Two key public resources are available to provide support for this training.

- The UN women "[I know gender](https://trainingcentre.unwomen.org/portal/product/i-know-gender-1-2-3-gender-concepts-to-get-started-in-international-frameworks-for-gender-equality-and-promoting-gender-equality-throughout-the-un-system/)" online course is an accessible online training course on gender equality and women's empowerment. This is set up for UN staff, but is available to anyone. It provides quick and clear training on basic gender concepts, though it is not specifically health related.²
- The WHO "[Gender Mainstreaming for Health Managers](https://genderandaids.unwomen.org/en/resources/2014/09/gender-mainstreaming-for-health-managers-a-practical-manual)", is a comprehensive facilitators guide that provides content and practical exercises for multi-day training.³
- The [Lancet journal series on gender equality](#) in health provides content information.

² <https://trainingcentre.unwomen.org/portal/product/i-know-gender-1-2-3-gender-concepts-to-get-started-in-international-frameworks-for-gender-equality-and-promoting-gender-equality-throughout-the-un-system/>

³ <https://genderandaids.unwomen.org/en/resources/2014/09/gender-mainstreaming-for-health-managers-a-practical-manual>

5.2. Care access: Gender-related barriers and facilitators to TB care

KEY TIPS

- Healthcare providers who are not sensitized to gender often indicate that they provide equal care for men and women and that gender is therefore not a consideration. This indicates that training is needed so that they can recognize and respond to gender-related barriers.
- Focusing on barriers to care is not enough. Facilitators to care also provide essential insight into how care can be improved.

Gender norms and roles can influence accessibility, availability and acceptability of TB care and treatment. Gender can have different impacts at different levels of the care cascade.⁴ For example, men may find it easier to access care than women due to financial resources and freedom of movement, but may find it harder to stay in care due to work commitments. Developing a solid understanding of barriers and facilitators to TB care and treatment will support healthcare managers and workers to design and provide sensitive, optimal care at all stages of the TB care cascade. Barriers and facilitators are dependent on context. This means that training needs to be focused on local realities.

LEARNING OUTCOMES

5.2 TB Care

After the training, trainees should be able to describe how gender might influence:

- Health-seeking behaviors
- Who has health-related decision-making power in households
- Who is prioritized for healthcare within households
- Care roles and their impact (mostly for women)
- Occupational roles and their impact (mostly for men)
- Transport access
- Social habits – such as substance use – and their impact on TB risk, care, and outcomes
- Experiences and consequences of stigma
- Different privacy and confidentiality needs
- Which healthcare providers can be accessed – women may only be sanctioned to access women healthcare providers

⁴ The TB care cascade describes the various stages of the care process from TB screening through diagnosis to treatment completion.

5.3. Biology: Sex differences and TB

There are social and biological differences in the ways that TB affects men and women. For example, on average men experience a higher burden of TB infection and disease than women, possibly due to the protective effects of estrogen for women. At the same time, diagnosing TB is often more difficult in women due to sputum sample quality, higher rates of disseminated TB, and the challenges with diagnosis during pregnancy. Training therefore needs to cover the different biomedical diagnosis and treatment needs of men and women.

LEARNING OUTCOMES

5.3 Biological Sex Differences

By the end of the training, trainees should be able to describe:

- The variance of TB types and different burden rates of these types in men and women (e.g., breast and genital TB in women)
- The biological reasons for generally higher rates of TB in men and lower rates in women
- Risk factors that often have gender dynamics (e.g. substance use for men)
- The proportionally higher TB risks generally faced by adolescent girls due to hormone fluctuation
- Challenges in microbiological confirmation of TB in women and possible needs for alternative diagnostic methods
- Sex and gender differences in common comorbidities
- TB and treatment regimens in pregnant and lactating women
- The influence of pregnancy and childbirth on diagnosis
- Rates and impacts of anemia and malnutrition in men and women
- Treatment considerations for women on hormonal contraception

5.4. Data: Sex disaggregated data collection, analysis and use

KEY TIP

- Training on sex disaggregated data analysis is effectively done through regular, routine assessment of programmatic data along the care cascade that includes team members. For an example of how gender-disaggregated data can be interpreted, see Appendix 1.

Through examining the trends in gender disaggregated data across the TB care cascade, TB care providers should be able to interpret where men, women, or gender-diverse communities are being left out, or have dropped out of care. It is therefore essential that team members, especially at the management level, are proficient in data analysis, interpretation, use and response.

LEARNING OUTCOMES

5.4 Gendered Disaggregated Data

After the training, trainee should be able to describe:

- What data sources are available and how these can be accessed
- How to use data collection tools accurately, including digital tools
- The stages in the TB care cascade
- How to recognize and interpret gendered trends in care cascade data in order to understand who is not accessing and/or staying in care
- How the gendered barriers to care manifest locally at each step of the care cascade
- Gendered differences in time to diagnosis and loss to follow up
- What the data can hide or misrepresent. For example, women may be underrepresented due to stigma undermining treatment seeking
- How to develop responses (research or implementation) to trends seen in the data
- The importance of gathering qualitative data to complement or explain quantitative analysis findings

5.5. Social needs: Gender-based counselling and support

KEY TIP

- The multiple myths that surround TB and pregnancy and the additional challenges of diagnosing pregnant women mean that it is essential to train healthcare providers to provide supportive and informative counselling to pregnant women.

In addition to a solid understanding of how gender affects us all, gendered barriers and facilitators to care, and biological sex differences, HCWs should be capable of using this knowledge for the health and wellness of all people affected by TB. This includes knowing how to provide gender-based counselling and how to recognize and respond to gender-based care needs for girls, women, boys, men and gender diverse people.

LEARNING OUTCOMES

5.5 Social needs: Gender-based counselling and support

By the end of the training, trainees should be able to:

- Counsel women who are pregnant or lactating
- Counsel couples and families in need of TB treatment support
- Understand and respond to the ways in which gender manifests in local TB key and vulnerable populations
- Provide additional support for all people who face additional barriers to care access and completion based on their gender
- Identify and respond to gender-based violence
- Respond to substance use during TB treatment
- Build trust and respond to stigma based on gender identity, sexual orientation, age, ethnicity, occupation, or marital status
- Recognize and respond to malnutrition and to job loss due to stigma
- Recognize and respond to criminalization of sexual orientation and gender identity/ criminalization of drug use and sex work
- Link people affected with TB to local social support mechanisms



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6. Training delivery methods

A wide range of methods can be employed to train about gender-based TB care provision. There is a place for **lectures**, especially to cover key and technical content areas such as, for example, information relating to the national TB guidelines. However, W7 grantees warned against relying on lectures too much and emphasized that experiential learning is more effective. **Self-assessment tools** such as questionnaires about individuals' own situation and perspectives can be used to help individuals recognize the ways that they have internalized gender and how it shapes their own lives (and therefore the lives of others. (See example 1, p20.)

Storytelling can be a very effective way of highlighting local gender norms. It can be particularly effective for ensuring that voices that are usually silenced are heard, or stories that are difficult to tell (e.g. women's stories of stigma) are told. While storytelling is most commonly used with TB affected communities, stories can be an effective training method for HCWs too. Story telling can also feed into the production of **animated short films** that are distributed more widely. (See example 2, p12.)

Training content can also be delivered through **audio modules**. These have the advantage of being available at times that suit trainees, accessible through common local technology, and easily shareable. (See example 3, p23.)

In group contexts, a **powerwalk** can be used to demonstrate the impact of different levels of access to power and resources. (See example 4, p24.)

Brainstorming and **role play** resulting in discussions can both be effectively used to sensitize trainees on gender norms and also to provide training on best possible care responses. **Case studies** – ideally developed from real life examples – can be similarly used. (See example 5, p17.)

Mentoring by a colleague who is more knowledgeable and experienced in working with TB and gender can play an important role in the long term maintenance of gender-responsive care. Learning how to understand and respond to the evidence produced by TB care cascade data is often best done through what we call "**participatory evaluation**", a process in which staff are included in discussions about data trends emerging and how to respond to them.

The next table provides a brief description of each of these methods. Where the method has been particularly recommended for a specific training area, this is mentioned.

Training methods summary

Training methods	Description/purpose	E.g.
Animated short films	Short films demonstrative of local context and/or possible care actions. These can either be accessed individually or shown to groups to generate discussion.	2 & 3, p22
Audio modules	Stories, interviews or lectures recorded in audio and made available and accessible to trainees	4, p24
Brainstorming	Collective idea generation about the ways that gender manifests locally in life and care and ways to respond to it	
Case studies	Short stories illustrative of situations that occur locally that are shared with trainees and used as a basis for generating discussions and solutions	6, p28
Lectures	Content delivered by an experienced teacher to a group. These are generally most effective if delivered in an interactive manner.	
Mentoring	Advice and support from a practitioner experienced in working with gender. This can be provided in real time, or through meetings in which questions are answered and previous learning topics are revised. This may be particularly useful for training on sex differences and TB.	
Participatory evaluation	Group engagement with data generated in the project context. This is particularly useful for training about data use.	
Power walk	A facilitated process in which trainees are assigned characters and asked to stand in a row and then step forward or backwards based on whether they answer "yes" or "no" to a list of questions set up to highlight gender and power differences. This results in a spatial demonstration of how some people "get ahead" and others are "left behind" dependent on their gender and social roles.	5, p27
Role play	A facilitated process in which trainees are provided with scenarios or likely healthcare situations demonstrative of local contexts that they act out and then discuss.	
Self-assessment questionnaires	Questionnaires filled in by the trainees themselves on how they think about gender and the impact of gender in their lives. Group discussions about the answers can be used for collective learning. This is particularly useful for unpacking personal biases and opinions.	1, p20
Storytelling	Stories about gender that are created by the trainees and shared for group learning. Stories can be further disseminated in audio or video form.	3, p23

*For a detailed description of implementing a power walk that demonstrates the ways that social positions (including gender) shape access to health care see the [WHO Gender Mainstreaming for Health Managers guide](#).

KEY TIP

- Select your training participants carefully – people from different backgrounds will need different levels of engagement
- Train in local languages
- Engage the health department and TB control programme to extend impact
- Time the training to fit in with healthcare provider schedules
- Ensure lively interactive sessions
- Use real patient examples and testimonies wherever possible
- Ensure time to socialize and use ice-breakers; gender is a sensitive topic
- Embrace trainees' diverse answers and perspectives

7. Training methods examples

Example 1: Self-assessment questionnaire

Organization: Innovators in Health, India
Website: <https://www.innovatorsinhealth.org/>

Innovators in Health developed self-assessment questionnaires for trainees. Questions were structured for “yes” or “no” answers and shared with trainees who filled them out individually. The facilitator then gathered the questionnaires and collated the answers. The collated answers were then used as a basis for group discussions and trainees were asked to share their own examples of events that related to the questions.

The questions included were as follows:

Home:

1. Are you comfortable sharing your household chores with male members of your family?
2. Do you ask for help from your family members while doing household chores if you feel unwell or tired?
3. Do you think you are often criticized or undermined at home by your family members?
4. If you return from work and feel hungry, but no one else has eaten yet, will you eat or wait for others to eat first?
5. If your favourite meal is cooked and you want to eat more of what is left, would you take more or leave it for others?
6. Do you think you have the freedom to spend your money as you wish?
7. Do you have to ask permission from any male member (husband/father) if you wish to visit any family/friend?
8. Do you have the freedom to wear what you want at home or when going outside?

At work

1. Do you feel confident to share your viewpoints in a team meeting?
2. Have you ever felt that your opinion or suggestions are not valued in your workplace?
3. Did you ever feel that your gender has stopped you from doing particular work assigned to you?
4. Do you think women are assigned stereotypical work in your office?
5. Have you ever felt that you are expected to do the caregiver work during meetings or training sessions? (serve food/clean or take away utensils)
6. Do you feel overburdened trying to balance your household work with office/field work?
7. Do you think the community treats you differently than your male counterpart?
8. Do you think government stakeholders treat you differently than your male counterpart?

Example 2: Lecture and animated video

Organization: icddr,b, Bangladesh
Website: <https://www.icddrb.org>

In Bangladesh, icddr, b used lectures supplemented by simple animated videos to train HCWS who, in turn, counselled community members. In the context of devaluation of girls' health and TB stigma having a greater effect on women and girls, the lectures and discussions highlighted the value womens' and girls' health. Topics included areas such as stigma and marriageability of girls and young women, the need for equal attention to all genders in health assessments, the vulnerability of pregnant women and older women, and various forms of TB, including genital TB. Lectures were accompanied by a simple, short animated video. The video works against gender stereotypes in small, but concrete ways: girl children are shown as sick with TB, a male figure is shown taking a girl child to hospital, a girl and a boy are taken to hospital together, and a girl is depicted wearing a school bag, suggesting the need for girls to be educated, and for their education not to be interrupted by TB.

See: <https://drive.google.com/file/d/1gfTNjzkVvlpRdixC-eeqlpE4sYqIdr8N/view>

Example 3: Storytelling and animated videos

Organization: ZMQ Development, India

Website: <https://www.zmqdev.org>

The ZMQ Development team invited community members of all genders and ages to story development sessions. The trainees were divided into small groups and given topics about which to create stories made up of four to five scenes. Each team had approximately 20 – 25 minutes to discuss the story within the group and draw it on paper. After creating the story, each team presented it in the form of a play or narration using puppets or other props. Once the presentation was over, all the trainees discussed the issue it raised, providing suggestions for responses where this was appropriate.

A representative selection of these stories was then developed in digital format using audio, animations, and characters. The final produced stories were supplemented with local text and a voice-over. These animated videos were then used for awareness campaigns and to generate discussion during training sessions. Stories were made available on YouTube and mobile applications so that trainees could continue to access the stories after training sessions had been completed.

See: <https://www.youtube.com/watch?v=-5drf6G5Ss>
<https://www.youtube.com/watch?v=EUpC6QgZK9M>
<https://www.youtube.com/watch?v=fhmDgbukWxQ>
https://www.youtube.com/watch?v=mVnKkhq1i_M



Example 4: Interactive voice response system audio training modules

Organization: REACH, India

Website: <https://www.reachtbnetwork.org/>

REACH developed interactive voice response system (IVRS) audio training modules for healthcare providers engaged by the Wave 7 project. Named 'CALL for Health' (Continued Access to Learning Line), the training can be accessed through any phone, including feature phones. Training is delivered in the local language in the format of engaging audio plays that resonate with the lives of the people listening. Topics cover TB and gender as well as areas such as substance use, gender-based violence and comorbidities. The topics respond to the knowledge areas requested by healthcare providers. Additional topics are added as needed and modules can be listened to as many times as needed, to cement or refresh knowledge and understanding.

The trainees navigate to the module they want to listen to using a simple numerical system. The modules can be accessed at any time at any place, which can be particularly important for women who need to fit training in around childcare and home duties. The system also records listening patterns, and includes an assessment of each module produced.

Frequent releases of new content keep listeners engaged, and constantly allow them to improve their knowledge, so that they can pass new information on to others in their care and broader communities. This has allowed the project staff to extend their role and has increased respect for them in their communities.

Domestic violence module transcript example

Scene: The character 'Ambalavaanan' is a Peripheral Health worker who had come to this community earlier to talk to people in the village about Hypertension. He took the disguise of an astrologer since people are more likely to approach an astrologer than a health worker. Ambalavaanan is talking about 'gender-based domestic violence', which is common in India but hardly ever spoken about.

Villager: Please tell us in detail what the law says about domestic violence.

Ambalavaanan: Domestic violence constitutes emotional and/or economic harm to a person, endangerment of their health, safety, life, limb or well-being, whether mental or physical, or when someone tends to do so and includes causing physical, sexual, verbal, emotional and/or economical abuse. These are punishable by law.

In the year 2005, a law was passed on domestic violence called the "Protection of Women from Domestic Violence Act 2005." (PWDVA). I told this earlier, but let me tell you again what constitutes domestic violence according to this law: The PWDVA gives a comprehensive definition of violence, allows for protection to women from an abusive husband, explains the role of the Protection Officer, Magistrate, and mentions the fast-tracking provisions and provides for linkage to support services. The 2005 Act states all this clearly.

Villager: But sir, how does domestic violence affect women?

Ambalavaanan: The violence, especially physical violence, that a girl or woman has to endure is not just about one day. The impact of domestic violence extends beyond what she endures today, tomorrow, or three months from now. Domestic violence affects an individual's ability to enter into a relationship with someone of her/his choice, to go out to work, to earn an income, to use public transport and to be financially independent. The threat of violence means that women may lead lives of fear. Most of all, violence denies an individual the right to lead a healthy life, free of injury, illness and disease.

Villager 1: During a fight, the shirt may tear, says my brother Vadivelu!

(reference to popular joke by Tamil/local comedy star)

Villager 2: What's there to be alarmed about violence? Violence is common in all households.

Ambalavaanan: Sir, when we walk on the street, we don't always get into accidents. But aren't accidents happening occasionally? Just like that, arguments may happen at home. But using intimidating words, slapping, hitting, forcing someone to behave the way we want them to, or using any other form of violence is wrong. The violence may cause her a serious injury or danger to her life, limb or health (mental or physical). Why should this happen? How is this justified?

Villager: What is someone wrongly accuses of violence? We will be dragged to police and court. Nowadays this happens too!

Ambalavaanan: When a husband uses violence on his wife, where should she go for help? Violence can cause depression, disturbed sleeping patterns, frequent menstrual pain, lack of appetite or aversion to food, and also affects women psychologically.

Villager 3 (woman): So what to do? If she marries a donkey, won't she be kicked? (cites common Tamil proverb)

Ambalavaanan: Sister, we live only one life. We have the right to live that life happily and peacefully. Beating, fighting, being in pain – does anyone want to live like this?

Example 6: Case study on gender sensitive TB diagnosis and treatment

Organization: Innovators in Health, India
Website: <https://www.innovatorsinhealth.org/>

Innovators in Health used a real example of a young women needing TB care in North Bihar, the area in which they work. This was read to healthcare providers and used as a starting point for a discussion, which was guided by set questions.

Case study:

Seventeen-year-old Shrishti is a native of Bibhutipur block in North Bihar. A few months back, she fell ill and faced severe symptoms like high fever, coughs and lack of appetite. She lives with her four siblings, parents and grandparents. Her father is a daily wage laborer and the sole earner in the family. Her family can barely manage two square meals per day, and did not pay heed to their eldest daughter's health condition. Shrishti herself felt ashamed that she kept coughing all the time and started distancing herself from her friends and family and hid her symptoms from them. After one and half months, her condition deteriorated further to a point that she could barely get up from her bed. Her father then asked a rural medical practitioner (RMP) to check her. After looking at her symptoms, the RMP suspected that she might have TB and suggested the family visit a private doctor or take her to the public health system. Her parents requested the RMP to treat her at home and ensure no one in their village gets to know that their daughter might have TB. They were already looking for prospective grooms for her marriage in the next two years and this news would ruin their prospects to get a suitable groom. Her treatment under the RMP continued for three weeks with little improvement.

Discussion:

Let's discuss what went wrong in the few months, from the onset of the symptoms, till she could access TB care, which was available free of cost at a government health facility 15 kms from where she lived.

1. What stopped Shrishti's family from taking her to a doctor in the first place?
2. What were all the challenges faced by Shrishti before she could access care?
3. If, instead of Shrishti, her 13-year-old brother was in this position, would he have faced similar challenges? Give reasons.
4. How could the delay in identification and diagnosis have been reduced?

Appendix 1: Gender disaggregated data analysis examples

In Wave 6 and Wave 7, the Stop TB Partnership's TB REACH initiative funded two projects in Viet Nam: IRD undertook community-based chest X-ray (CXR) screening in Wave 6 and Friends for International TB Relief (FIT) implemented private sector engagement in Wave 7. Both projects implemented activities across Hai Phong, Viet Nam third largest city. The cumulative Male : Female Ratio (MFR) of people diagnosed and treated for tuberculosis (TB) in this intervention site is 2.3. This is substantially lower than the MFR of 4.0 recorded during Viet Nam second TB prevalence survey⁵ and warrants further investigation through a gender-disaggregated analysis of project data.

Innovative Health Systems (IRD) Viet Nam: Community-based chest X-Ray Screening

The IRD project has screened substantially more females with CXR in the community than males (13,612 vs 8,940; MFR: 0.7). However, more males have been diagnosed and treated for TB than females (70 vs 20; MFR: 3.5). This MFR for All Forms of TB treated is broadly in line with the MFR of TB detected in the prevalence survey, indicating that there are no major gender-specific barriers/biases in participant mobilization, screening and/or testing.

	CXR Screens				All Forms TB Treated			
	Total	M	F	MFR	Total	M	F	MFR
IRD VN Project	22,552	8,940	13,612	0.7	90	70	20	3.5

5 The second national tuberculosis prevalence survey in Vietnam <https://doi.org/10.1371/journal.pone.0232142>

Friends for International TB Relief (FIT), Viet Nam: Private Sector Engagement

FIT's private sector engagement project has two strategies: 1) diagnostic referrals and treatment in public or private sites and 2) private TB treatment reporting and notification. In the project's first strategy, slightly more males were screened by CXR than females (20,622 vs 19,557; MFR: 1.1). In addition, more males have been diagnosed and treated for TB than females (584 vs 239; MFR: 2.4). This MFR is substantially lower than prevalence survey detection data, but is the same as public-sector TB notifications in the project's intervention area (MFR 2.4). These data indicate there are likely barriers which prevent males from being screened, detected and/or treated for TB at health facilities.

	CXR Screens				All Forms TB Treated			
	Total	M	F	MFR	Total	M	F	MFR
FIT Project, Strategy 1	40,179	20,622	19,557	1.1	823	584	239	2.4
Public-sector Intervention District Notifications					2,308	1,677	703	2.4

	Total	M	F	MFR
FIT Project, Strategy 2	529	351	178	2.0

In the project's second strategy, more males were privately treated for TB than females (529 vs 351; MFR: 2.0). The MFR for private TB treatment is even lower than the MFR observed in public sector treatment (MFR 2.0 vs 2.4), indicating that males face additional barriers for accessing TB treatment at private sites, or possibly that females preferentially seek TB treatment in the private sector. There is extensive evidence that women disproportionately suffer from stigma of TB and discrimination, which is often a barrier for health seeking.^{6,7,8} Additionally, women and girls in Viet Nam are particularly concerned about the confidentiality of their TB diagnosis and treatment, and they often go to extensive lengths to hide their disease⁹ Confidentiality is one of the major value propositions for seeking TB care in the private sector rather than in the public sector.^{10,11,12}

While the combined data indicate that Viet Nam TB REACH projects have an overall low MFR of 2.3, project- and strategy-disaggregated data provide a more nuanced understanding of gender dynamics for TB case finding. A strategy of community-based CXR screening can result in no/few barriers for TB screening, detection and/or treatment, whereas facility-based screening likely results in access barriers primarily affecting males. Private TB treatment in Viet Nam, may be preferentially sought out by females as a stigma avoidance or coping strategy.

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