



Defining and Advancing Gender-Competent Tuberculosis Service Providers

A Competency Framework and Technical Brief

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This framework and technical brief was prepared by USAID's Human Resources for Health 2030 Philippines.

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Acronyms

DOH	Department of Health
CDC	Centers for Disease Control and Prevention
DOTS	Directly Observed Treatment Shortcourse
ECDC	European Centre for Disease Prevention and Control
GTI	Global Tuberculosis Institute
HRH	Human Resources for Health
MDR-TB	Multiple drug resistant tuberculosis
OIs	Opportunistic Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/ AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

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Introduction

The Philippines National Tuberculosis Program (NTP) succeeded in cutting Tuberculosis (TB) mortality and prevalence in half compared to a 1990 baseline, meeting the 2012 Millennium Development Goal (MDG) targets for the country. However, despite advances the country continues to suffer from one of the highest TB and multiple drug-resistant (MDR-TB) burdens in the world and across all age groups, with more men having TB compared to women (DOH 2018). With TB remaining the 8th leading cause of death in the country and affecting men and women differently, there is a need to revisit patient-centered strategies and review the implementation of TB prevention, diagnosis, treatment and rehabilitation programs undertaken by health care facilities and providers.

In the Philippines, TB affects men and women differently (see *Table 1*, p. 4). For instance, usually men are unable to seek medical care for TB because clinic hours coincide with their working hours (USAID TB Portfolio Evaluation (2012)); TB Innovations, 2019). While women may have more time than men in visiting health facilities, they are often constrained financially due to insufficient access to income or economic dependence on husbands (USAID, 2014b). The 2010-2015 Philippine Plan of Action to Control Tuberculosis (PhilPACT) reports that major reasons for the burden of the disease are caused by non-action, prolonged delays in consultation, self-medication with traditional remedies or anti-TB drugs, and poor adherence to treatment (DOH, 2018). These challenges differ for men and women. Further, the Department of Health (DOH; 2017) identifies that these challenges are greatly interconnected with social, economic, cultural and political factors on both the provider and the patient which greatly influence case detection, health-seeking behavior and treatment outcomes in TB. Additionally, gender – or how a society ascribes day-to-day roles, rights, and responsibilities to women and men, is an important factor in TB (WHO, 2018b; WHO, 2015). Prevention, control and treatment must therefore be matched with gender-specific needs, opportunities and constraints to ensure differentiated care in TB.

To deliver effective TB services, which are different for men and women, providers must be able to understand gender and incorporate gender-aware approaches—or exhibit gender competency (see box). For example, providers should exhibit flexibility in terms of patient choice of a mutually agreed upon treatment plan and type of support that is important to their experience of the disease and treatment (DOH, 2017; WHO, 2014; GTI, 2008). Providers need to respond to patients' expectations and fears about how TB can impact the latter including their relationships with friends or families (CDC, 2010). Considering these needs, opportunities and constraints may vary among patients, and providers have to be more receptive about patients' expressed wants and views including that of their treatment plan.

While there are documented differences for men and women in TB prevention, control, and treatment, TB care has continuously been similar for both women and men patients (DOH, 2018). There is a need, therefore, to deliver a gender-focused approach to effectively control TB. In a systematic review conducted by Muralidharan

The Gender Competency Framework for Tuberculosis Service Providers offers a valuable guide for integrating gender in TB programming in the context of health care workers who are a crucial resource for improved TB health outcomes and gender equality.

HRH2030 DEFINITION Gender Competency

Gender competency as the capacity to identify when and how different norms, social constructs, roles, expectations, power differentials, opportunities, and constraints assigned to women, men, girls, and boys are manifested in daily life, and how they might affect health and well-being, including how the provider's own attitudes and norms about gender and power affect professional interactions.

and colleagues (2014), there was none to very little evidence showing gender-aware programs in relation to TB. Instead, the literature is rich about the development and integration of certain knowledge, skills and attitudes that providers need to possess in order to ensure a productive and satisfactory patient-provider experience especially in TB. This was often referred to as cultural competence owing to the context of delivering TB services to migrants in a country not of their origin (GTI, 2008).

Although gender issues manifest at all levels of health service delivery, there is an opportunity to examine the impact of gender bias on the accessibility, availability, acceptability, and quality of TB services. Research shows that when gender-transformative approaches are included in TB activities, they can:

- Improve positive patient health beliefs and health seeking behavior (GTI, 2008), including addressed myths and misconceptions on TB
- Reduce unpleasantness related to clinic visits (WHO, 2014)
- Create tension-free experience in the course of patients' treatment (HRH2030/Philippines, 2020)
- Strengthen successful uptake of TB diagnosis and adherence to a treatment regimen increasing chances of recovery (ECDC, 2016).

Given the gender disparities present in the TB burden, there is a need to enhance health care personnel competencies to identify and address gender-specific patient needs (WHO, 2005). This paradigm was first introduced by USAID's Human Resources for Health 2030 (HRH2030; 2019) in the Gender Competency Framework for Family Planning Providers, which delineates the knowledge, skills and attitudes family planning providers should demonstrate to provide equitable services for women, men, girls, and boys. But translating concepts such as gender into service provision is complex. Hence, by developing a parallel gender competency framework for TB providers, we can develop a global resource that can guide providers in the process for transforming gender concepts into real-life application of knowledge, skills and attitudes (Law-Wilde, et al., 2020).

Definition of Gender Competency for Tuberculosis Providers

Building on the HRH2030 definition of gender competency overall, HRH2030 developed the definition of gender competency for Tuberculosis providers (at right) to create a common terminology for the provider who is able to understand and act on gender in provision of TB services. Gender competency for TB consists of five domains, described in detail below.

HRH2030 DEFINITION **Gender Competency for Tuberculosis Providers**

Gender-competent TB providers are those that can demonstrate awareness and knowledge of different norms, social constructs, roles, expectations, power differentials, opportunities, and constraints assigned to women and men, and translate these to effectively provide care and treatment for TB. This is especially true in the notions of stigma and discrimination that is predominant in the experience of TB patients between their health care providers and other people – including family, friends and the community. It consists of five domains areas:

1. Using gender-sensitive communication
2. Designing and implementing gender aware TB prevention strategies
3. Creating tailored treatment strategies
4. Advancing stigma-free care for men and women
5. Addressing differentiated care for co-infection and risk

Rapid Gender and TB Patient Experience Analysis

While gender experiences vary for every individual, there are many common trends among men and women in their perceptions and encounters with the health system and providers. *Table 1* below provides a snapshot of how women and men experience in risk factors for TB and how their typically associated social and economic consequences interact with diagnosis, treatment, care and rehabilitation. This builds on information about gender differences in the infectious disease process (*Appendix 1*).

Table 1. Gender-specific opportunities and constraints to TB prevention, control and treatment

	♀ Women and girls	♂ Men and boys
Medical	<ul style="list-style-type: none"> • TB is one of the top five causes of death for adult women (ages 20-59); reported cause of 6-15% of all maternal mortality • TB progresses more quickly in women of reproductive age, when co-infected with HIV and/or diabetes • More women seek medical consultation compared to men but also more likely to self-medicate than men; delays happen when women face financial barriers 	<ul style="list-style-type: none"> • More than 60% of the estimated 1.5 million TB deaths in 2013 were men; higher likelihood of co-morbidities such as smoking or drinking • Smear-positive and bacteriologically confirmed TB were higher in men compared to women with a male-to-female ratio of 2.5:1 (global) and 2:1 (Philippines) • Men are less likely to seek medical care and more likely to consult with a non-medical professional, due to non-conducive clinic hours
Economic	<ul style="list-style-type: none"> • Economic dependence on partner or family impacts treatment; family resource allocation preferring men and children’s health above women • Expectations related to childcare and household responsibilities make adherence more challenging; may have restricted mobility to seek and stay on treatment 	<ul style="list-style-type: none"> • More likely to equate TB with financial problems (ex: job loss and reduced family income); greater access to money and treatment decision-making • Higher exposure due to occupational interactions or sectors; more likely to prioritize livelihoods and family needs over TB treatment
Psychosocial	<ul style="list-style-type: none"> • Dropouts a result of risk of family ostracization; higher likelihood to hide diagnosis or delay treatment; resistance to seeking services from a male provider; more affected by lack of privacy in health facilities 	<ul style="list-style-type: none"> • Expect more stigma at work, sexual relationships, ability to marry; harmful notions of masculinity may lead to delayed care-seeking behavior

Sources: HRH2030/Philippines, 2020; TB Innovations, 2019; USAID, 2019; DOH, 2018; WHO, 2018b; MEASURE, 2017; The Global Fund, 2017; Tupasi, et al., 2016; UNAIDS, 2016; WHO, 2015; Krishnan, et al., 2014; USAID, 2014a, 2014b; Onifade, et al., 2010; WHO, 2005

Further, the unique experiences of women and men may further vary with their intersectionality or the presence of additional social categorizations (e.g. age, disability, sexual orientation, social status, culture, etc.) and settings. For instance, children may not be diagnosed correctly due to lack of equipment or provider skill to diagnose childhood TB. The elderly or people with disabilities (PWDs) may lack support or mobility vessels to bring them to facilities for TB services. LGBTQIA+ persons have been found to receive substandard medical services due to provider bias. In terms of settings, people and communities living in geographically isolated and disadvantaged areas (GIDAs) or remote locations may suffer from poor access to TB facilities and services. People living in shared facilities or in urban slums are more at risk from contracting the disease. These intersectionalities and setting issues may overlap with gender-specific needs and challenges that have to be considered in TB service provision (Krishnan, et al., 2014; USAID, 2014b; WHO, 2005).

Methodology

Building on the definitions and framework developed in the earlier technical brief by USAID's Human Resources for Health 2030 (2019), the Philippines counterpart activity conducted a desk review to identify themes which were later classified into domain areas addressing gender and social inclusion issues in TB. The desk review was done between December 2019 to February 2020 which included published and grey literature on gender, cultural competency, patient rights, and ethics in the perspective of TB service provision as well as highlighted lessons learned from completed and current USAID health projects (including the desk review done by USAID's TB Innovations and Health Systems Strengthening Project) and the Department of Health's National TB Program (NTP). The desk review resulted in working domain areas and a preliminary competency framework which were reviewed with USAID Philippines Office of Health and its Implementing Partners (IPs). The recommendations for further development of this competency framework are discussed in detail in the final section of this brief, including its contribution to the Philippine Strategic TB Elimination Plan 1 (PhilSTEP1) 2020-2023 High Impact Interventions.

Theory of Change

The theory of change for TB provider gender competency suggests that IF service providers are competent at addressing gender issues in TB through five domains, THEN they can contribute to positive patient experience and, more broadly, improved TB treatment outcomes and gender equality (see Figure 1). Each of the five domains are explained thoroughly in the succeeding section.

Providers' knowledge, attitude, and skills greatly influence patient's perceptions of the health system and ability to access high quality health services. In 2014, the World Health Organization presented evidence from 40 years' worth of sociological and behavioral research that emphasizes the need to pay attention towards providers and how they relate to the health system delivery. These studies show that among interactions with patients, especially women, the main driver for TB treatment default is the poor interactions from health care providers and social stigma associated with the disease. In the Philippines, health care providers were found to be poorly trained on counseling skills causing instances for patient blaming in relation to poor TB case detection and high treatment defaults (DOH, 2017). In addition, interactions between men and women health care providers and patients were found to affect access to health services. An impact assessment commissioned by the DOH found that the perceived power of health care providers could impact women and men patients differently. These results pushed for the recognition about the importance of addressing gender differences in TB policy and strategy (TB Innovations, 2019).

Gender competency enables providers to more adequately and effectively meet patient's needs and retain them on treatment under a positive patient experience model (HRH2030/Philippines, 2020). The positive patient experience model identifies the goal of improved TB health outcomes and gender equality which is reinforced by several specific objectives such as a higher case detection rate (especially women), decreased reports of stigma and discrimination, and completed regimen matched with gender-specific care thereby reducing treatment defaults. *Figure 1* demonstrates the theory of change and the five domains.

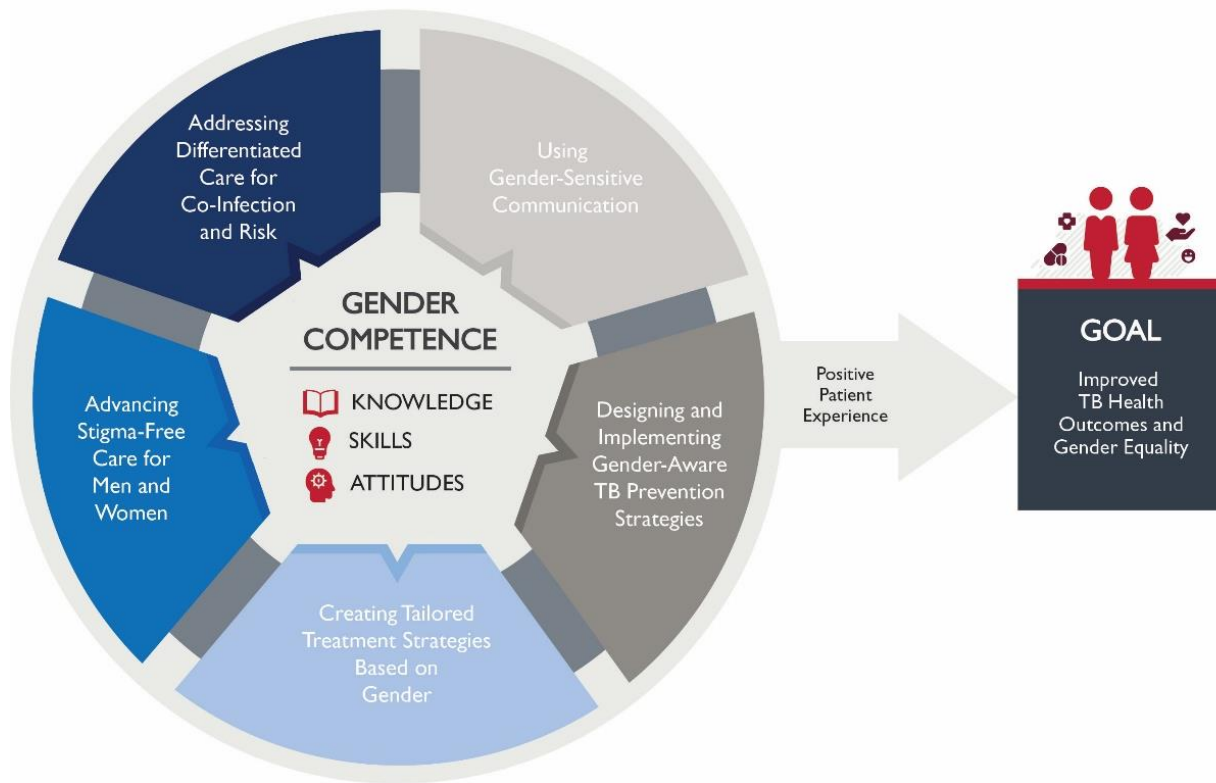
Gender Equity and Equality

Gender equity is the process of being fair to women and men, boys and girls. To ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men, boys and girls from operating on a level playing field.

Gender equality is the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources. Genuine equality means more than parity in numbers or laws on the books; it means expanded freedoms and improved overall quality of life for all people.

In this work providers who are gender competent contribute to an equitable process when they assess the needs of an individual based on the gender issues in the client's particular context to provide quality treatment, which may look different for different individuals. The actions of a provider who is gender competent seek to contribute to the goal of gender equality. The provider may exhibit gender competency but cannot achieve equality alone if other factors are not met, such as shared responsibility at home.

Figure 1. Gender Competency Framework for Tuberculosis Service Providers Theory of Change*



**See full definition of each domain on pp 6-10 and corresponding competencies in Figure 2 on pp 11-12.*

Domains

Each element of gender competency for TB providers contributes to increasing positive patient experience. The domains build on one another. They are defined below.

1. Using Gender-Sensitive Communication refers to the provider’s transmission of information through verbal and non-verbal communication in a way that is patient-centered and gender-specific recognizing unequal conditions. It contributes to a positive patient experience as providers share TB information with patients in an appropriate, comprehensible manner, resulting in patients’ improved ability to maintain adherence to treatment. The Department of Health (2017) emphasizes that health workers need to develop skills on active listening, health literacy, message-framing, motivational-interviewing and communication in order to create trust and effectively targeting and treating TB patients. For example, a gender competent provider would consider how literacy may differ for men and women when presenting diagnosis information or may consider gender norms related to experience of stigma and ability to participate in treatment (DOH, 2017; ECDC, 2016; GTI, 2008). TB providers can address patients’ inequitable situations through their interactions with their patients by assessing the desire for information, the appropriate format and the acceptable way for communicating health teachings and delivering continuum of care (TB Innovations, 2019; CDC, 2010; WHO, 2005).

Providers must also recognize their potential for bias based on gender and the potential impact on provision of TB services. For example, gender bias could affect the level of clinical suspicion and the sputum examination effectiveness since most providers associate TB with men and may not ask women to submit for sputum exam despite typical symptoms. Therefore, a gender competent provider must recognize their own biases but must

balance this with compliance to TB diagnostic requirements in order to achieve correct and adequate diagnostic investigations (Thorson, et al., 2007; WHO, 2005). Using gender-sensitive communication is important to establish trust. If not, patients may withhold certain details from their providers even though these may be crucial to their care (GTI, 2008) and may leave a visit with an unsustainable treatment regimen. Since women and men differ in TB symptoms and the experience of the disease, a gender competent provider actively solicits the inputs of the patient to build trust, emphasizing the need for patients to feel empowered in the TB diagnosis and subsequent care processes (HRH2030/Philippines, 2020; WHO, 2014; GTI, 2008).

2. Designing and Implementing Gender-Aware TB Prevention Strategies refers to the provider's capacity to convey correct information and co-plan effective strategies for preventing TB with consideration of barriers or disparities in women and men's health-seeking behaviors through integrated, people-centered, community-based and gender-responsive health education. Since women and men use their time and space differently inside and outside health facilities (e.g. home, school, community, workplace), a gender competent provider designs TB prevention programs based on and in response to how gender affects the individual, household and community practices (HRH2030/Philippines, 2020; USAID, 2019). For instance, the gender competent provider is aware of men's or women's working hours which may impede them from seeking certain health services (The Global Fund, 2020; GTI, 2008). Therefore, the provider may include alternative methods for targeted awareness raising from women through mobile services or integrated health advisories during women's health check-ups for reproductive, maternal and child health. A gender competent provider knows when men or women are mostly available to participate in prevention campaigns and therefore match their messaging and communication on tackling stigma, raising awareness and improving early case detection based on the availability and specific needs of women and men (MEASURE, 2017; ECDC, 2016).



A doctor checks the Chest X-ray result of a male patient suspected with TB. (Photo credit: HRH2030/Philippines)

3. Creating Tailored Treatment Strategies Based on Gender refers to the provider's ability to tailor a comprehensive treatment plan alongside TB patients depending on their full range of medical, economic and psychosocial needs, opportunities and constraints as women and men. Building on the provider's ability to use gender-sensitive communication, this domain leads to improved health outcomes by using gender as a key consideration for designing appropriate, sustainable treatment plans. In terms of the medical aspect of treatment, a gender competent provider realizes that obstacles and preferences may exist because of gender in the access, affordability and acceptability of Directly Observed Treatment Short-course (DOTS) services. Patient's gender may also impact their ability to follow through on recommended treatment plans. For example, the accessibility and affordability of DOTS services may be hampered in women's restricted mobility in particular cultures or settings; economic dependence on their husband; or resistance to seeking services from a male provider (USAID, 2014b; Krishnan, et al., 2014; WHO, 2005). Likewise, male patients may be more likely to prioritize their livelihoods and over TB treatment (TB Innovations, 2019). Providers therefore must realize how gender impacts TB patients differently for instance in factors like transportation, good nutrition to optimize treatment, and the need for

privacy or child-care facilities in health care settings. For example, a gender competent provider understands the ability to use funds to assist cost of transportation and/ or food that may be essential at addressing the gender-specific issues affecting access, affordability and acceptability of DOTS services (Tupasi, et al., 2016; WHO, 2014).

Likewise, gender has a large influence on social support systems, which are a key piece of TB treatment plans. A gender competent provider is able to navigate the collaboration among health care providers, patients, peers, families and communities considering the different preferences and resources for men and women

(HRH2030/Philippines, 2020; WHO, 2014). For example, since there is a lower prevalence of women with TB, peer patient groups dominated by men with TB may not work as an effective support system for women with TB. In this situation, as an alternative, a gender competent provider could give a woman with TB the option of a male or female peer educators to link with other current or recovered women patients, which may help neutralizing difficulties experienced during the long treatment regimen (Krishnan, et al., 2014). On the other



The nurse asks relevant questions from the male patient as part of the assessment.
(Photo credit: Chemonics/ USAID TIPS)

hand, men with TB may be linked with clubs or “buddy” programs in the workplace or even in the health care facility which have been found to be effective in successful treatment outcomes (The Global Fund, 2020). Health care providers, who are the first line of social support system to patients, are responsible for facilitating the expansion of this support system towards other groups that surround the TB patient.

4. Advancing Stigma-Free Care for Men and Women refers to the provider’s delivery of continuum of care implementing stigma-free strategies that counter harmful gender norms including those that risk gender-based violence from providers and other people against diagnosed and potentially infected TB/ MDR-TB patients. This domain contributes to positive patient experience by giving stigma-free services in observance of protocols in the health care setting. As presented in Table 1, since women are largely dependent on their husbands or families economically, stigma may be reinforced with even more realistic fears of isolation, rejection from family households, even divorce or perceived threats of gender-based violence in all forms in the household. Compared to men citing economic concerns, women’s primary reasons for treatment dropout include negative interactions from health care providers and social stigma. This type of stigma can even be made worse with multiple stigma associated with social status, race, ethnic status or overlapping illness (USAID, 2008; WHO, 2005). In a DOH study conducted in 2010, women patients with TB expressed their concern about the layout of most health care facilities due to the limited privacy that they experienced especially in the points of delivery of DOTS therapy. As a gender competent provider, women with TB may be given with TB diagnostic or treatment procedures in distinct outhouses or different entrances for the DOTS delivery in their clinics and hospitals in order to promote increased privacy and confidentiality as well as separating women patients from men when they feel uncomfortable (The Global Fund, 2017, 2020; Onifade, et al., 2010).

Likewise, a gender competent provider recognizes that diagnosis of TB may have the potential to do harm, which may be different for men and women. They are able to consider the different experiences of women and men in the disease in order to avoid discriminatory attitudes, behaviors and actions that may lead to gender-based violence or unpleasantness in clinic visits. For instance, evidence shows stigma plays a greater role in shaping the experience of women in illness and health-seeking behavior more than men due to various reasons not limited to social isolation, marriage prospects, fertility concerns, among others (The Global Fund, 2020; Krishnan, et al., 2014; WHO, 2007). In turn, this may put women at risk for interpersonal violence. In turn, gender-based violence due to diagnosis may lead not completing treatment. A gender competent provider must be comfortable discussing with the patient, if desired, topics such as partner notification and support resources available (ECDC, 2016; UNAIDS, 2016; Courtwright & Turner, 2010).

5. Addressing Differentiated Care for Co-Infection and Risk refers to the provider’s inclusive strategy and timely response to potential coinfection of TB with HIV and other co-morbidities such as diabetes, cardiovascular disease and other opportunistic infections (OIs) such as pneumonia. These co-morbidities may pose risk and experience that may be specific based on a patient’s sex or gender and therefore require differentiated care provision.

Since TB presents unique biological differences in illness progression and treatment outcomes, a gender competent provider is aware about how differentiated care provision is

implemented. Providers can incorporate a gender lens in analysis of susceptibility, immunity, exposure, treatment, morbidity and mortality. A gender competent provider is aware of special considerations when conducting these interventions during pregnancy of a possible TB patient. The provider also explains any of these considerations and safety precautions through providing health education or by answering the questions and concerns of patients or couples (Kaplan, et al., 2009). Ignoring gender and other socio-behavioral determinants in treatment would lead to ineffective treatment results or to patients becoming nonadherent because of treatment side effects that patients may not fully understand without sufficient and timely information (WHO, 2014).



A medical technologist working in a facility with TB services.

(Photo credit: Chemonics/ USAID TIPS)

Gender Competency Framework for Tuberculosis Service Providers

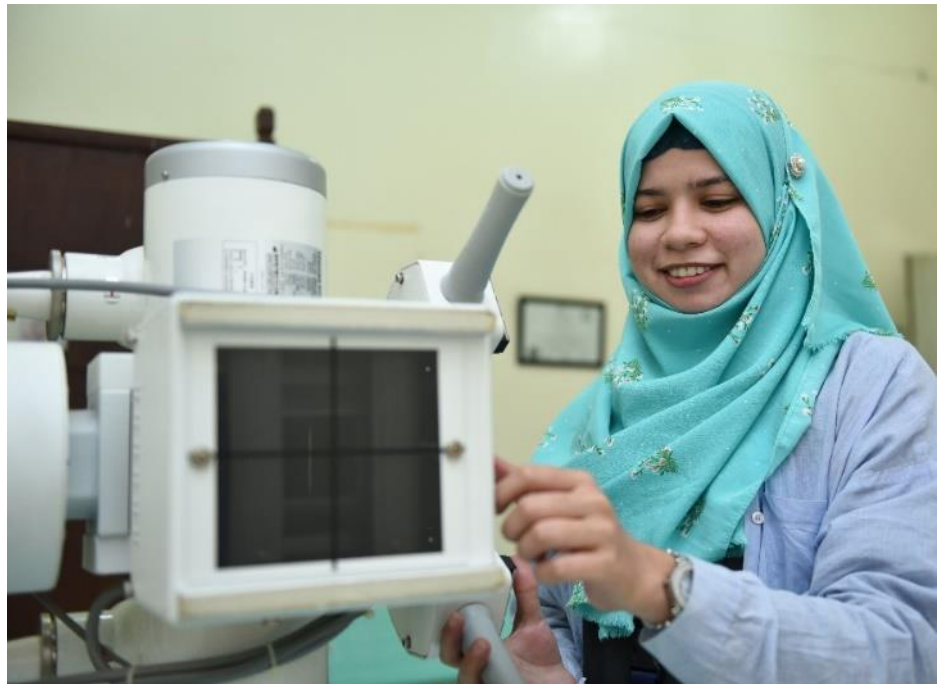
The Gender Competency Framework for Tuberculosis Service Providers lists the essential knowledge, skills, and attitudes, for a provider to be gender competent. Since TB services are provided by many types of providers, including nurses, community health workers/volunteers, health educators, clinicians, physicians, and pharmacists, the competency framework applies to these different cadres.

Knowledge, skills, and attitudes are essential building blocks of competencies and are also important elements of learning and development. All are required to successfully perform critical job functions and enable managers to evaluate work, including establishing

performance standards according to a specific role and setting. Training programs, such as preservice education for health professionals, should result in increased knowledge, strengthened skills, and improved attitudes about the subject matter. Learning objectives in any training program or curriculum should address knowledge, skills, and attitudes to holistically contribute to improved performance. Supervision and monitoring should be based on the desired knowledge, skills, and attitudes that are specified in service delivery standards, training programs, and performance expectations given in job descriptions. In the framework, the essential knowledge, skill(s), and attitude(s) for each competency are defined and are identified using the icons shown in the key.

By building on the five domains that were identified in the desk review contributing to an overarching gender-transformative strategy towards improved TB health outcomes and gender equality, USAID's HRH2030/Philippines developed a two-page "Gender Competency Framework for TB Service Provision in the Philippines" found in the succeeding section of this technical brief. The competency framework identifies 30 competencies categorized under the following five domain areas:















1. Using gender-sensitive communication
2. Designing and implementing gender aware TB prevention strategies
3. Creating tailored treatment strategies
4. Advancing stigma-free care for men and women
5. Addressing differentiated care for co-infection and risk























A medical technologist prepares the Genexpert test which is a molecular test for TB.
(Photo credit: HRH2030/Philippines)

Figure 2. Gender Competency Framework for Tuberculosis Service Providers

IMPORTANT: The competencies within this table focus on gender-related aspects of TB services and they do not address clinical competencies more generally. As such, they should be considered in conjunction with the most current comprehensive TB service guidelines and standards of care, such as the Compendium of WHO Guidelines and Associated Standards, second edition (WHO, 2018a), the Clinical Practice Guidelines on the Diagnosis, Treatment, Prevention and Control of Tuberculosis (Philippine Coalition Against Tuberculosis, 2016) and the National Tuberculosis Control Program Manual of Procedures, sixth edition (DOH, forthcoming in 2019).

Key	Knowledge 	Skills 	Attitudes 
Domain	Competency		
<p>1. Using Gender-Sensitive Communication refers to the provider's transmission of information through verbal and non-verbal communication in a way that is patient-centered and gender-specific recognizing their unique and unequal conditions as well as potential experience of stigma or discrimination and that promotes equality for all diagnosed and potentially infected TB patients.</p>	 a. Aware of the unequal conditions that may exist because of gender, culture, education, economic status or other differences and that affect vulnerability to TB transmission and access to information and care.		
	 b. Aware that provider's gender may influence quality of patient-provider relationship and a tension-free experience.		
	 c. Imparts clear information to patients to obtain continuum of care, considering challenges created by the patient's gender including literacy, experience of stigma, and ability to participate in treatment.		
	 d. Listens and addresses comfortably the patient and significant others' fears, concerns and challenges which may be different with women or men surrounding their continuum of care from diagnosis to recovery.		
	 e. Maintains relaxed, friendly and attentive body postures and eye contact, as appropriate, to show respect for and establish trust from the patient, in consideration to gender and diagnosis.		
	 f. Recognizes that sex and gender disparities not only influence TB-affected persons but also provider ability to make a TB diagnosis.		
<p>2. Designing and Implementing Gender Aware TB Prevention Strategies refers to the provider's capacity to convey correct information and co-plan effective strategies for preventing TB with consideration of barriers in women and men's health-seeking behaviors through integrated, people-centered, community-based and gender-responsive health education.</p>	 a. Familiar with the sex and gender disparities in the health-seeking behavior, transmission, testing, symptoms, treatment and adherence with TB infection.		
	 b. Understands that gender, geography, mobility, financial capacity, legal status, stigma and other factors may facilitate or deter the patient's recommended prevention, control and treatment strategies in TB.		
	 c. Addresses perceptions or attitudes influenced by gender power and decision-making relations that can affect understanding, planning and implementing TB prevention strategies		
	 d. Delivers health education campaigns on TB prevention strategies that considers the availability and specific needs of women and men at home, school, community or workplace.		
	 e. Acknowledges that healthcare services may be hard to reach and procedures too rigid and reluctant to adapt with patient's needs, opportunities and constraints influenced by their social status, sex or gender.		

Key	Knowledge 	Skills 	Attitudes 
Domain Competency			
<p>3. Creating Tailored Treatment Strategies refers to the provider's ability to tailor a comprehensive treatment plan alongside TB patients depending on their full range of medical, economic and psychosocial needs, opportunities and constraints as women and men.</p>	 a. Realizes the gender-specific obstacles and preferences of individuals to access, Directly Observed Treatment Short-course (DOTS) services.		
	 b. Aware that gender may influence the preference of TB support groups, whether social or familial.		
	 c. Uses available funds to assist with gender-related barriers to TB treatment such as cost of transportation, food and lodging (as applicable).		
	 d. Practices or role-plays scenarios to strengthen the patient's ability to discuss TB especially with his/her direct social group, e.g. partner or family.		
	 e. Analyzes causes of patient nonadherence to treatment in relation to harmful gender norms perpetrated in the household, community or workplace.		
	 f. Accepts and facilitates the patient's decision to explore additional approaches of treatment that address gender-specific needs.		
	 g. Encourages the patient to share gender-specific concerns such as fears of isolation or rejection from friends and family.		
<p>4. Advancing Stigma-Free Care for Men and Women refers to the provider's delivery of continuum of care implementing stigma-free strategies that counter harmful gender norms including those that risk gender-based violence from providers and other people against diagnosed and potentially infected TB/ MDR-TB patients.</p>	 a. Conscious that harmful gender norms may create stigma impacting ability to manage illness and complete treatment.		
	 b. Provides care and treatment in which universal infection control and standard precautions are always observed in the same manner with all patients.		
	 c. Asks questions about stigma, discrimination and GBV of clients due to their diagnosis when they disclose that they have experienced such or when the patient shows signs and symptoms.		
	 d. If trained, conducts warm and compassionate counseling while using the 4R's approach to GBV: Recognition, Recording, Reporting and Referral.		
	 e. Responds to gendered concerns on confidentiality, privacy, and safety including partner notification.		
	 f. Reinforces a client's right to be treated with respect; free from threats, violence, or coercion; and free from victim-blaming and stigma.		
<p>5. Addressing Differentiated Care for Co-Infection and Risk refers to the provider's inclusive, timely response to potential coinfection which may be specific based on a patient's sex or gender and therefore require differentiated care provision.</p>	 a. Aware that people can have increased risk of TB due to biological (including sex and lifecycle) and behavioral (including gender factors) factors that compromise immune functions.		
	 b. Discerns that differential treatment is medically advised for individual patients according to their sex and gender as well as the needs and conditions warranted by the coinfection of HIV and other OIs.		
	 c. Provides more information about the effects of TB medication which can vary between sex, gender or when pregnant to reduce the risk of patients becoming nonadherent when experiencing side effects.		
	 d. Acknowledges that the client has a right to make the final decision about whether to follow treatment modifications and behavioral change advice.		

Recommendations for Future Directions

The Gender Competency Framework for Tuberculosis Service Providers offers a valuable guide for integrating gender in TB programming in the context of health care workers. There are many opportunities to operationalize the competencies including TB e-Learning modules, contributing to designs of TB programs, or developing Philippines-specific dissemination tools for TB providers and DOTS facilities.

While the current framework already brings together the best practices and lessons learned from USAID programs, the DOH NTP and scientific researches, there is a need to develop and validate the framework for the successful adaptation and integration in different forms and approaches. The following recommendations are identified:





A nurse delivers health education campaign on TB in a clinic in Tarlac, Philippines. (Photo credit: HRH2030/Philippines)

- 1. Convening an Expert Consultation Group.** The Gender Competency Framework for FP Service Providers was vetted by experts in gender, FP and gender-based violence who provided feedback which was incorporated into subsequent versions of the framework. USAID Philippines can advocate other IPs to further vet this current five-domain framework by bringing together a wide range of expertise on gender and TB from experts in the Philippines and around the world.
- 2. Validating the Framework with TB Providers.** To test the applicability of the concepts within the framework, there is a need to validate the resource in the country with central-level stakeholders and TB service providers in the health care facilities. The validation would allow stakeholders and providers to discuss the framework's domains, obtain feedback about the language used, and find real-life examples for each domain area.
- 3. Disseminating through Research.** As part of disseminating the framework, lessons learned can be shared in health/ medical conferences tackling TB concerns or be published in research articles or journals. This provides an opportunity to uphold the implementation and adaptation of the gender competency framework for health workers as these events bring together other TB experts, practitioners, civil society, development partners, and policy makers. Journals, on the other hand, open the opportunity for gender researchers in the field to further the literature and adapt the concepts in future researches.
- 4. Integrating into Trainings and Programming.** For sustaining gender competencies and building local human resources for health (HRH) capacity, the knowledge, skills and attitudes identified in each domain area can be translated into learning materials and designs for traditional and e-Learning methods of pre-service education and in-service training for health care workers and certification of TB service providers. This is the single most effective way of sustaining the efforts of the work as the technical brief is developed in such a way that it is easily adapted to competency assessment for providers.
- 5. Pilot-test Trainings/ Programs Integrated with Competencies.** To further refine content of the framework, especially its domains, the pilot testing of TB trainings and programs integrated with the gender competency framework will reveal strengths and weaknesses of health care providers involved in TB service delivery. This also responds to any changes or updates in the delivery of TB service delivery in relation to clinical competencies.

The objectives of this combined work outlined in these recommendations are to effectively develop a gender-competent TB workforce by making available to relevant stakeholders the resources to increase gender competency among TB service providers so they can address gender-specific issues, challenges and constraints and contribute to positive patient experience and ultimately achieve the broader goal of improved TB health outcomes.

Appendix 1: Gender Differences in Infectious Disease

Table 3. Typical differences between males and females in the infectious disease process

	Who becomes ill? 		Course and Outcome 	
Lifecycle	Susceptibility or Immunity	Exposure	Treatment	Morbidity and Mortality
Infants	Males have naturally weaker immune systems.	Exposure is similar for male and female infants.	In some countries, boys are more often taken for treatment outside the home.	There is greater male mortality from infectious diseases.
Children	Levels of immunization for boys and girls are similar in most parts of the world.	In some societies, there are mobility differences (boys spend more time outside the home), which may account for differences and incidence and mortality for some diseases.	In some countries, boys are more often and/ or more quickly taken for treatment outside the home.	These are disease-specific differences in severity and outcome. Morbidity and disability may have different consequences for girls and boys.
Adults	For most infectious diseases, differences in incidence rates between males and females are more likely to be due to differences in exposure than to differences in immunity.	Men and women have different occupational exposures. Women have greater exposure in homes; men have greater exposure outside. Women are exposed in care-taker roles within the family and in care-giving occupations.	In some societies, women have poorer access to health care outside the home; access to outside care is controlled by males or other family members. Research on treatment often uses males – so there is less evidence for results for females.	There are disease-specific differences in severity and outcome. Morbidity and disability may have different consequences for males and females.
Pregnant and lactating women	Important changes in the immune system occur during pregnancy. Large knowledge gaps exist about the specific changes.	Exposure to some diseases may change during pregnancy. Pregnant women have more exposure to health care settings, so may be at greater risk for some nosocomial infections (infections developed while in the health care facility).	Some treatments and control measures are harmful to pregnant women or to fetus or breastfeeding baby. Pregnant women are excluded from research on treatment. Some treatments not given pregnant women because of insufficient evidence of safety.	Some diseases are particularly virulent during pregnancy. Some diseases adversely affect fetus or breastfeeding baby.
Elderly	Both males and females have poorer immune systems in old age.	Lack of evidence.	Diagnosis is more difficult in the elderly for both males and females due to atypical presentations.	There are more women than men in this age group. Males die younger. Very little information is available on sex and gender differences and infectious diseases in this age group.

Adapted from WHO, 2007.

References

- Center for Disease Control and Prevention (CDC). (2010). *Promoting Cultural Sensitivity: A Practical Guide for Tuberculosis Programs Providing Services to Karen Persons from Burma*. Atlanta, GA: U.S. Department of Health and Human Services.
- Craig, G.M., Daftary, A., Engel, N., O'Driscoll, S. & Ioannaki, A. (2016). Tuberculosis stigma as a social determinant of health: A systematic mapping review of research in low incidence countries. *International Journal of Infectious Diseases*, 56: 90-100.
- Courtwright, A. & Turner, A.N. (2010). Tuberculosis and Stigmatization: Pathways and Interventions. *Public Health Reports*, 4(125): 34-42.
- Department of Health (DOH). (2017). *National TB Control Program: Joint Tuberculosis Program Review*. Manila: Author.
- Department of Health (DOH). (2018). *National Tuberculosis Prevalence Survey 2016 Philippines*. Manila: Author.
- Department of Health (DOH). (2019, forthcoming). *National Tuberculosis Control Program Manual of Procedures*. Sixth Edition. Manila: Author.
- European Centre for Disease Prevention and Control (ECDC). (2016). *Guidance on tuberculosis control in vulnerable and hard-to-reach populations*. Stockholm: Author.
- Global Tuberculosis Institute (GTI). (2008). *Cultural Competency and Tuberculosis Care: A Guide for Self-Study and Self-Assessment*. New Wark, NJ: New Jersey Medical School.
- Higgins, J., Hoffman, S. & Dworkin, S. (2010). Rethinking Gender, Heterosexual Men, and Women's Vulnerability to HIV/AIDS. *American Journal of Public Health*, 100 (3): 435-445.
- Human Resources for Health 2030 Consortium (HRH2030). (2019). *Defining and Advancing Gender-Competent Family Planning Service Providers: A Competency Framework and Technical Brief*. Washington, DC: USAID.
- Human Resources for Health 2030 Philippines (HRH2030/Philippines). (2020). *Filipino Patient Experience Framework, Cross-Case Analysis and Patient Experience Assessment Tool*. Manila: USAID.
- Interagency Gender Working Group of United States Agency for International Development (IGWG of USAID). (2008). *Addressing Gender-Based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers. Second Edition*. Washington, DC: USAID.
- International Center for Research on Women (ICRW). (2011). *Suspending Judgment: A report of the training workshop on stigma reduction for health care workers*. New Delhi: Author.
- Irani, L., Hardee, K. & Bishop, M. (2015). *A Tool to Assess the Gender Sensitivity of a Health Facility*. Washington DC: Futures Group, Health Policy Project.
- Joint United Nations Programme on HIV and AIDS (UNAIDS). (2016). *Gender assessment tool for National HIV and TB responses.: Towards gender-transformative HIV and TB responses*. New York, NY: UNAIDS and Stop TB Partnership.
- Joint United Nations Programme on HIV and AIDS (UNAIDS). (2017). *Background Note: Zero Discrimination in Health Care Settings*. Geneva: Author.
- Kaplan, J., Benson, C., Holmes, K., Brooks, J., Phar, A.P. & Masur, H. (2009). *Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents*. Atlanta: Centers for Disease Control and Prevention.
- Kidd, R., Clay, S., Stockton, M. & Nyabblade, L. (2015). *Facilitator's Training Guide for a Stigma-Free Health Facility*. Washington, DC: USAID.
- Krishnan, L., Akande, T., Shankar, A., McIntire, K., Gounder, C., Gupta, A. & Yang, W.T. (2014). Gender-Related Barriers and Delays in Accessing Tuberculosis Diagnostic and Treatment Services: A Systematic Review of Qualitative Studies. *Tuberculosis Research and Treatment*, 2014 (215059).
- Law-Wilde, S., Tangcalagan, K. & Poling, A. (2020). *Equitable Services through Improved Gender Competence of Family Planning Providers: Lessons from the Philippines for Global Application*. Paper presented at the International Social and Behavior Change Communication Summit 2020, Marrakech, Morocco.
- MEASURE Evaluation. (2017). *The Importance of Gender in Tuberculosis Data*. Chapel Hill, NC: Author.
- Michael, O., Sogaolu, O., Fehintola, F., Ige, O. & Falade, C. (2016). Adverse Events to First Line Anti-Tuberculosis Drugs in Patients Co-infected with HIV and Tuberculosis. *Annals of Ibadan Postgraduate Medicine*. 14 (1): 21-29

- Muralidharan, A., Fehringer, J., Pappa, S., Rottach, E., Das, M. & Mandal., M. (2014). *Transforming Gender Norms, Roles, and Power Dynamics for Better Health: Evidence from a Systematic Review of Gender-integrated Health Programs in Low- and Middle-Income Countries*. Washington DC: Futures Group, Health Policy Project; and Chapel Hill, North Carolina: MEASURE Evaluation.
- Murphy, M., Wills, G., Murphy, S., Louw, C., Bateson, A., Hunt, R., McHugh, T., Nunn, A., Meredith, S., Mendel, C., Spigelman, M., Crook, A., & Gillespie, S. (2018). Gender differences in tuberculosis treatment outcomes: a post hoc analysis of the REMoxTB study. *BMC Medicine*. 16 (189).
- Onifade, D., Bayer, A., Montoya, R., Haro, M., Alva, J., et al. (2010). Gender-related factors influencing tuberculosis control in shantytowns: A qualitative study. *BioMed Central Public Health*, 10(381): 1-11.
- Pathmanathan. I., Pevzner, E., Cavanaugh, J. & Nelson, L. (2017). Addressing tuberculosis in differentiated care provision for people living with HIV. *Bulletin of the World Health Organization*, 95:3.
- Philippine Coalition Against Tuberculosis (PhilCAT), Philippine Society for Microbiology and Infectious Diseases (PSMID) & (Philippine College of Chest Physicians (PCCP). (2016). *Clinical Practice Guidelines for the Diagnosis, Treatment, Prevention and Control of Tuberculosis in Adult Filipinos: 2016 Update*. Manila: PhilCAT.
- Royal College of Nursing (RCN). (2017). *Tuberculosis Nurse Competency Framework for TB Prevention, Care and Control*. London: Author.
- TB Care I. (2014). *International Standards for Tuberculosis Care*, Hague: USAID.
- TB Care I. (2013). *TB Competencies for Pre-Service Nurses in East, Central and Southern Africa Region*. Washington, DC: USAID.
- TB Innovations and Health Systems Strengthening Project (TB Innovations). (2019). *Gender Desk Review*. Manila: USAID.
- The Global Fund. (2017). *Tuberculosis, Gender and Human Rights Technical Brief*. Geneva: Author.
- The Global Fund. (2020). *Technical Brief: Tuberculosis, Gender and Human Rights*. Geneva: Author.
- Tupasi, T., Garfin, A.M.C., Kurbatova, E., Mangan, J., Orillaza-Chi, R., et. al. (2016). Factors Associated with Loss to Follow-up during Treatment for Multidrug-Resistant Tuberculosis, the Philippines, 2012-2014. *Emerging Infectious Diseases*, 22(3): 491-502.
- Thorson, A., Hoang Long, N., Johansson, E. & Diwan V. (2007). *Tuberculosis and Gender*. Denmark: WHO European Ministerial Forum.
- United States Agency for International Development (USAID). (2014). *LGBT Vision for Action: Promoting and Supporting the Inclusion of Lesbian, Gay, Bisexual, and Transgender Individuals*. Washington, DC: Author.
- United States Agency for International Development (USAID). (2016). *Gender-Sensitive Indicators for Use in Europe and Eurasia*. Washington, DC: Author.
- United States Agency for International Development (USAID). (2019). *A Time of Change: Accelerating the Response to TB. Tuberculosis Report to Congress*. Washington, DC: Author.
- Van den Hof, S., Najlis, C.A., Bloss, E., & Straetmans, M. (2010). *A systematic review on the role of gender in tuberculosis control*. Washington, DC: USAID.
- World Care Council (WCC). (2006). *The Patients' Charter for Tuberculosis Care: Patients' Rights and Responsibilities*. San Francisco, CA: University of California.
- World Health Organization (WHO). (2005). *Gender in Tuberculosis Research*. Rome: Author.
- World Health Organization (WHO). (2007). *Addressing sex and gender in epidemic-prone infectious diseases*. Geneva: Author.
- World Health Organization (WHO). (2008). *Essential Actions for Effective TB Infection Control Safety without Stigma*. Geneva: WHO and Stop TB Partnership.
- World Health Organization (WHO). (2015). *Tuberculosis in Women*. Geneva: Author.
- World Health Organization (WHO). (2018a). *Compendium of WHO guidelines and associated standards: Ensuring optimum delivery of the cascade of care for patients with tuberculosis. Second Edition*. Barcelona: Author.
- World Health Organization (WHO). (2018b). *Global Tuberculosis Report 2018*. Lyon: Author.