



HIV/TB Gender Assessment Workshop

Building capacity for TB activists to advance gender equality through Global Fund and national Programmes REPORT



**Nairobi, Kenya
13-15 January 2015**

Co-Organised by the Global Fund, the Stop TB Partnership, UNAIDS, the Global Coalition of TB Activists (GCTA) and AIDS Strategy, Advocacy and Policy (ASAP)

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Acronyms and abbreviations

CCM =	country coordinating mechanism
CRG =	Community, Rights and Gender
GCTA =	Global Coalition of TB Activists
Global Fund =	Global Fund to Fight AIDS, Tuberculosis and Malaria
NSP =	national strategic plan
SSA =	sub-Saharan Africa
TA =	technical assistance
TB =	tuberculosis
UNAIDS =	Joint United Nations Programme on HIV/AIDS
WHO =	World Health Organization

Executive Summary

Gender dynamics in prevention, health seeking and treatment behaviour of men and women living with HIV, TB-HIV co-infection or suffering from TB vary substantially and require a systematic assessment from a gender perspective. Gender assessments play an important role and inform national planning and budgeting for gender-responsive TB and gender-transformative HIV responses, including developing plans and programmes for joint TB/HIV applications for support from the Global Fund under their new funding model.

Recognising this UNAIDS, the Stop TB Partnership and the Global Fund, are working together to enhance support for countries that wish to improve their ability to analyse TB and HIV programming in a gender sensitive manner. The Stop TB Partnership has worked closely with UNAIDS, with support from the Global Fund, to extend the existing HIV gender assessment tool to include TB and have developed the tool for national HIV and TB responses, now called the *HIV/TB Gender Assessment Tool*.

The aim of this workshop was to strengthen the capacity of TB activists and gender equality advocates to integrate gender equality perspectives in TB and HIV national programme planning. The workshop was also an opportunity to ensure that key advocates understood and are able to use the new TB/HIV Gender Assessment Tool as well as contribute to the development of the “Cheat sheet” with gendered interventions that will support programming on TB and TB/HIV from a gender equality perspective. Workshop also provided an opportunity for stakeholders already strongly involved in the Global Fund to explore the Global Fund as a spring board for better integration of gender in Global Fund resourced TB and HIV.

Discussion ended with a few next steps to be taken by the Stop TB Partnership such as;

- Reviewing and integrating all comments on the **Tool**. Participants were invited to submit additional comments by 31 January 2015
- **Pilot-testing** of the Tool will be done in Lesotho, most likely in April. Lessons learned will be disseminated as part of a training for consultants who will conduct similar assessments in other countries.
- Reviewing all detailed notes on the ‘**cheat sheet**’ and developing a revised version.

1. Introduction and Overview

Tuberculosis (TB) has long been one of the world's most persistent and deadliest health threats. In India alone, some 1,000 people die of TB each day. Worldwide, TB is responsible for 25 percent of the deaths of all people living with HIV. An increase in infections of drug-resistant strains means that curing TB among a large share of people is time-consuming, debilitating and expensive, thereby placing greater burdens on patients, caregivers and health care systems.

Yet despite its massive health toll, TB remains poorly understood, addressed or prioritized by donors and governments alike, especially in comparison with conditions such as HIV and malaria. TB's low profile also is clearly seen in the relatively limited data and evidence as to its impact in many countries. Effective responses and programmes rely on decent data; when insufficient or inadequate information exists, it is difficult to design and implement interventions that reach those in need in the best ways possible. Community and other civil society advocates worldwide can play key roles in demanding for, and helping gather, better TB-related data and evidence.

An important component of such work should focus specifically on TB and gender, a relationship that is often unexplored and not reflected in programmes and interventions. TB appears to affect men more commonly than women, in general, but the absence of sex-disaggregated data or thorough analysis of the structural drivers of the disease in different contexts make any conclusions difficult to draw. For this reason and others, the relationship between TB and gender was at the centre of a global workshop held in Nairobi, Kenya from 13-15 January 2015 that was attended primarily by community-based advocates and representatives of several leading multinational allies.

1.1 About the workshop

The workshop was sponsored by the Global Fund and organised by the Stop TB Partnership in collaboration with the United Nations Programme on HIV/AIDS (UNAIDS) and the Global Coalition of TB Activists (GCTA), with support provided by AIDS Strategy, Advocacy and Policy (ASAP). The more than 30 participants, who represented 21 nationalities, included 17 from community and other service-delivery groups, 11 from organising partners and 3 support personnel. (Annex 1 contains a full list of all participants.)

All but four of those at the workshop were women. The attendees had a range of experience, with some having expertise primarily on gender issues; some having had TB in the past or having family members with the disease at some point; some having worked directly with TB patients and/or community or patient groups focused on TB; some with primarily research backgrounds; and some who were living with HIV and whose work largely focused on that epidemic. Also, some had direct experience engaging with the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the leading funder of TB programmes worldwide, at country level. (Several participants could fit comfortably in more than one of the above categories.)

The main overall goal of the workshop was to help to advance gender equality in TB programming and responses. The following objectives were specified at the beginning of the workshop:

- to strengthen the capacity of TB activists and gender equality advocates to engage at country level with national planning, and the Global Fund and its funding model, from a gender equality perspective;
- to ensure that key advocates understand and are able to use the new TB/HIV Gender Assessment Tool, developed by UNAIDS with the Stop TB Partnership and supported by the Global Fund;
- to take steps to develop a core list of gendered interventions that will support programming on TB and TB/HIV from a gender equality perspective;
- to strengthen partnerships and engagement between gender equality advocates, TB activists, including people personally affected by TB, and stakeholders already strongly involved in the Global Fund; and
- to build mutual capacity in gender, TB and Global Fund processes securing high level engagement with the Stop TB Partnership, Global Fund and UNAIDS from a gender equality perspective.

The workshop included two main types of activities: i) informational (through presentations and plenary discussion) and ii) brainstorming and feedback (through working groups). The informational activities were designed primarily to give some essential background on TB and gender, with the others geared toward soliciting participants' input on the most recent draft of the TB/HIV Gender Assessment Tool. UNAIDS and its partners will use the comments and suggestions from participants when reviewing and revising the Tool and associated products aimed at 'genderizing' TB programming.

1.2 About this report

This report provides a summary of presentations, discussions and working groups input from the 13-15 January Nairobi workshop. It is not intended to be an in-depth account of all proceedings and thus does not necessarily discuss all information and resources chronologically or extensively (if at all). Instead, by providing an account of the workshop it aims to support advocacy and decision-making efforts related to key TB- and gender-related concerns and priorities as well as efforts to finalize the TB/HIV Gender Assessment Tool.

The report is structured as follows:

- background information on TB and gender, including the Global Fund's role (Section 2);
- presentation of and input provided on the TB/HIV Gender Assessment Tool (Section 3);
- presentation of and input provided on a 'cheat sheet' for helping incorporate gender-sensitive TB programming (Section 4); and
- planned next steps (Section 5).

The report also contains a full list of participants (Annex 1).

Background material, including the full text of many of the presentations, is available at www.stoptb.org

2. Background TB, Gender and Programming

The first part of the workshop consisted of a series of presentations that provided background information and observations. Collectively, they covered technical, political, social and financing aspects such as building a movement on TB and gender, existing data and evidence, and the role of and opportunities available through the Global Fund. The intention was to set the scene and context before participants considered the TB/HIV Gender Assessment Tool.

Summaries of the presentations and subsequent discussion are provided below.

2.1 Building a movement and existing evidence

2.1.1 Key definitions and mobilization

A conceptual presentation on TB and gender included discussion of a couple of key definitions:

- Important distinctions should be made between the terms '**sex**' and '**gender**'. At the core, the former is inflexible while the latter is flexible. Sex is biological, something one is born with, which cannot be changed, and which does not vary by culture or context. Gender, meanwhile, refers to a socially constructed set of rules and responsibilities. It is something that can be learned and personally determined; as such, it can be changed and there are variations by culture, context and over time.
- Two similar terms, '**gender equality**' and '**gender equity**', are also often used interchangeably even though they have different meanings and implications. Equality refers to men and women having equal value and thus being treated equally. Yet establishing conditions of equality does not always mean everyone can participate or has access to what she or he needs. Tipping the balance is sometimes necessary to ensure gender equity – when, for example, resources, programmes and decision-making are available to both females and males without any discrimination or imbalance on the basis of sex. As such, proactive measures sometimes must be taken to achieve gender equity even when gender equality is established or mandated. Advocates should keep in mind that 'equal' sometimes does not work for everyone.

The definitions above are important to understand when considering TB and gender, including the associated differences and gaps in impact and data. For example, although about 60 percent of TB cases and deaths occur among men, the impact on women is also extremely high and may not be fully recorded. That is because TB affects women differently and, perhaps, disproportionately. In 2013, for example, an estimated 3.3 million women fell ill with TB and 510,000 women died from the disease. Also, i) of all HIV-related TB deaths globally, around half (180,000) were among women; ii) TB is among top killers of women of reproductive age; and iii) huge numbers of young women and girls are getting TB and dying.

Moreover, disproportionate impact on women can be seen in TB's effect on maternal health. It is linked to higher risk of stillbirth and deaths from haemorrhage, and genital TB – which is

notoriously difficult to diagnose – has been identified as an important cause of infertility, which is highly stigmatizing in many cultures.

Such factors and associated gaps in data and services underscore the need for a movement to better address them. As one participant put it, building a movement in general occurs when like-minded people come together to achieve something. Mobilization for any movement, including for TB and gender, requires will, allies, belief, commitment and agreement on most key issues. It also requires passion, which often comes from the engagement and leadership of people who (for example) have personally experienced the challenges of having and being treated for TB and the stigma attached to the disease.

Community stakeholders are often best placed to be effective advocates who, as part of a movement, can create change. Armed with data and evidence, they can help devise actions and outcomes that influence decision-makers. Better progress on TB and gender can and must be achieved so services are made available to the people who need them most. Platforms such as GCTA can help advocates share successes, obtain support and facilitate global, national and local change that reflects the gender dynamics of TB.

2.1.2 Existing data and evidence: findings from a rapid review

Based on a rapid review, a summary of evidence regarding TB and gender was presented to workshop participants. A critical underlying issue is that TB is an airborne disease, and thus all people are at risk when (for example) they are in a room with someone with active TB. Prevention is therefore fundamental, irrespective of sex.

As such, gender in the context of TB is as much about men as women. In general, as indicated in one study from 2008, the value of gender studies in TB control can be enhanced by i) the ongoing collection of accurate sex-disaggregated data, and ii) capturing not only the experiences of both men and women in data collection and analysis, but also the “interactions” of critical social, cultural and environmental determinants of health. In other words, sociocultural factors are essential to understand and evaluate in the context of gender in TB research.

Available evidence from the past several years indicates the following key risk factors for TB: HIV, malnutrition, diabetes, alcoholism, silicosis, overcrowding, poverty, smoking and male sex. Miners are the population with the highest risk globally for TB; in southern Africa, notably, 3.5 percent of miners a year develop TB. This health and human rights issue has a core gender component in that miners are almost always men.

The greater impact on men, as per available data from the World Health Organization (WHO), can be seen in findings that two of every three people with TB are men in all 20 high-burden countries except Afghanistan (where the ratio is more or less equal). Other studies have shown similar sex-skewed ratios. The differences in such ratios per age also are important factors to consider regarding the gender aspects of TB. According to one study from 2014 that is based on case reports, there is higher incidence of TB among girls than boys aged 10-19, but then “everything changes” in older age groups where incidence among men is far greater.

Among the overall findings from the rapid review are that:

- more males than females are diagnosed with TB;
- treatment success rates are better for women than men in many settings (e.g., Nigeria, Mexico, India, Malaysia and the United Kingdom) and equivalent in others (e.g., Brazil, Egypt and Syria); and
- women have better treatment adherence than men.

Other gender-relevant observations as per the rapid review include the following:

- Being female is a risk factor for extrapulmonary TB. Diagnosing such TB is difficult, and often cannot be done with diagnostic tools available in district health facilities. The difficulty in screening for and diagnosing extrapulmonary TB is among the reasons for the lack of evidence of TB among women in many instances.
- Research undertaken in South Africa recently, yet before the GeneXpert diagnostic tool was rolled out, indicates that women are tested for TB in significantly greater numbers than men – but that more men are diagnosed with it. The findings indicate therefore that the yield is lower among women.
- HIV is the strongest risk factor for TB. Yet despite higher HIV prevalence among women than men in sub-Saharan Africa (SSA), TB incidence is still higher in men.
- Among women 15-24 years of age in SSA, incidence of TB is higher among girls than boys (which might be related to higher HIV prevalence among girls than boys, etc.)
- Genetic factors may play a role in TB susceptibility by gender. One hypothesis suggests that having two X sex chromosomes, as women do, offers more protection from TB than having just one X chromosome (as men's two sex chromosomes are XY).
- Gender-related behaviour appears to be important in explaining higher incidence of TB among men. Most miners are men, for example, and men are more likely than women to smoke tobacco and drink alcohol excessively.
- Pregnancy status is notable in regards to TB identification and control. According to some studies, prevalence of latent TB in pregnant women in HIV-endemic areas can be high. Yet case finding appears to be harder with lower incidence – for example, one study showed rates of TB diagnoses among pregnant women ranging from just 0.4 per 1,000 pregnant women in Brazil to 10.3 in South Africa (which still correlates to only 1 percent of all women surveyed).
- There is inadequate capturing of TB information from antenatal care (ANC) and maternal and newborn health (MNH) services. This is due in part to too little screening for TB.

According to the research specialist who undertook the rapid review, “TB control requires implementation of locally relevant, evidence-based interventions to address the special issues of

both genders (including pregnancy among women) and all ages to maximize effective access to the spectrum of essential services.”

Other participants echoed that assertion during plenary discussion following the presentation, with several stressing the many differences per context in various parts of the world (and even within individual countries). Differences exist not only in terms of susceptibility and incidence, but also regarding the type of stigma experienced. For example, some qualitative research has indicated that men especially worry about stigma in the workplace, with women worrying more about it in the family. Such a difference is a reminder that TB affects women and men differently in many ways.

Evidence is at the centre of the key action point. Because the data are limited and often rather old, there is a great need for better and more extensive data, numbers and evidence to be collected and published. More targeted research also is needed, including (as one participant suggested) around adolescent TB, given apparent connections between TB and hormonal balance. Other participants observed that from their experiences and “reality”, the true impact of TB among women cannot be seen without getting the “right” kind of data – such as the impact of access and stigma. In their view, a better understanding is urgently needed of how such issues affect diagnosing among women.

2.2 The Global Fund’s role, impact and opportunities

The Global Fund provides some 80 percent of the multilateral, international money for TB responses, making it by far the most important source of global funding. Since it is such an influential stakeholder, it can push for funding for interventions that governments might be reluctant to support.

In many countries, key issues regarding gender are among the areas government partners are disinclined to prioritize. The Global Fund in recent years has become more serious about gender, human rights and community engagement, and institutionally there is growing understanding that these three linked things are essential for effective efforts to respond to all three diseases (HIV, TB and malaria). As a result, there are more opportunities for influencing interventions at country level. The Global Fund also has been more proactive in urging the WHO to require more detailed data collection, thereby helping overcome the lack of sex-disaggregated TB and HIV data in many countries.

In recognition of the necessity of a gender approach, the Global Fund Board approved a Gender Equality Strategy (GES) in 2008. Though a quality document, it has not been implemented well or successfully. A GES Action Plan 2014-2016 aims to rectify the gaps by focusing on four focus areas of the GES, with the overall goal of ensuring that gender is integrated into all aspects of the Global Fund’s work. Such an effort has limitations because of how the Global Fund is structured (e.g., the prioritization of ‘country ownership’) and the fact that it has partnerships only with certain countries.

Nevertheless, progress toward implementing the GES is moving forward, especially since the new funding model (NFM) took effect beginning in 2013. The NFM is a notable step forward for

countries' planning purposes because each country is told in advance how much money it will receive for each disease response, assuming its formal proposal is acceptable. The model also offers numerous opportunities for integrating gender into TB responses, including the following:

- a country's national strategic plan (NSP), which is supposed to form the basis of all Global Fund proposals and interventions;
- the ongoing and regular country dialogue process, in which the participation of community-based organisations and women's groups (among others) is required;
- the drafting of concept notes, which essentially are the proposals submitted to the Global Fund; and
- the grant making process, which includes practical discussions with a principal recipient (PR) on what will be funded and to what extent. Monitoring grant making is important because there is the possibility that interventions specified in a concept note are weakened or underfunded during grant making.

To date, women's participation in key Global Fund structures, such as country coordinating mechanisms (CCMs), has lagged far behind men's. Access and engagement are even lower among members of community groups and key populations who are female. A new requirement for "a balanced gender representation" for eligibility will hopefully address the lingering gaps, although it is important to ensure that the vast majority of women's participants are not from the government sector. TB community representation on CCMs, now required, also continues to lag.

In addition to CCMs, advocates are encouraged to explore ways to be more involved in all Global Fund processes, such as by getting invited to participate in country dialogues and participating in the drafting of a concept note. Staff at the Global Fund Secretariat, including those in the Community, Rights and Gender Department (CRG), are able and willing to support advocates who encounter resistance when attempting to engage as expected under Global Fund guidelines.

The CRG also offers additional funding for technical assistance (TA) to ensure that key populations, communities and local civil society organisations are meaningfully engaged in the country dialogue and concept note development processes at the country level. By being better engaged, advocates can gather support for and help organise **gender assessments of concept notes**, an important activity for helping improve the inclusion of gender-transformative interventions. Gender assessment in TB is also considered necessary because, among other things:

- gender differences, both biological and social, can result in different health risks, health-seeking behaviours and responses from health systems, often therefore resulting in different health outcomes;
- gender dynamics in TB enrolment, treatment and cure rates are not uniform. For example, women often do not enjoy the same rights, opportunities and access to services as men;
- gender norms also affect men's health, thus promoting risk-taking behaviour or neglect of their health; and
- lack of uniformity in health-seeking and treatment behaviour of men and women requires a systematic assessment from a gender perspective to inform national planning and budgeting for gender-responsive TB and gender-transformative HIV responses, including joint applications to the Global Fund.

As of January 2015, gender assessment had been undertaken of 30 HIV/AIDS concept notes, yet only one TB concept note (Afghanistan). Preliminary review of these assessments indicates that they are often done well, but that the findings and recommendations are not always reflected in the grants. Much work therefore needs to be done to translate identified expectations into actual interventions.

Detailed information about the CRG TA funding can be found on the Global Fund's website at www.theglobalfund.org/en/fundingmodel/technicalassistance/communityrightsgender/.

Technical assistance opportunity from the Stop TB Partnership

In an agreement with the Global Fund, the Stop TB Partnership recently launched an initiative to provide demand-based technical assistance to countries as they develop their Global Fund concept notes. Such support is especially aimed at building the capacity of communities to meaningfully contribute to the development of robust NSPs, participate effectively in country dialogues, draft and monitor joint TB-HIV concept notes, and implement gender assessments in partnership with UNAIDS, among other things.

The initiative is intended to complement the TA offered by the Global Fund's CRG (see Section 2.2). Among the differences are that applicants are encouraged to implement the interventions themselves; the Global Fund, on the other hand, usually sends consultants from its roster. Of note is that in addition to TB communities, requests for support can be submitted by CCMs, principal recipients and sub-recipients, national TB programme managers, and other non-governmental organisations.

There are no deadlines for the demand-driven grants, which are usually funded at around US\$20,000 apiece. (An exception is in regards to concept notes, as requests connected with them should be submitted before concept note writing commences.) The Stop TB Partnership is also willing and able to support communities and other TB stakeholders in seeking funding from other sources. All requests of this sort, as well as questions about the TA initiative, should be directed to Fariham Malik (fariham@stoptb.org).

According to Global Fund representatives at the workshop, it usually takes 6-8 weeks after an application for TA is received before someone is in the country with a budget. Also of note is that the CRG's TA initiative can be used by community groups and advocates to ensure they are fully involved in the grant making process in order to monitor whether funding is actually allocated.

In summary, good policies are in place, but they are not working as well as they should. At the Secretariat and Board level, the Global Fund is pushing for countries to be more responsive to gender, but the results in concept notes have not been as good as hoped.

3. The TB/HIV Gender Assessment Tool

3.1 Explaining the Tool

The new TB/HIV Gender Assessment Tool was developed by UNAIDS and the Stop TB Partnership to help address some of the gaps and obstacles mentioned in Section 2 above. It is intended to help advocates and other users to disaggregate data on gender, among other things, and thus support local and national efforts to more effectively respond to TB by creating and implementing better programmes that are gender-responsive.

It builds on and expands the UNAIDS HIV Gender Assessment Tool, which focused on the need for more systematic data collection on gender equality and HIV. Both the new and older Tools are different from UNAIDS Modes of Transmission spreadsheets and reports because they focus primarily on gender and seek to go beyond just identifying transmission trends.

The establishment of a comprehensive TB/HIV Tool is especially useful now that the Global Fund has required a large share of its partner countries to submit joint TB/HIV proposals in recognition of the close links between the two diseases in many contexts. A main priority of the Nairobi workshop was to formally present the new Tool and solicit feedback and input from TB and gender advocates from around the world, since they and their colleagues are the individuals who are most likely to employ it or otherwise support its use in the future.

The new Tool aims to standardize different tools used in various contexts and regions. As such, it has been directly influenced by mechanisms and approaches used worldwide. The Tool has four main stages, each explained simply yet comprehensively:

- Stage 1: Preparing for the gender assessment of the national TB and HIV response
- Stage 2: Knowing the national TB and HIV epidemic and context
- Stage 3: Knowing the national TB and HIV response and identifying gaps
- Stage 4: Analysing the findings of the assessment and identifying interventions for a gender-transformative TB and HIV response.

Within each stage, the Tool guides users by outlining suggested approaches, steps, specific questions, and priorities. For example, in Stage 1 the need to develop a resource plan and organise a multi-stakeholder gender assessment workshop is noted. In Stage 2, issues such as social, cultural, economic, legal and political factors are considered in regards to available and accessible data. Stage 3 concentrates on areas such as whether TB and HIV policies and programmes exhibit gender equality in framework, design and expenditure allocation. Stage 4, meanwhile, discusses the most effective type of outputs, including a brief and succinct narrative report and an advocacy plan.

Of note is that the Tool is written and structured so that those who are not gender experts can apply it. In terms of timing and use, gender assessments should be tied to specific events and process in order to respond to them. For example, NSPs are reviewed regularly, usually with advance notice on what that will occur.

Current plans are for the new Tool to be pilot-tested in at least one country (Lesotho) in the upcoming few months. Ideally the Tool used there will be informed by comments and suggestions from Nairobi workshop participants.

3.2 Observations from completed gender assessments

A participant with experience in gender assessments using the UNAIDS HIV-specific tool offered some observations based on her application in several countries. Although she did not use the exact TB/HIV Tool recently developed by UNAIDS and the Stop TB Partnership, the assessments she has been involved with (most in West and Central Africa) have included many of the same approaches, guidelines and challenges since the new Tool is based closely on the one she used.

The following were among the gender expert's reflections on her work to date, each of which also suggests some practical steps:

- Mobilization of financial support to carry out a gender assessment is essential, and funding may be available not only from national TB and HIV programmes but from groups such as UNAIDS and UN Women as well. [*Stage 1 as per the new Tool*]
- Mobilization of political support is key, for example by obtaining a formal letter from top-level health ministry personnel specifically allowing lower-level staff to participate. [*Stage 1 as per the new Tool*]
- The bulk of preparation time goes to desk review, along with filling in the assessment document. There may be difficulty in finding all relevant data and then determining their quality. Also, often data are just not found (e.g., in regards to transgender populations); in such cases, a major recommendation for the future may be to gather such data. [*Stage 1 as per the new Tool*]
- During the actual assessment, maintaining links with national disease programme leadership and staff is critical. Among other things, this can help ensure country ownership and that programme staff are not surprised by any findings. Maintaining links with the CCM, and updating its members regularly, is also useful for the same reasons. [*Stage 2 as per the new Tool*]
- Consultative team members should organise and attend meetings on a regular basis with consultants, who are directly responsible for assessments. This can help ensure good feedback and guidance. [*Stage 2 as per the new Tool*]
- Stage 4, follow-up, proved to be the weakest link in the gender expert's opinion. The key is that once the report is written, people and organisations must take responsibility for "keeping the ball rolling". Gender assessments are only effective when and if recommendations are reflected in NSPs, Global Fund concept notes, and budgets. It can be difficult to maintain momentum once consultants are gone and consultative team members have moved on to other jobs, etc. In Gabon, for example, UNAIDS stepped in to try to ensure that recommended actions from the gender assessment eventually appeared in relevant budgets. [*Stage 4 as per the new Tool*]
- Activists can help disseminate gender assessment reports, or at least summaries of interventions, to partners and stakeholders. By doing so, they can help create awareness

and rally greater support for the implementation of the recommendations. [*Stage 4 as per the new Tool*]

In addition, the following are among the other lessons and challenges noted by the gender expert:

- Stakeholders may not feel free to talk, or may not be available to do so, at workshops where results from assessments are discussed and analysed. It therefore may be necessary to tweak such workshops to get the most out of the experiences.
- Validating the results of desk review can be difficult, especially given time constraints. In several countries, there was insufficient opportunity for participants to review and fully consider questions in working groups focused on validation. In some, distinct cultural practices – e.g., the expectation that a working group would shut down for several hours during a day – proved constraining.

Experience to date indicates that comprehensive gender assessments of the sort outlined in the new Tool can take 3- 4 weeks to implement from beginning to end.

3.3 Input on Tool from participants

Workshop participants started the process of responding to and providing input on the TB/HIV Gender Assessment Tool through an exercise involving three working groups. Each group corresponded to a specific region – Africa, Asia and Latin America – and participants were asked to review a fictitious case study that resembled a ‘typical’ situation in the region in regards to TB-related epidemiology and trends, health infrastructure and financing, and relevant social and economic factors.

The working groups then considered how the Tool might be applied in such a setting, including process, identifying and engaging with stakeholders and partners, and likely opportunities and barriers. Through such work, they were asked to consider how the Tool might be strengthened for practice in national TB programmes; what additional technical support might be needed; and what additional tools could assist in undertaking comprehensive and effective gender assessments.

Each group then reported back to the plenary, which also included a panel discussion with one high-level UNAIDS and Stop TB Partnership representative apiece. Much of the discussion focused on working groups’ consideration of how the Tool could be used in the contexts they discussed. As part of the process of providing input on the Tool, they also considered what adjustments might be needed and what more is needed to be known to successfully apply the Tool.

Each of the three working groups provided extensive feedback as per the key focus areas specified for the group work. Listed below is a summary of some of the common and more notable inputs offered by the groups during the report-backs. Of note is that not each of the inputs below was provided by every working group.

Identifying in-country stakeholders to undertake a gender assessment for TB and HIV

- Key government ministries (e.g., Ministries of Health, Gender, Planning, etc.)
- National AIDS Council

- Wide spectrum of civil society and community groups, including networks of key populations (including people living with HIV) and affected communities, as well as women's groups
- Private-sector representatives, including from businesses and medical associations

Challenges that may arise, such as in i) accessing relevant TB and gender data, and ii) addressing both TB and HIV together

- Lack of reliable (or any) sex-disaggregated data on TB and HIV in general, on key populations, on TB case identification, etc.
- Stakeholders may not be willing to share data
- Weak or inefficient national information systems
- Structural challenges, such as “verticalisation” or “siloing” of the two diseases (HIV and TB) within government ministries
- Stigma and discrimination, which may make information and observations even more difficult to obtain
- Insufficient expertise on TB, HIV and gender

Barriers that might exist to applying the TB/HIV Gender Assessment Tool and applying the findings to programming

- Difficulty in getting buy-in from stakeholders, many of which have extensive workloads and are unwilling to take on more responsibilities
- Limited understanding of TB and HIV, and of TB/HIV co-infection
- Information that is too extensive or complicated for countries and stakeholders to understand and use
- Involving civil society, especially groups that are involved in TB service delivery primarily and have little experience or interest in planning

Additional tools that might be useful

- Focus group discussion (to help explain methodology, etc.)
- Use of key informants
- Pilot assessments, followed by dissemination of lessons learned
- Score-cards
- Use of What Works for Women (www.whatworksforwomen.org/) to help provide the evidence necessary to inform country-level programming

What adjustments might be needed to the Tool

- It should be revisited to make sure it is relevant to TB, in particular by looking at risk factors for TB
- Careful consideration must be undertaken to ensure the Tool is looking at gender in its diversity (men and women)
- The Tool is currently too long and repetitive
- A three-tier system feedback might be useful (involving policy makers, implementers and community)

What else those who use the Tool might need to know

- What is the source of information provided to Tool questions? For example, is the information based on opinions? How can users validate the qualitative responses, as responses may be subjective?

Discussion regarding regional working groups' feedback

Below are some of the comments to the working groups' presentations from the UNAIDS and Stop TB Partnership representatives on the panel. In some cases the representatives were responding directly to the challenges and barriers specified; in others they were making observations based on their experience with TB, gender and assessments.

Ensuring stakeholder engagement and support. The best approach when presenting the Tool – preparing to launch an assessment – is to have “everyone in the room” when it is done. In that way, the breadth of stakeholder engagement and interest, as well as the importance of the assessment, are clearly evident. Inviting a large group also makes more stakeholders feel as though they are “insiders”, which can help increase their cooperation and support. Buy-in from critical government stakeholders is more likely when they are treated as partners from the very beginning, to the fullest extent possible.

Recognizing and approaching those with clout. Identifying and obtaining support from key “gatekeepers” can be essential. These individuals, organisations or ministries often have direct access to essential data and can convince their staff and other groups to participate in the assessment. In many countries, health ministers have the greatest clout in this regard, but often it is more useful to consider not the position but the skills.

Working with “what you have”. Data are key. But data on TB and HIV more generally, let alone disaggregated data regarding gender and key populations, may simply not be accessible or even exist at all. In such instances, it may make sense to work with estimations and to base input in the assessment on knowledge of context such as where stigma and discrimination are most common, early marriage, gender-based violence, the existence and strength of civil society and patient groups, etc. Through such an exercise, it is often possible to recognize where the main gaps are, such as when key populations are not reflected or involved in national responses. Specific interventions can then be identified based on those gaps.

Another approach when faced with huge limitations in regards to data might be to review assessments done in countries with similar epidemics and contexts. If those assessments have had access to useful data, that information could be used (adapting as needed) as the basis for interventions and priorities in a country faced with a significant data deficit.

Crafting and using key messages. Based on gaps and priority areas identified during the assessment, key messages that are simple, forceful and clear and should be developed. The acronym KISS – ‘keep it simple and smart’ – is useful to keep in mind here. If what the key messages are cannot be summarized in two pages or less, and the argument cannot be made for financing, then it will be difficult to “sell it” well.

The next step is to figure out who can help sell it, including by raising awareness. For example, if one key message is related to the huge share of new infections among young women, then youth and women's groups as well as government ministries working for such populations should be alerted and brought on board. Using messages to find allies can be the best way to change things.

The panellists also noted the following in regard to feedback to the Tool:

- agreement that the Tool is “too long”;
- acknowledgement that it may be worthwhile to look more critically at it “from TB eyes”, especially since the Tool may be used solely for TB programming assessment. The extensive emphasis on HIV in the current version results from two factors: i) the fact that the new Tool is based on UNAIDS’ HIV-specific one, and ii) the move toward greater TB/HIV integration in planning (which is encouraged by the Global Fund and other stakeholders); and
- reminder to workshop participants that Tool users should “feel free” to remove or skip parts as long as the most essential and sensitive topics and issues remain. It will always be important, for example, to focus on issues such as violence against women and barriers to key populations even when some stakeholders do not want to talk about them.

Next steps on the Tool and final comments

In terms of next steps for the Tool, representatives from UNAIDS and the Stop TB Partnership said that all comments would be considered as they moved forward in finalizing the initial draft of the Tool and releasing it for broader use. They also reminded participants that the Tool should be considered a “living document” that can and should be revised as needed in the future.

Also of note is that the Tool will be tested in one country (Lesotho) that is submitting a concept note to the Global Fund in April 2015. During this pilot use, there will be concrete indications of what parts of the Tool work well and whether and what type of changes might be useful.

During the final part of the panel discussion, participants were invited to give additional suggestions for improving the Tool and otherwise ensuring that gender assessments are comprehensive and successful. The following are among their comments:

- **Faith and religious leaders** are not mentioned in the Tool. They should be specified as stakeholders because they are often the main people with influence.
- All who use and review the Tool should keep in mind that **TB is an airborne disease**. Thus the risk factors are different depending on living conditions (for example) and from other diseases (e.g., HIV).
- **Young people** must play a role and be involved.
- **Extrapulmonary TB** is often ignored, usually because the focus has been on forms of TB that are infectious and which spread. Also often ignored for similar reasons are childhood TB and genital TB, both of which are also especially difficult to diagnose. It is essential to better understand such forms of TB, and to seek better data on them.

- The **women and girls section** of the Tool should be clearer.
- It is important to identify early on the targeted populations. They might be women, men, children, etc. Greater guidance and precision can only be ensured when assessments and analysis are **context-specific**. For example, talking about and focusing on men and boys may be critically important given a country's TB context. Gender is not only about women and girls.
- **Collaboration across countries** can be helpful when preparing and implementing gender assessments.
- The Tool focuses almost exclusively on diagnosis, treatment and care. It does not focus sufficiently on **prevention**. This is a major oversight since there is often a lack of understanding and awareness about how TB is transmitted (or even that it is an airborne disease).

4. 'Cheat Sheet': Reviewing and Providing Input on Complementary Gender-Responsive Tool

Developers of the TB/HIV Gender Assessment Tool acknowledge that gender analysis can be a complicated and difficult undertaking. As part of an effort to make it easier, partners behind the Tool have created a 'cheat sheet' – a document that attempts to highlight gender-responsive interventions that can help make TB programming more gender-sensitive. The main idea is that the 'cheat sheet' will complement the Tool by helping users identify and focus on priority activities and actions.

The draft document as presented to participants had 14 characteristics (termed "epidemic situation") that might apply to an epidemic in a specific context, such as "high TB prevalence/risk among young women" and "high prevalence of TB and gender-based violence due to stigma and discrimination". Following those 14 were four potentially relevant programmatic gaps, such as "non-existent/limited availability of age- and sex-disaggregated data to fully understand gender dimensions of the epidemic". Each of the 14 epidemic context points and 4 programmatic gaps was associated with a series of "interventions to consider" for effectively responding to the situation and gaps.

The 'cheat sheet' is in the early stages of development. Its creators are seeking extensive input from various stakeholders, including Nairobi workshop participants, as to its contents and value. To that end, participants were divided into three regional working groups (Africa, Asia and Latin America), similar to the ones that discussed the broader Tool, and asked to review the 'cheat sheet' and consider the following questions about it:

- Is this the right information?
- What is missing?
- How can we strengthen the information?

Based on their consideration of the questions above, each working group made tracked changes to a draft of the ‘cheat sheet’. Collectively, they proposed extensive revisions, additions and deletions – including to the specific wording of most proposed interventions. The document’s developers plan to review all such inputs and suggestions as they further hone the text.

All participants had a brief opportunity to review some of the inputs suggested by the other two working groups (i.e., the groups they themselves were not part of). During that brief review, they were asked to signal support for a small number of the other groups’ proposals and comments. Listed below is a sample of working groups’ inputs that received the greatest support overall, as well as some additional comments that were raised in plenary discussion. (When suggested additions are noted below, they are followed by an indication of where they should be placed. The 14 “epidemic situation” characteristics are marked as ‘A’, with the 4 “programmatic gaps” marked as ‘B’.)

- A standardized package of services, including information about TB services, should be made in conflict and post-conflict settings. This is especially important for people whose treatment regimens are disrupted due to conflict. [*Add to A.1 interventions*]
- Provider-initiated TB screening for the elderly should be integrated in outpatient and other health care facilities. [*Add to A.6 interventions*]
- Develop a gender policy guide to address the lack of TB and gender policy [*Add as new programme gap and intervention to address*]
- Mapping of TB transmission ‘hot spots’ for each high risk group should be a priority intervention [*Add to all relevant A characteristics*]
- Extrapulmonary TB should be specified and discussed [*Add as intervention to A.7, B.2 and B.3*]
- Translate some of the interventions from the level of recommendations to more action-focused interventions [*General suggestion regarding overall ‘cheat sheet’*]
- Increase individual treatment counselling because of higher risk among men of loss to follow up or not seeking treatment in the first place. (This takes into account that health is usually not a priority for young men.) [*Add as intervention to A. 4*]
- The point about gender equality, currently specified in one epidemic setting characteristic (A.9), should be considered relevant for the entire ‘cheat sheet’ because the entire document should be seen as being about gender equality.
- The following cross-cutting issues should be reflected throughout the document, where relevant: i) include interventions for TB infection control for all the target groups; ii) include nutrition interventions and initiatives for all targeted groups.

- Change language throughout the document to be less prescriptive and more suggestive: e.g., instead of “to provide” use “provision of”.
- It was difficult to understand or recognize the gender implications of the sections on high prevalence of TB among prison inmates (A.10) and miners/mining communities (A.11). There were no specific proposed interventions in the draft text, which made it even harder to conceptualize from an overall gender perspective.
- The discussions on TB associated with specific economic activities and industries (e.g., mining) should specify that often it is young people who are most affected. Making this connection is necessary as part of a ‘know your epidemic’ exercise.
- Services need to be brought down to communities, and this should be reflected in interventions. For example, mobile vans should be sent to mines and communities where miners live to offer them health check-ups, TB testing, counselling and consultations. X-rays can be sent to doctors in specialized clinics by phone to be diagnosed (telemedicine). *[Add as intervention to A.11]*
- More extensive and clear language should be included in regards to the gendered aspects of TB responses, including structural drivers.
- Language and interventions should be included in regards to infection control, especially often-ignored populations such as women caregivers in houses.
- The ‘cheat sheet’ could be strengthened if it were structured differently. For example, interventions could be divided into different categories (prevention, care and treatment, etc.) and then associated with policies at different levels and of different types. Such a structure could look something like this:

Policy	Prevention	Care and Treatment	Support and Education
Engagement			
National			
District			
Facility			
Community			

5. Conclusions and Next Steps

5.1 Workshop partners

Workshop organisers and partners outlined a series of steps that will be taken to move forward the ‘cheat sheet’, TB/HIV Gender Assessment Tool and further integration of TB and gender more broadly. Among them were the following:

- The Stop TB Partnership and partners will review and integrate all comments on the **Tool**. Participants were invited to submit additional comments by 31 January 2015 to Darivianca Elliotte Laloo at dariviancal@stoptb.org.
- **Pilot-testing** of the Tool will be done in Lesotho, most likely in April, and perhaps in Côte d'Ivoire. Lessons learned will be disseminated as part of a training for consultants who will conduct similar assessments in other countries. UNAIDS and partners will make available information about the process, including the training, once it is finalized.
- The Stop TB Partnership and partners will review all detailed notes on the '**cheat sheet**' and develop a new version. They will work with members of a volunteer advisory group comprising participants at the Nairobi workshop. The goal is to have the next version of the 'cheat sheet' completed within one month (i.e., the middle of February 2015).

5.2 Informal pledges by participants

In an informal exercise at the end of the workshop, participants also considered future steps they might take to advance work on gender and TB after departing the Nairobi meeting. The following were among the actions and activities that several participants pledged to undertake, as part of a personal commitment, by the end of January 2015, within the next three months, or by the end of 2015.

- Ensure that the information and learning from the workshop be reflected and integrated in the concept note currently being developed in Guatemala.
- Review the tools discussed, including the TB/HIV Gender Assessment Tool and the 'cheat sheet', and work with community allies to provide input into the NSP in Indonesia. Support will be sought, if needed, from the Global Fund CRG and the Stop TB Partnership.
- Take back ideas and messages from the workshop to colleagues at the Treatment Action Campaign (TAC) and seek to genderize TB/HIV in South Africa's national plan. This effort will also include "knocking on" ministers' doors. A notable opportunity in the relatively near future is influencing the Global Fund concept note expected to be submitted by South Africa in June or July 2015.
- Engage more with the Stop TB Partnership and GCTA on TA opportunities that Jhpiego might be able to provide and support.
- Call for more studies on TB and gender at the national and international level, with particular attention on the impact of gender-based violence and extent of political will to push for rights-based responses.
- Inform fellow International Community of Women Living with HIV/AIDS (ICW) members of the information and message from the workshop, and urge colleagues to develop interest TB and gender issues since they are closely linked with all HIV-related ones.

Annex 1. List of Participants

The following individuals attended the January 2015 workshop in Nairobi. They are grouped into three categories: representatives of advocacy, community and client groups; partner institutions (including organisations sponsoring the workshop); and workshop support personnel. Participants within each category are listed in alphabetical order. The country listed refers to where each individual is currently based.

Community and advocacy groups			
Name	Country	Organisation	Email
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Victoria James	Zimbabwe	Independent consultant	victoria@nedico.co.zw
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Kibibi Mbwavi	Senegal	Independent consultant	kibibi.mbwavi@gmail.com
Silvia Pilar Morales Angulo	Bolivia	Asociación Nacional de Pacientes Contra la Tuberculosis (ASPACONT)	drasilviamorales@hotmail.com
Maurine Murenga	Kenya	International Community of Women Living with HIV/AIDS (ICW)	maureenmurenga@gmail.com
Dorothy Namutamba	Uganda	ICW East Africa	dnamutamba@icwea.org
Elizabeth Rowley	United States	PATH	erowley@path.org
Oxana Rucsineanu	Moldova	Global Coalition of TB Activists (GCTA)	oxana_rucs@yahoo.com

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Partners

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Resource people

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