



TB DIAH Gender Strategy

November 2021



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Introduction

Gender equality is critical to achieving global public health goals, and the international public health community recognizes that programs and policies need to address gender-related inequalities and disparities (e.g., World Health Organization [WHO], 2015; United Nations [UN], 2015; The United States President's Emergency Plan for AIDS Relief [PEPFAR], 2013). Strong gender-integrated health programs require sufficient high-quality data to assess program implementation and the gender and health outcomes of their activities, and to guide decision making at the local, subnational, and national levels.

For tuberculosis (TB) programs, it's important to understand how gender drives outcomes and influences transmission, testing, treatment, and adherence. Monitoring and evaluation (M&E) activities can help determine whether TB activities promote gender equity or exacerbate gender inequalities.

This document describes the approaches that will be used to integrate gender into the TB Data, Impact Assessment and Communications Hub (TB DIAH) project. **The objectives of this strategy are to enable TB DIAH to integrate gender across the three intermediate results (IRs) and associated strategic approaches and enable the project to monitor and learn from its implementation of gender integration approaches.**

This gender strategy describes the importance of gender in TB data and how the project will address gender under the three IRs and associated strategic approaches, monitor progress toward and outcomes of gender integration, and continue to learn about the issue. The strategy also describes the TB DIAH systems that will help to implement and monitor gender integration. The strategy will allow TB DIAH to monitor its responsiveness and accountability regarding gender integration to USAID and the stakeholders it supports and serve as a learning tool for the project.

The gender strategy is a living document and should be adapted as necessary to ensure that the project can effectively meet its gender integration objectives.

Gender and TB

How gender influences TB has been a neglected research area, and little attention has been paid to gender in TB control. Globally, TB affects men at much higher rates than women. Adult men accounted for 56% of all TB cases in 2020; by comparison, adult women accounted for 33% and children for 11% (WHO, 2021). While men are more likely to report risk factors associated with TB exposure (van den Hof, 2010), men are less likely to have TB detected and reported than women, and men account for the majority of TB deaths among HIV-negative and HIV-positive people (WHO, 2021).

However, TB progresses more quickly in women of reproductive age than in men of the same age group (UN Development Programme [UNDP], 2015). TB is the reported cause of 6–10% of all maternal mortality in settings with low HIV prevalence, and 15% in settings with high HIV prevalence (UNDP, 2015).

As pointed out in the Global Fund’s “Technical Brief: Tuberculosis, Gender and Human Rights” (2020), gender-related risks and barriers to TB services take many forms and affect everyone:

A growing body of literature highlights how notions of masculinity can negatively impact health-seeking behavior of men, which may be manifested as late or missing TB diagnoses and lower rates of TB treatment access and completion. In many places, men are more likely to have employment, such as mining or blasting, that is associated with increased risk of TB. Men are more likely to engage in behavior with increased risk of TB, including smoking, alcohol consumption, and drug use.

On the other hand, women may have less access to TB treatment and prevention services than men due to cultural norms and inequalities. For women and girls, diagnostic delays and lower service efficiency may be due to increased stigma associated with having TB and the non-integration of TB services with other reproductive, maternal and child health services. Women may have difficulty gaining access to TB services because male family members are unwilling to pay for these services, women’s health may not be considered as important as that of male family members, or because TB in women is more stigmatized than in men. Women generally wait longer than men for diagnosis and treatment and may be discouraged from seeking care by a lack of privacy or child-care facilities in health care settings. In some settings, women have been less likely to undergo sputum smear examinations due to cultural norms and perceptions about femininity as well as gender dynamics of service provision.

Studies from Vietnam show that women with pulmonary TB are diagnosed on average two weeks later than men due to health care provider delays. Negative social consequences have been shown to be more of importance to women, and stigma is still associated with TB disease (Thorson et al, n.d.).

Because TB kills more women and men than any other infectious disease, including malaria and AIDS, it is important to understand how the disease affects women, men, girls, and boys differently so programs and interventions can be tailored appropriately.

Gender Clauses in the Leader Award

The TB DIAH project is an Associate Award of the MEASURE Evaluation Phase IV Leader Award. As such, gender clauses from the Leader Award flow into the TB DIAH Associate Award. These clauses were developed in response to USAID's 2011 Gender Policy document. Specifically, the MEASURE Evaluation Phase IV Cooperative Agreement¹ states:

As described in USAID's Gender Equality and Female Empowerment Policy [2012], gender equality and female empowerment are core development objectives, fundamental for the realization of human rights and key to effective and sustainable development outcomes: (1) To reduce gender disparities in access to, control over, and benefit from resources, wealth, opportunities and services; (2) To reduce gender-based violence (GBV) and mitigate its harmful effects on individuals; and (3) To increase the capability of women and girls to realize their rights, determine their life outcomes, and influence decision-making. Strengthening the fields of M&E and health information system (HIS) is critical to the documentation of these outcomes.

MEASURE Evaluation Phase IV will play a technical leadership role in the growing field of gender-related M&E and will offer innovative M&E guidance and tools to support gender-sensitive programming and policy making in the health sector. The project will work to ensure that gender becomes integral to existing and newly created M&E systems. It will facilitate the collection of high-quality, sex-disaggregated data and will build capacity at country and global levels for the effective use of gender sensitive data for program management, development of innovative interventions, informed policy making, and health system strengthening. (Page 102)

Updated Guidance from USAID

In 2020, USAID issued updated guidance in the Gender Equality and Women's Empowerment Policy. The global health section of that document makes specific comments related to TB and to requirements for USAID's operating units (OUs) to report on cross-cutting indicators related to gender. The policy states:

There are important differences between men's and women's vulnerabilities to infectious diseases...The impact of stigma-related barriers associated with a diagnosis of TB also differs between men and women, insofar as such barriers relate to health-seeking and treatment-retention behavior and outcomes. Men are more likely to experience stigma in the workplace and community after a TB diagnosis, while women experience more social isolation or shunning and stigma from family. (Page 36)

Regarding Agency requirements, the policy explains:

In annual PPRs [performance plans and reports], OUs must report on results realized during the reporting fiscal year, including by using the standard indicators maintained by the Office of Foreign Assistance at the US Department of State which are required as applicable. The master indicator list includes cross-cutting indicators that cover gender equality, women's empowerment, GBV, women's economic empowerment, and W-GDP [women's global development and prosperity] and WPS [women, peace, and security]. All USAID OUs should work with implementation partners to collect data and report on one or more of the standard

¹ Cooperative agreement number No. AID-OAA-L-14-00004.

indicators on gender if the OU's programming produces data that contribute to the measurement of these indicators. In addition, all USAID's people-level standard and custom performance indicators must be sex-disaggregated. (Page 46)

TB DIAH Intermediate Results and Gender Integration

The objective of TB DIAH is to ensure optimal demand for and analysis of routine and nonroutine TB data for decision making, performance management, and informing national governments, ministries of health, national TB programs (NTPs), USAID, and other stakeholders' interventions and policies. To achieve the overall project objective, the award stipulates three IRs:

IR 1: Strengthened collection, analysis, and use of routine health and TB data

IR 2: Improved design and implementation of M&E frameworks and information gathering processes, including tools, methodologies, and technical guidance to meet users' needs

IR 3: Strengthened reporting and communication as well as methods, tools, and approaches improved and applied to address communication gaps

Under TB DIAH, achieving the IRs will lead to a cycle of improved evidence generation, analysis, presentation, and improved use of performance-based measurement systems to inform maximize resources.

Gender Integration across TB DIAH Outcomes

Gender integration begins with identifying gender differences and inequalities and the resulting implications for specific programs, projects, and research. Gender integration is the process of addressing these differences and inequalities in the design, implementation, monitoring, and evaluation of programs (Data for Impact, 2021).

This section of the gender plan describes how gender will be integrated across the TB DIAH outcomes (IRs), assuming adequate funding, Mission support, and applicability to the activity. Gender will be addressed under the IRs as follows.

Data Collection

The first step to understanding potential gender inequalities is to disaggregate key indicators by sex and age. The

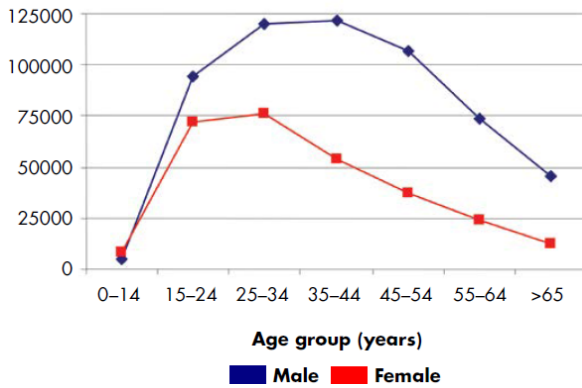
Key Gender and TB Questions

One can ask a number of questions to assess if and how gender influences TB data and outcomes. We list some here:

- Are there differences in exposure or risk between men, women, boys, and girls?
- Are differences in exposure or risk a result of traditional gender norms, expectations, behaviors, or occupations?
- Are there biological differences between the sexes that may affect susceptibility to TB infection?
- Are there gender differences in access to information or knowledge about TB?
- Are there gender differences in who is being immunized for TB?
- Are there gender differences in TB case detection?
- Are there gender differences in obtaining medical treatment?
- Are there gender differences in how TB patients are treated?
- Are there gender- or biological-related patterns in treatment outcomes?
- Are there gender differences in who is completing referrals for TB treatment or testing?
- Are there gender constraints around who has the authority to access health services?
- Do women need permission to seek services for themselves or their children?
- Are there social or cultural perceptions about seeking healthcare?
- Are women or men more likely to care for the sick?

(MEASURE Evaluation, 2017)

Figure 1. Notifications of new smear-positive TB cases, by sex and age, Southeast Asia



Source: WHO Southeast Asia Regional Office

resulting data can identify where, when, and if gender inequalities exist, as shown in Figure 1.

Most routine health information systems do not disaggregate TB outcome data by sex beyond the facility level. We will address the gap by advocating for disaggregation in these systems and strengthening the capacity of NTPs in data collection and analysis, disaggregated by sex² and age where it is not already occurring, by promoting analyses that highlight sex differentials and gender effects and by demonstrating how to present and use the findings. Integrating attention to gender during the development of applications and automated analyses will ensure that data users see relevant

data presented by sex, which otherwise might be overlooked.

Among the ten core indicators in the PBMEF, which are now part of the PPR reporting for Missions, eight require sex disaggregation (or, in contexts where there is a third gender option, such as certain Asian countries, data for these indicators should be disaggregated by gender). Countries reporting against these core indicators will be encouraged to keep the sex disaggregations as the data is reported up and conduct data analysis to inform programmatic course corrections based on the potentially varied differences in indicators by sex.

² Although the goal is for data categories to include transgender, intersex, etc., and some partners and Missions are moving toward this goal, most data currently are still limited to male or female sex only. For that reason, we use the term “sex-disaggregated” rather than “gender disaggregated.”

We will help strengthen the capacity of NTPs to assess what types of data are best suited to answer gender- and health-related questions. For example, some gender and health questions involving relationship and power dynamics are too nuanced and complex to be answered through routine or other quantitative data.

We will also support NTPs to address gender in their data gathering processes. The local gender context affects how data collection can be conducted, including where and when subgroups can be interviewed, the age and sex of the interviewer, the type of TB information shared with communities, and many other aspects of implementation. We will work with NTPs and activity leads, as needed, to identify gender aspects of data collection and other M&E processes to ensure they are integrating gender as much as possible. With this enhanced capacity, NTPs can design data collection efforts that are stronger and better able to answer the client's questions and yield valuable evidence to inform program development and policies.

Development of Tools, Questionnaires, and Curricula

Drawing from experience under the leader, TB DIAH will integrate gender into any development of curricula, including the TB M&E training. TB DIAH should consider how gender can be incorporated into project products such as the Performance-Based M&E Framework (PBMEF), Data to Action (D2A) Continuum, and the Assessment of TB Data Collection, Reporting, and Analysis Capacity (ARC) tool. Integrating gender into these products will help TB DIAH achieve broader dissemination of capacity strengthening on gender and data collection, and will allow use to extend beyond immediate local partners.

In helping NTPs develop database tools for health information systems, we will push for allowing sex- and age-disaggregated TB data.

Integrating Gender into National Statistics

The UN definition of gender statistics shows what is involved in integrating gender into any statistical system, such as an HIS. The four components relate to how data are collected, analyzed, and disseminated:

- 1) Data are collected and presented by sex wherever applicable;
- 2) Data that reflect gender issues are produced;
- 3) Data are based on concepts and definitions that accurately reflect the diversity of women and men and capture all aspects of their lives;
- 4) Data collection methods consider and find ways to overcome stereotypes and social and cultural factors that may cause gender bias in the data.

(WHO, 2021)

Development of Reports, Publications, and Products

Gender will be addressed through systematic inclusion in data visualization applications, such as dashboards and automated programming, to highlight gender-related (and age-related) findings for data-informed decisions. In addition, TB DIAH will explore innovative ways to include gender-sensitive information in data interpretation products and data visualizations, such as the way data is presented in Figure 2. This will encourage data producers and users to think beyond sex disaggregation.

It is essential to include gender data in data visualization products and tools because it will help data analysts and decision makers easily identify gender gaps, generate demand for increased gender data, and lead to action planning to address such gaps. During our work to strengthen the capacity of NTPs to use data visualization techniques, TB DIAH will promote the importance of gender throughout the development and institutionalization of applications.

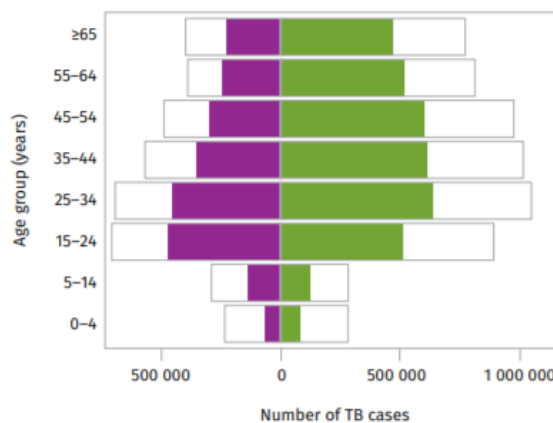
Gender will be woven throughout data use approaches and plans, ensuring that attention to gender gaps, best practices, or opportunities for improvement revealed by the evaluation are available to meet users' needs when they need them, and in easily digestible formats.

Trainings, Workshops, and Stakeholder Engagement

In our assessment of capacity and skill needs as well as planning for capacity strengthening, we will ensure we are paying attention to how gender plays a role in our processes. For example, whenever possible, we will endeavor to work with male, female, and gender and sexual minority staff of local partners and in-country teams, assessing needs across all groups. Also, we will pay attention to whether female staff may be disadvantaged in relation to taking part in capacity strengthening opportunities because of conflicting gender role responsibilities (e.g., they cannot travel to an activity in another city because of childcare obligations).

While engaging stakeholders, we will be conscientious to make sure all voices are heard. We will be aware of our own biases when engaging with local partners and respect women's and men's viewpoints equally.

Figure 2. Global estimates of TB incidence (black outline) and case notifications of people newly diagnosed with TB disaggregated by age and sex (females in purple; males in green), 2020



Source: Global TB Report 2021, WHO

Monitoring, Evaluation, and Learning Plan

TB DIAH’s Monitoring, Evaluation, and Learning (MEL) plan clarifies the steps taken by the project to monitor gender.

Activities that support achievements against specific project indicators A1, A2, A3, A5, A6, A8, B1, B2, B3, B6, C1, and C2 (Table 1) will include practices that address the UN Sustainable Development Goals 5³ and 3⁴, Target 3.3, WHO recommendations, and USAID priorities. The documentation of results against these indicators will include specifics about gender integration in data management, analysis, and use practices, if available. Many TB indicators reported to the WHO are not sex- (nor age-) disaggregated. But when possible, our data systems will collect and report disaggregation by sex for improved analytics and decision making. These data will be tracked by the project management information system.

Table 1. TB DIAH’s Gender-Relevant Indicators

No.	Indicator
A1	Number of TB data hub resources (e.g., reporting tools, templates, dashboards, etc.) developed/updated by TB DIAH
A2	Number of assessments completed by or with support from TB DIAH
A3	Number of field-funded TB M&E and surveillance strengthening activities (12+ months in length) completed
A5	Number of countries that requested support from TB DIAH for PBMEF reporting
A6	Number of products (e.g., reports, visualizations, guidance etc.) developed/updated by TB DIAH
A8	Number of individuals reached through TB DIAH electronic media dissemination of TB information products
B1	Number of countries that utilized a TB data hub resource to produce a TB information product (e.g., reports, visualizations, etc.)
B2	Number of use instances of an action plan by a TB stakeholder following completion of an assessment
B3	Proportion of field-funded TB M&E and surveillance strengthening activities that result in a demonstrated change in a specific M&E and surveillance practice
B6	Proportion of TB DIAH products used by a TB stakeholder
C1	Number of countries that use TB M&E and surveillance data for TB program and/or policy decision making
C2	Number of countries that demonstrate a change in the performance of a TB M&E and surveillance system

³ United Nations Sustainable Development Goal 5—Achieve Gender Equality and Empower All Women and Girls. Retrieved from <https://sustainabledevelopment.un.org/sdg5>

⁴ United Nations Sustainable Global Development Goal 3—Good Health and Well-Being; Target 3.3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. Retrieved from <https://sustainabledevelopment.un.org/sdg3>

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Appendix: Definitions

Gender is the culturally defined set of expectations about the roles, rights, and responsibilities associated with being female and male, as well as the power relations between and among people based on those expectations. Gender varies over time and within and between cultures.

Transgender persons, whether they identify as women or men, are also subject to these gender expectations. (Interagency Gender Working Group [IGWG])

Sex refers to the classification of people as male or female. At birth, infants are assigned a sex based on a combination of bodily characteristics including chromosomes, hormones, internal reproductive organs, and genitalia. (USAID, March 2012 Gender Equality and Female Empowerment Policy)

Gender identity refers to a person's deeply felt internal and individual experience of gender, which may or may not correspond with their sex assigned at birth. This includes the personal sense of the body which, if freely chosen, may involve modification of bodily appearance or function by medical, surgical, or other means, as well as other expressions of gender including dress, speech, and mannerisms. (American Psychological Association [APA], 2015)

Sexual orientation refers to whom a person is physically, spiritually, and emotionally attracted. Categories of sexual orientation typically have included attraction to members of one's own sex (homosexual), attraction to members of the other sex (heterosexual), and attraction to members of both sexes (bisexual). While these categories continue to be widely used, sexual orientation does not always appear in such definable categories and can occur on a continuum and be fluid. (APA, 2012). Public health professionals often use the abbreviations MSM (men who have sex with men) and WSW (women who have sex with women) as neutral terms to describe sexual activity of individuals, which may not necessarily correlate with a person's sexual orientation.

Gender equality is the concept that all human beings are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices. Gender equality means that the behaviors, aspirations, and needs of all people are considered, valued, and favored equally.

Gender integration entails identifying gender differences and the resulting inequalities pertaining to specific programs and projects. Gender integration is the process of addressing these differences and inequalities in the design, implementation, monitoring, and evaluation of programs. (USAID, March 2012 Gender Equality and Female Empowerment Policy)

Gender analysis is a systematic way of looking at the different impacts of development, policies, programs, and legislation on women and men that entails, first and foremost, collecting sex-disaggregated data and gender-sensitive information about the population concerned. Gender analysis can also include the examination of the multiple ways in which women and men, as social actors, engage in strategies to transform existing roles, relationships, and processes in their own interest and in the interest of others. (Global Fund Gender Equality Strategy, 2009)

Sex- and age-disaggregated indicators are regular health indicators that are presented both for men and women or boys and girls. We emphasize disaggregating by sex because most data are collected according to male and female sex. However, some surveys are beginning to include

other identities, such as transgender, in which case the data would be disaggregated by gender identity. Striving to include all gender identities in future M&E efforts will enhance health- and gender-focused programs by allowing them to understand and respond to all gender differences. (Population Reference Bureau's Framework to Identify Gender Indicators for Reproductive Health and Nutrition Programming, 2002)

Gender-sensitive indicators are those that address gender directly and go beyond sex disaggregation alone, for example: gender-based violence, complex indicators such as gender attitudes and norms, power differences, female autonomy, and access to educational and economic opportunities. Gender-sensitive indicators should be disaggregated by sex when possible. Gender-sensitive indicators make it easier to assess how effectively gender dynamics that negatively influence health service access and outcomes have been addressed. (USAID, ADS Chapter 205)

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