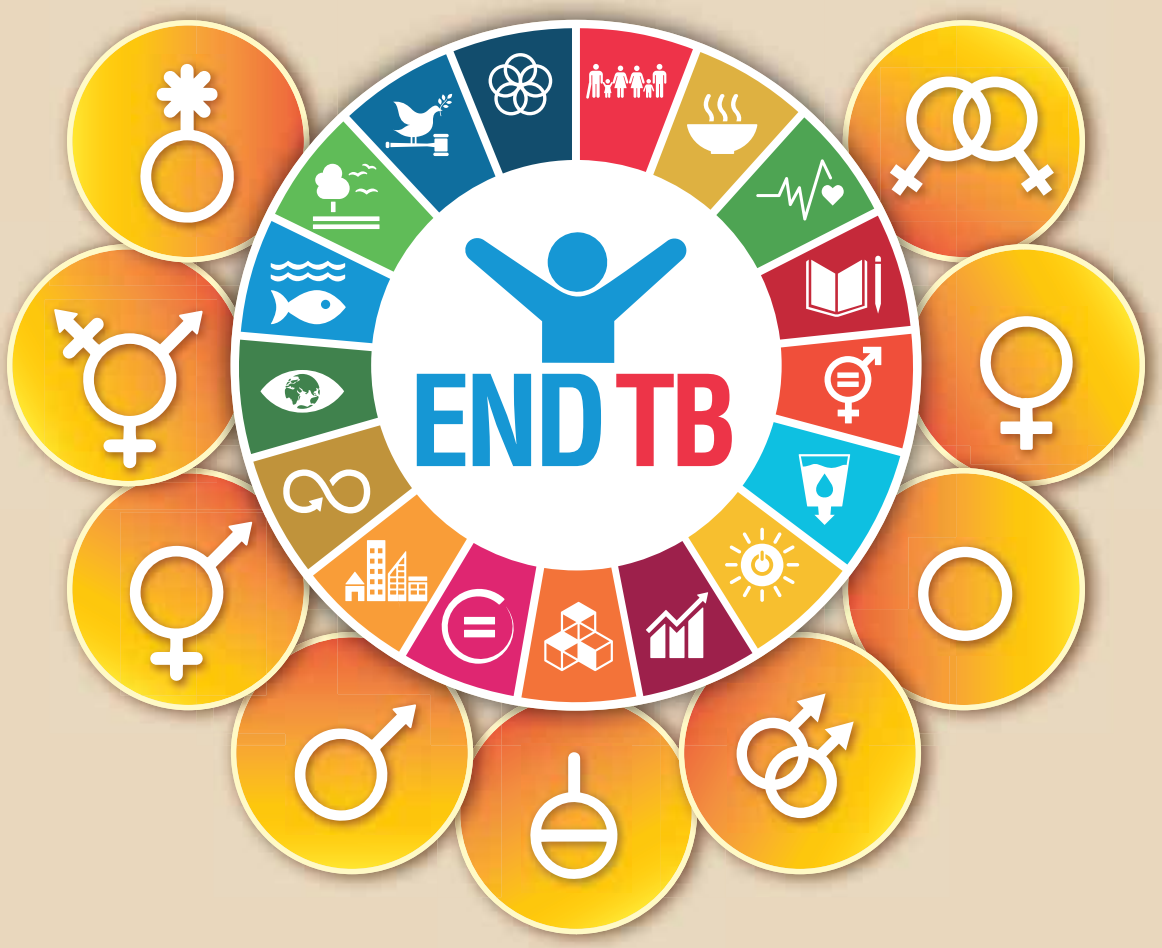
Ministry of Health and Family Welfare
Government of India

NATIONAL FRAMEWORK FOR A GENDER-RESPONSIVE APPROACH TO TUBERCULOSIS

Inclusive Quality TB Care for People of Varied Sexual Orientation, Gender Identities and Expressions and Sex Characteristics



Central TB Division
Ministry of Health and Family Welfare, New Delhi

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NATIONAL FRAMEWORK FOR A GENDER-RESPONSIVE APPROACH TO TUBERCULOSIS

[Inclusive Quality TB Care for People of Varied Sexual Orientation, Gender Identities and Expressions and Sex Characteristics]

अपूर्व चन्द्रा, भा.प्र.से.
सचिव
APURVA CHANDRA, IAS
Secretary

सत्यमेव जयते

आज़ादी का अमृत महोत्सव

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Foreword

India's commitment to achieving the Sustainable Development Goals (SDGs) is reflected in the nation's ambitious policies and strategies across various sectors. Goal 5 of the SDGs specifically refers to the achievement of gender equality and empowerment of all women and girls. Over the years, gender issues have been integrated into all policies in a cross-cutting manner.

The linkages between health and gender are well established. We know that good health and well-being and gender equality are strongly linked. At the individual level, a person's gender identity and sexual orientation strongly impact his/her access to health services, experience of health care systems and health outcomes. At the Ministry of Health and Family Welfare, we are working to ensure that we provide person-centred, high-quality care to all those who need it. This includes making sure that care is gender-responsive and that services are provided with dignity and confidentiality.

The National TB Elimination Programme is one of the first large-scale health programme in India to develop a gender-responsive strategy and work dedicatedly to embed this in all its actions and interventions. This updated National Framework for a Gender-responsive approach to TB is an explicit commitment to providing services that are cognisant of the diverse needs of people of all gender identities and sexual orientations.

I congratulate the NTEP and all those who have contributed to the development of this framework. I am confident that the lessons learned from the implementation of this framework will be shared with other health programmes and help India achieve our vision of both a TB-free India and a gender-equal nation.

Dated 13th March, 2024

(Apurva Chandra)

Room No. 156, A-Wing, Nirman Bhawan, New Delhi-110 011
Tele : (O) 011-23061863, 23063221, E-mail : secyhfw@nic.in

एल. एस. चाँगसन, भा.प्र.से.
अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)
L. S. Changsan, IAS
Additional Secretary & Mission Director (NHM)

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhawan, New Delhi - 110011

Message

India has been one of the first countries globally to develop a 'National Framework for a Gender-responsive approach to TB' in 2021. This path-breaking document was an integral part of our accelerated and ambitious efforts to achieve tuberculosis elimination in India and in keeping with our commitment to achieve the Sustainable Development Goals (SDGs). We have worked towards the SDG goals systematically and with creativity, recognising the need to adopt an intersectional approach to health. The gendered nature of health was well-established, and this framework was one of the first policy documents to apply a gender lens to a specific disease, i.e. tuberculosis.

Today, in 2024, on behalf of the Ministry of Health and Family Welfare, Govt. of India, it gives me great pleasure to present a more inclusive and updated Framework, which makes an explicit commitment to ensuring 'inclusive Quality TB Care for People of Varied Sexual Orientation, Gender Identities and Expressions and Sex Characteristics'. In other words, we recognise and will respond, with sensitivity and respect, to the diverse gender-specific needs of people and communities affected by TB, including women, LGBTQIA++ persons and men.

I congratulate the National TB Elimination Programme Team and all its partners for developing this remarkable document. We can only end TB when every single person receives the highest quality of care possible, and this framework is another giant leap towards achieving that goal. We must continue our efforts to translate the ambitious vision of this framework into tangible action at every level and harness all our energies to end TB in India.

TB Harega, Desh Jitega!

(Ms. L. S. Changsan)

'A' Wing, Nirman Bhawan, New Delhi-110011
Tel. : 011-23061723, 23061773, e-mail : lschangsan@nic.in

डॉ. के. के. त्रिपाठी, आई.ई.एस.
Dr. K.K. Tripathy, IES
आर्थिक सलाहकार
Economic Adviser

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली-110011
GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
NIRMAN BHAWAN, NEW DELHI-110011

Message

India's ambitious National Strategic Plan for Tuberculosis Elimination outlines the pathways to ending TB in India by ensuring universal access to high-quality tools and regimens, adopting person-centred strategies, engaging affected communities and focusing on key vulnerable populations.

Ensuring a gender-responsive approach is key to providing person-centred care, as outlined in this unique National Framework for a Gender-responsive approach to TB. Every individual has a complex sense of 'identity', driven by our age, gender, sexual orientation, where we live, the languages we speak, our socio-economic background etc. These factors also influence the health care we seek and the services we receive, and it is our responsibility as policymakers and health care providers to acknowledge these complexities. This updated Framework clearly outlines how gender and sexual orientation are determinants of health and why we must strive to make our services even more inclusive of our diverse communities.

Every individual with TB or TB symptoms must be able to walk into our health facilities, knowing that they will receive care that is non-discriminatory and respectful of their privacy and confidentiality. It is this bold goal for which the Framework lays a strong foundation.

I congratulate the NTEP and partners for this updated Framework, which is the outcome of extended deliberation with technical partners, civil society and affected communities. The Framework reiterates our resolve and determination to work towards our goal of ending TB in India.

K. K. Tripathy

(Dr. K. K. Tripathy)

Dated:- 13.03.2024

Room No. 244, 'A'-Wing, Nirman Bhawan, New Delhi-110 011, Tel. : 23061447, 23062157, E-mail : kk.tripathy@nic.in

Dr. Rajendra P. Joshi
Deputy Director General
Central TB Division

सत्यमेव जयते

भारत सरकार
GOVERNMENT OF INDIA
स्वास्थ्य और परिवार कल्याण मंत्रालय
MINISTRY OF HEALTH & FAMILY WELFARE
ROOM NO. G2 (GROUND FLOOR),
JEEVAN VIHAR BUILDING, 3, SANSAD MARG,
CONNAUGHT PLACE
NEW DELHI - 110001
ddgtb@rntcp.org
ddgtb-mohfw@gov.in
011-21400941

Message

The last few years have seen the adoption of several new and ambitious strategies within NTEP, including the engagement of TB survivors as Champions, the involvement of families and caregivers, and the increased participation of elected representatives and community leaders. This updated National Framework for a Gender-responsive Approach to TB is yet another example of our commitment to ending TB in India and builds on our ongoing efforts to address the gender dimensions of the disease. India is one of the first countries to focus on this important area with the Gender Assessment, followed by collaborative efforts to develop the first iteration of this Framework, the development of robust training curricula, and the roll-out of pan-India training workshops to draw the attention of the senior NTEP teams to the gender-specific aspects of the disease.

I am proud to share that this Framework goes even further, expanding our understanding of the manner in which gender and sexual orientation impact access to TB and the experience of TB care services. The Framework introduces new vocabulary to the NTEP, adopting the nomenclature of SOGIESC (sexual orientation, gender identity and expression, and sex characteristics) for the first time, as well as the use of 'cis women' and 'cis men'. The Framework also declares our commitment to extending our engagement of families to 'chosen families', particularly for trans communities who are affected by TB, thereby recognising that familial ties are not limited to biological relationships.

On behalf of the NTEP, I extend my sincere gratitude to all the partners and experts who have contributed to the development of this updated Framework. I call on the NTEP team at the national, state, and district levels to pay close attention to the nuances of TB and gender outlined in this document, which will fast-track our progress towards becoming a truly inclusive and equitable health programme. Let us work together to achieve a TB-free India!

(Dr. Rajendra P Joshi)

Dr. Sanjay Kumar
MD (Public Health): DTCD
Adl Deputy Director General (ADDG)
NTEP, Central TB Division

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स्वास्थ्य और परिवार कल्याण मंत्रालय
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स्वास्थ्य सेवा महानिदेशालय
Dte. General of Health Services
निर्माण भवन, नई दिल्ली - 110011
Nirman Bhawan, New Delhi - 110011

The National Framework for a Gender-Responsive Approach to Tuberculosis, adopted in 2021, made India one of the first countries to integrate gender into the TB response. The Framework is a comprehensive strategy under India's NSP for fostering cross-cutting gender-responsive TB interventions under the programme. In keeping with the NTEP's practice of strengthening existing policies, this updated version of the Framework incorporates inputs from several LGBTQIA++ organisations and individuals and lessons learnt in early implementation.

The Framework summarises and cogently presents what we know about TB, gender, and sexual orientation. It describes in detail the various intersections of TB, gender, and sexual orientation, including the Biology and Epidemiology of TB, Exposure, Risks, and Vulnerability to TB, Health-seeking Behaviour and Access to Health Care, TB-related Stigma, Treatment Adherence and Completion, and the Socioeconomic and Psychosocial Impact of TB.

Further, the Framework outlines key objectives and guiding principles and delineates essential actions to operationalise each key pillar of the NSP – Detect, Treat, Prevent, and Build. The Framework has a comprehensive list of actions at the health system and community level that, if implemented, can help us achieve its objectives. Finally, the Framework offers suggestions on cross-cutting approaches, such as making our M&E systems and ACSM efforts more gender-inclusive and promoting a robust research agenda to address gaps in our knowledge about TB, gender and sexual orientation.

I am very grateful to all the members of the Sub-committee of Experts for Gender-responsive and LGBTQIA++-affirmative Actions in TB, whose unstinting efforts over the last several months have resulted in this aspirational Framework document. I especially thank the Chair, Dr Beena Thomas, and the Vice-Chairs, Simran Shaikh Bharucha and Dr Sundari Ravindran, for leading the deliberations. I am confident that we can continue to work together to operationalise the many elements of this Framework and ensure that our TB response is truly gender-responsive in both spirit and action.

(Dr Sanjay Kumar Mattoo)

टीबी हारेगा, देश जीतेगा / TB Harega, Desh Jeetega

Tel : 011-21401716, E-mail : mattoos@rntcp.org, sanjayk.mattoo@gov.in, sanjaykmattoo@gmail.com

ACKNOWLEDGEMENTS

A gender-responsive approach to tuberculosis (TB) is integral to the National Strategic Plan 2017-2025. This approach not only addresses the social determinants of TB but also discerns and mitigates the impact of gender identities and sexual orientations on the causes and consequences of TB, encompassing experiences of men, women, and the LGBTQIA++ community. Moreover, it plays a crucial role in mediating health-seeking behaviour and access to healthcare.

Recognising the sociocultural impediments to TB care across its continuum, India utilised the Communities, Rights, and Gender Tool developed by STOP TB Partnership. To comprehend the interplay of TB with gender and identify measures for gender-responsive TB care services in the National Tuberculosis Elimination Program (NTEP), the Central TB Division established a National Technical Expert Committee on TB in Women, focusing on gender issues in October 2018 with Dr Anjali Tempe as the chairperson along with, the government officials, esteemed academicians, community members, and partners as members of the committee.

The National Framework for a Gender-responsive Approach to TB in India, launched in 2020, integrates gender perspectives into the TB response. Rooted in the gender-responsive approach, the initial version of the Framework is a comprehensive document addressing key gender issues throughout the TB care cascade, outlining principle gender-responsive interventions along the Detect-Treat-Prevent-Build continuum.

As a dynamic document, the Framework allows for continuous evolution and integration of emerging insights and evidence. In pursuit of this, inputs from representatives across diverse sexualities and gender identities were received. Further, to ensure the Framework is comprehensive and inclusive of all gender and sexual identities, a new committee focusing on 'gender-responsive and queer-affirmative actions in TB' was constituted. The committee consisted of Dr Beena Thomas, chairperson, Ms Simran Barucha, and Dr Sundari Ravindran, former Professor Sree Chitra Tirunal Institute for Medical Sciences and Technology, vice-chairs. The members of this Committee are Mr Chapal Mehra, TB & LGBTQIA++ Rights Advocate and Public Health Specialist; Dr Ramila Bisht, Professor, Centre of Social Medicine and Community Health, JNU; Ms Ashna Ashesh, Lawyer and Public Health Professional (SATB); Ms Priti Sridhar, CEO, Mariwala Health Initiative; Ms Anupama Srinivasan, Asst. Director, Resource Group for Education and Advocacy for Community Health (REACH); Dr Santosh Giri, Kolkata Rishta; Mr Saurabh Kirpal, Senior Advocate, LGBTQIA++ Activist; Dr R P Joshi DDG (TB) CTD, MoHFW (Ex-officio); Dr Sanjay Kumar Mattoo, Adl DDG (TB), CTD, MoHFW (Ex-officio); Dr Karikalan N, Scientist 'C', ICMR-NIRT; Dr Stephen A, Scientist 'B', ICMR-NIRT; Dr Pooja Tripathi, National Consultant for Paediatric TB and Gender, CTD, The Union; and Dr Aman Gupta, National Consultant for TB Comorbidity & AI, CTD, WHO. A series of meetings were held to deliberate and finalise the Framework. In addition, a writing

group responsible for the content development of the framework was formed. The Writing Group members are Ms Anupama Srinivasan, Ms Ashna Ashesh, and Dr Pooja Tripathi.

We thank all the members of the National Technical Expert Committee on TB in Women and the drafting group for their contribution towards developing the first framework: Dr Ashok Kumar - Ex. Additional DGHS, Chairperson, NCG (Chairman); Dr Anjali Tempe from Lok Nayak Jai Prakash Hospital (Chair); Dr R.D. Pai representing FOGSI (Co-chair); Dr Ramila Bisht - Professor, Centre of Social Medicine & Community Health, Jawaharlal Nehru University (Co-chair); Dr K.S. Sachdeva -DDG (TB) - CTD, MoHFW (ex-officio); Deputy Commissioner (MH) - MoHFW (ex-officio); Dr J H Panwal - Joint Technical Advisor, Ministry of Women & Child Division; Dr Jana Narayan – Centre for Social Studies; Dr J B Sharma, Department of Obstetrics and Gynaecology, AIIMS; Dr Beena Thomas, Department of Social and Behavioural Research, NIRT; Dr Sundari Ravindran - Former Professor, Sree Chitra Tirunal Institute for Medical Sciences and Technology; Dr Jaikishan Karahyla, MM Institute of Medical Sciences; Dr Rama V Baru - Professor, Centre of Social Medicine & Community Health, Jawaharlal Nehru University; Dr Poonam Shivkumar, Mahatma Gandhi Institute of Medical Sciences, Wardha; Dr Suman Vishwakarma- Deputy CS (TB) Bhiwani; Dr Lakshmi Murali – District TB Officer, Tiruvallur; Dr Upasna Aggarwal, NITRD; Dr Amita Pitre - Gender Consultant, REACH; Dr Nalini Krishnan - Director, REACH; Dr Santosh Giri – Kolkata Rishta; Dr Sanjay Kumar Mattoo erstwhile Joint Director, Central TB Division; Dr Deepak Balasubramanian, Ex- Consultant, Central TB Division; Ms Nandita Venkatesan; Ms Rhea Lobo; Ms Amrita Limbu from Bolo Didi; Mr Sudeshwar Singh from TB Mukt Vahini; Ms Gopa Kumar from Touched by TB, and representatives from The Union, WHO, USAID, JEET, JHPIEGO, World Bank, National Tuberculosis Institute, Bengaluru and State TB Officers of Rajasthan and Mizoram.

In fostering health-equitable solutions, we ardently acknowledge and honour the resilience of the TB-affected LGBTQIA++ communities. Their formative involvement in shaping this framework is valued and essential as we strive for inclusivity, understanding, and a united front against our fight to End TB. Together, we embrace diversity, recognising that each voice contributes uniquely to the robust tapestry of our collective well-being. Special appreciation is reserved for Ms Anupama Srinivasan, Ms Ashna Ashesh, and Dr Pooja Tripathi for their exceptional work in shaping the framework through literature review, research and content development.

The CTD recognises, with profound gratitude, Ms Amrita Goswami's impactful work and dedicated advocacy for inclusivity within the TB Programme.

Our heartfelt thanks go to the United States Agency for International Development (USAID) for supporting the development of this document through its partner, REACH, and Mariwala Health Initiative for supporting the designing of the infographics. We anticipate the Framework will further fortify the NTEP's commitment to providing inclusive, high-quality TB care for all individuals.

CONTENTS

EXECUTIVE SUMMARY

I. Gender And Sexual Orientation As Determinants Of TB: Introduction

Tuberculosis (TB) remains a significant public health challenge in the 21st century. On average, India contributes to over a quarter of the global burden of TB. In 2022, Tuberculosis affected an estimated 10.6 million people globally, of which around 3.5 million were adult women (age 15 years and above). The National TB Elimination Programme (NTEP)'s National Strategic Plan for Tuberculosis Elimination (NSP 2017–2025) has identified women and LGBTQIA++ persons as key populations in terms of vulnerability to TB; the NSP highlights the need for concerted efforts to reach and address TB in these populations. In keeping with the vision outlined in the NSP, this National Framework for a Gender-responsive Approach to TB (Framework) in India acknowledges and aims to respond to the unique needs of cis women, LGBTQIA++ persons, and cis men affected by TB, building on the central understanding that gender and sexual orientation significantly impact the experience of TB and access to TB care.

Gender differences and inequities play a significant role in how cis women, LGBTQIA++ persons, and cis men access and receive healthcare in the public and private sectors. In 2023, of the over 25.5 lakh TB cases notified to the NTEP, 61% were male, 39% were female, and <1 % were transgender. Evidence is limited on vulnerability to TB for LGBTQIA++ persons. However, the end of the global tuberculosis epidemic requires that no one is left behind in terms of access to and availability and quality of TB care, irrespective of their sexual orientation, gender identity, expression, and sex characteristics (SOGIESC).

In addition, gender, sexual identity and associated inequities are powerful and cross-cutting determinants of health, in conjunction with other factors such as age, socioeconomic status, disability, ethnicity, and sexual orientation. (World Health Organisation, 2011, n.d.). Globally, gender inequities place the health of millions of cis women, girls and LGBTQIA++ persons at risk. Addressing gender inequities is the first step towards countering the historical burden of inequality and deprivation of rights faced by cis women, girls and LGBTQIA++ persons in households, communities, workplaces and healthcare settings.

This framework demonstrates how sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) are social determinants for TB and impact health-seeking behaviour and access to quality healthcare. The framework outlines a vision for TB care that is people-centred, rights-based, and gender-responsive. It highlights the available evidence, gaps, and challenges in providing gender-responsive TB care. At the heart of this framework is defining an inclusive approach to TB care and identifying and recommending potential actions for a people-centred, rights-based, and gender-responsive approach to TB.

II. Gender, Sexual Orientation and TB: Interactions

TB Burden and Epidemiology:

As per the Global TB Report, 2023, the burden of TB was higher in adult men (55% of all TB cases in 2022) than in adult women (33%). Although TB disease affects men more than women in absolute numbers, the number of women with TB globally and in India is significant. As per the findings of India's National TB Prevalence Survey (2019-2021), the prevalence of microbiologically confirmed pulmonary TB (PTB) in men was three times higher than in women (472/lakh population in men and 154/lakh population in women). The NTEP data shows a nearly equal notification of TB in both sexes in the age group of 15 to 24 years in most states and a higher notification of TB in girls between 0 to 14 years. 15 to 24 years is also the age group that accounts for the highest number of cases among all age groups for both women and men. After this age, TB notifications among men increase steadily compared to women. There is also evidence that the presentation of pulmonary TB in women may differ somewhat from in men, contributing to delays and making it difficult to diagnose TB in women. Historically, studies on health issues have excluded LGBTQIA++ persons. This is true in the case of TB as well, where there is a paucity of data on the burden of the disease in LGBTQIA++ persons, which needs to be addressed through inclusive research.

Gendered risks and vulnerabilities:

Gendered roles, responsibilities and expected behaviours can place cis women, LGBTQIA++ persons and cis men at an increased risk for TB. Women across the world, generally, and in patriarchal cultures, particularly, face a triple burden: paid work outside their homes, a significant share of unpaid care work within their homes, and caretaking responsibilities for children and older adults. The gendered division of labour results in women being primarily responsible for domestic tasks (including water and fuel-related work), child caring and rearing, and caring for older adults and the sick, with usually little help from their male counterparts. Moreover, decisions that will impact their well-being are often made for them, where women often might not have a say. In cases where the man is the sole income earner in the house, women are also financially dependent, further curbing their agency. These gendered roles and resulting power differentials make women vulnerable to TB in multiple ways.

The marginalisation and discrimination of LGBTQIA++ persons by family and society have led to social, educational, and economic exclusion and loss of socioeconomic advancement opportunities (Nadal et al., 2014). This vicious cycle of exclusion and marginalisation results in low education levels, discrimination in employment, poverty, and lack of access to safe housing and adequate nutrition. For instance, due to this cycle of marginalisation, many LGBTQIA++ persons are forced to live in overcrowded and poorly ventilated informal settlements. Furthermore, healthcare

is inaccessible for LGBTQIA++ persons due to anticipated and experienced discrimination in healthcare settings (Kcomt et al., 2020). In addition, a dearth of culturally competent knowledge (Kattari et al., 2015) and a lack of privacy in the health system lead to delayed not only diagnosis of TB and transmission for a longer duration but also poor adherence and a greater likelihood of not completing the treatment. Lastly, social and economic marginalisation, physical and sexual violence, gaps in legal and protective frameworks, and minority stress make sexual and gender minorities vulnerable to risk-prone behavioural and substance use (Meyer, 2003; Burgess et al., 2007; Coleman et al., 2012), which in turn increases vulnerability to TB.

Due to deeply entrenched gender roles, men are expected to earn an income and manage the household. Though gradually changing, gender norms and expectations still pressurise men to appear strong, be masculine, hide feelings of vulnerability and be ready to take risks when required. This often translates into perceived markers of masculinity such as smoking, drinking and taking risks regarding their health in order to be accepted by society at large. Therefore, while alcohol use and smoking among women are poorly accepted, these behaviours may be condoned or even encouraged in men due to prevailing gender norms. Smoking and alcohol consumption are, therefore, specific, but not exclusively, gender-linked factors increasing vulnerability to TB and barriers to timely TB diagnosis and treatment for men. TB is also an occupational risk for men and women, particularly those engaged in the informal sector. With regard to paid work, about 8.3 million people in India, primarily men, are estimated to be at risk of silicosis (Rastogi, 2018). They are employed in mining, quarrying, metals and construction industries. Their socioeconomic conditions may predispose them to TB, compounding the risk of TB secondary to silica-exposure.

Health-Seeking Behaviour and Access to Healthcare:

Conceptual mapping of gendered delays in care seeking for TB and access to TB services, described in detail in this Framework, highlights the differences and delays in accessing health care at the individual and systemic levels for cis women, LGBTQIA++ persons and cis men.

Experience of TB-related Stigma:

Despite the gains made in diagnosing and treating TB, the stigma and associated discrimination experienced by persons with or who are affected by TB is still pervasive. Although stigma associated with TB has multiple layers, whether perceived (or anticipated), experienced (or enacted), social (or internalised by one who is affected), it is detrimental to everyone affected by TB. Stigma is a fundamental barrier across the TB care cascade, affecting care-seeking behaviour, diagnosis, and treatment adherence. Moreover, shaped by social mores, beliefs, and interpersonal attitudes, TB-related stigma functions as a social determinant of health. Persons of all genders and sexual orientations experience stigma and discrimination. However, the experience and the impact of TB-related stigma varies for different genders and sexual identities.

Studies show that social isolation and job loss owing to TB-related stigma and reduced income

are primary concerns reported by cis men (Nair et al., 1997; Long et al., 2001). For cis women, the stigma is associated chiefly with marriage and marriage-related problems, harassment and differential treatment within the household. In LGBTQIA++ persons, the effect of stigma is layered and potentially threefold — the stigma of being socially discriminated against as an LGBTQIA++ person, as an LGBTQIA++ person with TB or presumed to have TB and as an LGBTQIA++ with HIV and TB or presumed to have HIV. LGBTQIA++ persons experience stigma and discrimination within health systems and are thus deterred from accessing care early.

Treatment Adherence and Completion:

Tuberculosis treatment adherence and completion are critical components of successfully combating this infectious disease. Factors influencing TB treatment adherence can be categorised into structural and individual factors. Structural factors pertain to the external conditions and systemic challenges that may affect a person's ability to adhere to treatment. On the other hand, individual factors involve characteristics and behaviours specific to the individual. Factors influencing TB treatment adherence range from external conditions and systemic challenges that may affect a person's ability to adhere to treatment. These may include socioeconomic factors, such as poverty, loss of livelihood, discrimination and isolation, and logistical barriers like transportation issues or distance from healthcare facilities. These factors, in turn, interact with a person's sexual orientation, gender identity, gender expression and sex characteristics and influence TB treatment adherence and completion.

Studies show that women have a higher probability of completing treatment, with better treatment outcomes, while men face challenges on this front. Married women may be unable to complete treatment for various reasons, including TB not being disclosed to the in-laws and the woman feeling compelled to hide her TB diagnosis because of social stigma, self-stigma and fear of rejection, or information on the safety of first-line TB drugs in pregnancy not adequately emphasised. Affected women and families end up prioritising the foetus's health over the mother's due to the unfounded fear that the medication will harm the foetus or a woman's fertility.

As outlined earlier, due to economic instability, social discrimination, internalised stigma and stigma within the health system, LGBTQIA++ individuals are often hindered from completing treatment. As a result, in many cases, they reinitiate treatment in the private sector at an increased cost of care. In cases documented by Survivors Against TB (SATB), LGBTQIA++persons found it hard to continue treatment due to discrimination and stigma in healthcare despite having no behavioural risk factor.

Studies have demonstrated that men struggle to complete TB treatment, particularly men who smoke or who use alcohol (Das et al., 2014; Jain et al., 2014; Nair et al., 2017; Ramachandran et al., 2017; Veerakumar et al., 2016). Adverse drug reactions or toxicity to TB drugs, migration, and taking medicines from other centres are also some of the reasons provided by people with TB for not completing treatment.

Socioeconomic Impact of TB:

The socioeconomic impact of TB varies across cis women, LGBTQIA++ persons and cis men. For instance, though studies of catastrophic expenses due to TB pertain to both men and women, most studies underline that the costs incurred by men were more than those by women (Ananthakrishnan et al., 2012; Muniyandi et al., n.d.; Rajeswari et al., 1999). The loss of income or employment affects men economically and socially, given the culture's ingrained expectation that men should be primary or sole income earners and provide for their families.

Studies on TB's socioeconomic and psychosocial impact on the lives of LGBTQIA++ persons in the region are scarce. However, given the existing marginalisation, health inequities, and socioeconomic exclusion experienced by LGBTQIA++ identities, it is safe to conclude that TB's socioeconomic and psychosocial impact is not only magnified for LGBTQIA++ persons but adds to the multiple layers of oppression. The socioeconomic effects of TB are further compounded for LGBTQIA++ persons as they often do not have the social safety nets of families and structured communities.

Psychosocial Impact of TB:

The psychosocial impact of TB is well documented. In recent years, several studies have shown the correlation between TB and mental illnesses as comorbidities. People on treatment for TB, as well as TB survivors, have reported mental health issues like depression, anxiety disorders, suicidal thoughts, and low self-esteem at some point in their TB journey.

A TB diagnosis and having to start treatment is traumatic for women, given the stigma and fear of rejection by families. Women face rejection, especially in joint families they were married into, and sometimes from their parental families (Weiss et al., 2006). The reduction of self-worth for the women themselves stemming from their inability to care for their children and perform routine household activities further exacerbates the family dynamics. On the other hand, studies also point to men being impacted due to the diagnosis of TB, the impact being more in terms of their inability to work, support the family and employment loss. Sometimes, there is also rejection from the family. While men also suffer the psychosocial impact of TB, instances of rejection by families are fewer than among women. The economic impact, impact on employment and impact on their families causes the maximum psychosocial trauma for men. However, men have the freedom and mobility to travel for work and live independently. Such options are often closed to women.

There is a paucity of studies on the psychosocial impact of TB on LGBTQIA++ persons. The interaction of discrimination, stigma, and minority stress endured by LGBTQIA++ persons with TB severely affects their mental health. Additionally, evidence demonstrates that stigma is a critical determinant of a person's mental well-being and affects health-seeking behaviour (Safer et al., 2016).

Gender, Sexual Orientation, and Healthcare Systems:

Just as society is organised along the lines of gender binaries resulting in gender inequalities, the health

system is also a gendered institution. Rights for people with TB as enshrined in NSP include providing essential information at each stage of treatment, including regarding medication side effects and effective communication by the health system. The NTEP proactively involves community members such as TB Champions and support groups to ensure adequate feedback regarding such challenges reaches the programme managers in real-time.

However, some of the barriers linked to gender, which affect the understanding of TB and the provision of adequate services, remain. For example, most NTEP programme managers across the country are predominately men. This reinforces the image of TB as a predominantly male disease. Similarly, the representation of TB survivors from cis women and LGBTQIA++ persons is crucial for an inclusive approach because of their lived experience and insights into community needs.

III. Framework for a Gender-Responsive Approach to TB and Its Programmatic Implementation

Overall Guiding Principles:

An effective and gender-responsive TB programme must incorporate programmatic and institutional mainstreaming elements (WHO, 2011). The programmatic approach ensures gender and sexuality mainstreaming in all aspects of implementing interventions and activities. At the same time, the Institutional approach ensures that institutions running the TB programme create an enabling environment that respects people of diverse sexual orientations, gender identities, gender expressions and sex characteristics. Moreover, it ensures that organisational procedures and mechanisms do not reinforce or reproduce societal inequities based on gender or sexual identity. For institutional gender mainstreaming, it is vital that affected communities co-lead agenda setting, policy development and governance, recruitment, staffing, budgetary allocations and administration.

The overall framework is based on the principles of access for all, respect for all, non-discrimination, promoting the rights-based care of individuals and groups, informed consent, informed choice, confidentiality, working in partnership, engaging communities, linking prevention, treatment and care, and fostering accountability. The framework delineates strategies and actions fundamental for gender-responsive TB care based on the four pillars of the NSP - Detect, Treat, Prevent and Build. Except for actions specific to the NTEP, most activities and actions also apply to the private sector. Therefore, private health providers must be sensitised to recognise and incorporate gender-responsive care into their service provision.

Training on Gender-responsiveness for NTEP Staff:

Building the health system's capacity to provide gender-responsive care is a critical first step in

creating a national TB elimination programme that acknowledges and responds to diverse needs across gender identities and sexual identities. All NTEP staff at the national, state, district and sub-district levels will be trained to understand the concepts of sex, gender and SOGIESC (Sexual Orientation, Gender Identity/Expression, and Sex Characteristics) and how gender and TB interact. The main objectives of the training will be to bring about a change in the knowledge, attitudes and practices of all staff, thereby equipping them with the cultural competencies and skills to provide gender-responsive care to people with TB and implement this framework. The training will emphasise actions that can be taken to make the TB programme gender-responsive at all levels through interactive activities and role-plays. The training curriculum can be adapted for different cadres of NTEP staff from different regions, focusing on key action points.

Gender-Responsive Approach to Detecting TB:

Essential actions at the health-system level include:

- For conducting community-level mapping, screening and active case finding among vulnerable groups, ensure representation of those affected. For example, engage with organisations and collectives led by women and LGBTQIA++ persons. Ensure representation of those affected. Ensure that those involved from the community are adequately compensated for their work, not just given a token honorarium.
- Ensuring that Active Case Finding (ACF) efforts are designed to incorporate an understanding of local communities to identify and prioritise vulnerable groups. There should be adequate and proportionate representation of people of all genders and sexual identities within ACF teams.
- Training healthcare providers to understand and acknowledge varied clinical presentation of symptoms for cis women, LGBTQIA++ persons, and cis men for both pulmonary and extrapulmonary TB.
- Tracking and analysing access to diagnostics across people of diverse genders and sexual orientations, including mapping access for those in remote areas.

At the Community level:

- Strengthen the participation of TB Champions, survivor-led networks and LGBTQIA++ collectives in reaching out to the community to sensitise them about the symptoms of TB and facilities available for testing.
- Engage TB Champions, local community leaders and LGBTQIA++ collectives in ACF drives to sensitise the community on upcoming ACF to improve acceptance among people of all genders and sexual orientations.
- Strengthen feedback from the community regarding diagnostic facilities and their accessibility through community monitoring. Fostering collaboration for TB screening with other community structures such as the National Livelihood Mission, Jan Aarogya Samiti, Mahila Aarogya Samiti, and Integrated Child Development Services centres.

Gender-Responsive Approach to Treating TB:

Key actions at the health-system level:

- Ensuring the NTEP staff are well-trained to recognise and respect gender-specific needs during treatment initiation.
- Ensuring that health staff do not practice gender stereotyping. Providing a private and non-judgemental safe space for all people with TB to enable them to speak freely.
- Identifying and addressing the specific needs of transgender persons diagnosed with TB and are on hormone therapy or during gender-affirmative procedures.
- Preventing systemic discrimination of cis women and LGBTQIA++ persons at all health facilities. All healthcare providers must be trained to understand the diverse needs of people of various genders and sexual orientations and practice respectful, empathetic, inclusive, and consistent communication to build rapport.
- Ensuring gender-inclusiveness in access to new treatment regimens in programmatic settings. Based on the available evidence, this is especially important for pregnant women and LGBTQIA++ persons, and ensuring informed consent, privacy and confidentiality.
- Ensuring that the identities of people with TB, including their gender identities or sexual orientation, are not revealed without their consent to their families or communities.
- Facilitate access to support services for people with TB who may experience gender-based violence. Train healthcare providers to be vigilant of this possibility and accordingly support linkages with relevant support services. For example, helpline numbers of relevant departments may be provided to them for reporting an incident.

At the Community level:

- Identifying and facilitating training and capacity-building of TB survivors and Champions to provide gender-responsive peer support to people with TB who are on treatment.
- Ensuring representation of women and survivors who identify as LGBTQIA++ as TB Champions in regular patient-provider meetings (with prior intimation to participating persons with TB). Also, provide targeted outreach to engage these members; for example, have a specific LGBTQIA++-led campaign encouraging LGBTQIA++ survivors to be involved as TB Champions.
- Enlisting the support of TB forums and survivor-led networks for community monitoring and feedback on the quality of treatment services.
- Ensuring that TB Forums are constituted at the district, state and national levels, with adequate and proportionate representation of affected community members of all genders and sexual identities, and that concerned programme officials will ensure that meetings are convened at regular intervals as required to identify and flag treatment-related challenges to the NTEP, in keeping with the mandate of Forums.

Gender-Responsive Approach to Preventing TB:

Key actions at the health-system level:

- Adopting a gender-responsive lens in ensuring contact screening of people with TB of diverse genders and sexual identities.
- Identifying those particularly vulnerable within families and ensuring that they are screened, including but not limited to women who are caregivers of people with TB, women who use solid fuels for cooking, pregnant and postpartum women in contact with people with TB, people of all genders and sexual identities who smoke, use drugs or alcohol and LGBTQIA++ persons and their contacts who are forced to live in crowded communities and have limited access to healthcare.
- Devising evidence-based, gender-responsive public health communication strategies and content on TPT or future vaccines that address the community's hesitancy about safety and efficacy.

At the Community level:

- Training and engaging TB Champions, survivor-led networks, and LGBTQIA++ collectives to provide appropriate counselling to promote the uptake of TPT.
- Ensuring availability of TPT beyond clinical settings by providing homes or community dwellings through trained health workers.
- Seeking feedback from people with TB, TB Champions, and survivor-led networks about common socio-cultural problems faced by people with TB, particularly cis women and LGBTQIA++ persons, in maintaining cough hygiene within households and accessing preventive care.

Building A Gender-Responsive Health System:

Essential actions for building resilient, gender-responsive health systems at the health-system level:

- Investing in sustained and long-term capacity building of NTEP staff at all levels, from national to sub-district and facility-level, on gender-responsiveness. In addition, discussions on gender issues must be incorporated in all routine programme meetings and reviews and not limited to a one-time training.
- Aiming for gender parity in the health system workforce to achieve nearly equitable participation of people of all genders and sexual orientations in the long term. However, in the short-term, ensure adequate and proportionate representation, focusing on making hiring practices inclusive to enable increased representation of cis women and LGBTQIA++ persons in the workforce.
- Adopting a gender-diverse and inclusive approach in selecting treatment supporters in the community, ensuring appropriate representation of people of all genders and sexual orientations.

At the Community level:

- Identifying and investing in learning from the experiences of affected communities. Building advocacy capacity of TB survivors and Champions, ensuring appropriate representation of

people of all genders and sexual orientations.

- Facilitating or supporting the formation of support groups for people with TB, ensuring appropriate representation of people of all genders and sexual orientations.
- Ensuring proportionate and appropriate representativeness of affected community representatives of all genders and sexual orientations in leadership roles and participation in TB Forums.

Advocacy, Communication and Social Mobilisation Activities:

Advocacy, Communications and Social Mobilisation (ACSM) around gender-responsive TB care is critical to ensuring meaningful community engagement and mobilisation for awareness and advocacy on gender-responsive TB care and services. The TB-affected community, including TB survivors, should be engaged as co-creators and equal partners in designing, planning and implementing gender-responsive ACSM activities. All ACSM committees and subcommittees should have adequate and proportionate representation of TB survivors of diverse genders and sexual identities, particularly those underrepresented, such as cis women and LGBTQIA++ persons. All ACSM training, materials, and campaigns should be diverse, equitable and inclusive, featuring people of diverse genders and sexual identities and ensuring the content is accessible and locally relevant. The messaging of ACSM content is to be differentiated and targeted as per the varied messaging needs of different genders and sexual identities.

Supervision, Monitoring and Evaluation with a Gender Lens:

In implementing the gender-responsive framework, monitoring and evaluation should also focus on the convergences and divergences in impact across all genders. It should focus on recording, interpreting and applying gender-disaggregated data to devise mechanisms that ensure gender-responsive interventions. Evaluation of gender-responsive programming should be incorporated into the existing evaluation framework used by the programme at all levels and should not be undertaken as a standalone activity. For example, ensuring that all monitoring and evaluation processes, including Joint Supportive Supervision, Central Internal Evaluation (CIE), and Annual Reviews, incorporate a review of gender dimensions, including the provision of gender-responsive care across the TB care cascade. The gender-responsive review should be co-led by members from the affected community, including LGBTQIA++ persons. Moreover, monitoring and evaluation are best co-led by CBOs through the community accountability framework, and evaluators from the community should have proportionate representation of all gender and sexual identities. Evaluating gender and sexuality training of staff and mainstreaming gender in all programme components.

Roles and Responsibilities of Various Stakeholders:

Building a gender-responsive response to TB in India is a joint process that requires the understanding and sustained efforts of everyone within the programme and other stakeholders outside the programme. The framework describes the roles and responsibilities of key institutions and players who are part of

the TB response, such as the Central TB Division; State TB Cell, District TB Cell; Medical Officers - MOTC and Medical officers of Peripheral Health Institutions; Peripheral healthcare workers; Civil Society Organisations and community groups including but not limited to TB survivor-led networks, women-led groups, LGBTQIA++ community collectives; TB Champions and Survivor-led Networks is outlined.

IV. Research Priorities and Collaboration

Research and Knowledge Building with a Gender Lens:

Cis women and LGBTQIA++ persons are inadequately represented in TB research. Further, research on TB often ignores social determinants like gender and sexual orientation and their impact on access to TB care. Research must focus on marginalised and socially vulnerable groups to understand better their health needs and interventions suited for these. Persons affected by TB from marginalised and socially vulnerable communities, including cis women or LGBTQIA++ individuals, persons with disabilities, or persons from marginalised castes, classes, and groups must be involved by the government, and public and private research institutions as equal partners in identifying research priorities, and in designing and conducting research in keeping with the principles of participatory research. It is also essential to ensure adequate, proportionate participation of all genders and sexual orientations and socially vulnerable groups, including but not limited to cis women, LGBTQIA++ persons, older persons, persons with disabilities, girls, and boys. Further, all research data must be disaggregated by age, gender, sexual orientation, class, caste, disability, ethnicity, religion, occupation and other relevant socio-demographic indicators for analysis. Finally, an ethics committee must review all research protocols, and such committees, in turn, should have adequate and proportionate representation of persons affected by TB across all genders and sexual orientations. At least 30% of the committees should be comprised of cis women and LGBTQIA++ persons with the relevant expertise.

Inter-Ministerial Collaboration and Multi-Stakeholder Engagement:

TB requires a multisectoral response as a socioeconomic disease with consequences beyond the clinical. This involves building and strengthening collaboration with ministries and departments beyond health at national and state levels to achieve a gender-responsive approach to TB by addressing its social determinants.

The framework is intended for programme managers and healthcare providers at the district, state, and national levels in the NTEP, as well as civil society and community representatives involved in providing and evaluating TB care services in the not-for-profit and private sectors. The framework is expected to initiate dialogue and interventions at all levels within the TB programme and among key stakeholders, strengthening the collective understanding of TB and gender. Once implemented, the framework envisages a gender-responsive programme to catalyse and accelerate efforts to end TB in India.

ABBREVIATIONS

AAAQ	Available, Accessible, Affordable, Quality care
ACF	Active Case Finding
ACSM	Advocacy, Communication, and Social Mobilisation
AFAB	Assigned Female At Birth
AIDS	Acquired Immunodeficiency Syndrome
AMAB	Assigned Male At Birth
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
ASHA	Accredited Social Health Activist
AYUSH	Ayurvedic, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BCG	Bacille Calmette Guerin
CAB	Community Advisory Benefits
CAFAB	Coercively Assigned Female At Birth
CAMAB	Coercively Assigned Male At Birth
CHC	Community Health Centres
CBO	Community-Based Organization
CIE	Central Internal Evaluation
CTD	Central TB Division
DHS	District Health Society
DME	Department of Medical Education
DOTS	Directly Observed Treatment, Short-course
DR-TB	Drug-Resistant TB
DS-TB	Drug Sensitive TB
EPTB	Extrapulmonary TB
FOGSI	Federation of Obstetric & Gynaecological Societies of India
HWC	Health and Wellness Centres
ICDS	Integrated Child Development Services
ICSSR	Indian Council of Social Science Research
ICMR	Indian Council of Medical Research
IEC	Information Education and Communication
IMA	Indian Medical Association
IAP	Indian Academy of Paediatrics
JSSM	Joint Supportive Supervision Mission

LGBTQIA++	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and Other Identities
LPG	Liquid Petroleum Gas
MSW	Male Sex Workers
MDR-TB	Multi-Drug-Resistant Tuberculosis
NAAT	Nucleic Acid Amplification Test
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NFHS	National Family Health Survey
NPY	Nikshay Poshan Yojana
NRC	Nutritional Rehabilitation Centre
NSP	National Strategic Plan
NTEP	National TB Elimination Programme
OPD	Out-patient Department
PLHIV	People Living with HIV/AIDS
PAF	Population Attributable Fraction
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PNC	Post Natal Care
PPM	Public Private Mix
PTB	Pulmonary TB
REACH	Resource Group for Education and Advocacy for Community Health
RMNCH+A	Reproductive Maternal Newborn Child and Adolescent Health Programme
RPwD	Rights of Persons with Disabilities Act
SANKALP	Skill Acquisition and Knowledge Awareness for Livelihood Promotion
SOGIESC	Sexual Orientation, Gender identity, Expression, and Sex Characteristics
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
STO	State Tuberculosis Officer
STS	Senior Treatment Supervisor
TB	Tuberculosis
TPT	TB Preventive Treatment
UDST	Universal Drug Susceptibility Testing
VHND	Village Health and Nutrition Day
WCD	Women and Child Development
WHO	World Health Organization

GLOSSARY

I Gender

Gender:

The socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for individuals based on the sex they were assigned at birth.

Gender role:

A set of societal norms dictating what behaviours are generally considered acceptable, appropriate or desirable for a person based on their actual sex or perceived sex or gender.

Masculinity/Femininity:

Possession of the qualities associated with men and women in a particular society at a particular time.

The Gender Binary:

"A traditionally Western concept is classifying gender into two distinct, supposedly "opposite" forms, labelled men/boys and women/girls. While many cultures* have historically recognised a variety of gender identities with corresponding roles in society, these identities may have been suppressed with the spread of Western colonisation. As these traditions are rediscovered and Western understanding evolves, it is clear that the gender binary fails to capture the nuances of lived gender experiences. The gender binary has also historically been used to oppress women and people with diverse gender identities, preventing them from exercising their human rights and participating as equals in society. Adherence to the gender binary in language (for example, by using male/female pronouns or only referencing men, boys, women and girls), data collection and services excludes other genders and limits our ability to provide appropriate and respectful assistance." Historically, South Asian cultures in countries like India recognise a plurality of gender identities and acknowledge gender fluidity.

Gender Diversity:

The equitable representation of people of different genders, including cisgender and transgender men and women, other transgender people, non-binary people, and other people with diverse gender identities.

II Gender Identity

Gender Identity:

Each person's deeply felt internal and individual experience of gender may or may not correspond with the sex assigned at birth or the gender attributed to them by society. It includes the personal sense of the body, which may or may not involve a desire for modification of the appearance or function of the body by medical, surgical or other means.

Cis/Cisgender:

A person whose gender identity and the sex they were assigned at birth align.

Hijra:

A broad term used in South Asia, and particularly in India, which sometimes refers to individuals who do not identify as men or women and in other contexts to refer to women who were assigned the sex of male at birth. Also referred to as khawaja sara and zenana in Pakistan and northern India." Individuals may identify as Kothis, Aravanis or Jogappas in southern India. Numerous texts from the 14th century in Sanskrit and Bengali, such as the Krittivasa Ramayana, have emphasised the tradition in India. While Hijras were acknowledged and held significance in our ancient customs and practices, their status has declined with each generation.

Trans/Transgender:

Terms used by some people whose gender identity differs from what is typically associated with the sex they were assigned at birth. Trans, transgender and non-binary are "umbrella terms" representing a variety of words that describe an internal sense of gender that differs from the sex assigned at birth and the gender attributed to the individual by society, whether that individual identifies as a man, a woman, simply "trans" or "transgender," with another gender or with no gender.

Non-Binary:

An adjective describing people whose gender identity falls outside the male-female binary. Non-binary is an umbrella term that encompasses a wide variety of gender experiences, including people with a specific gender identity other than man or woman, people who identify as two or more genders (bigender or pan/polygender) and people who do not identify with any gender (agender).

Gender Queer:

A person who identifies as neither or both male or female or a combination of genders.

Gender Fluid:

An adjective describing someone whose gender is not fixed over time.

III Gender Expression

Gender Expression:

Individuals use a range of cues, such as names, pronouns, behaviour, clothing, voice, mannerisms and bodily characteristics, to interpret other individuals' genders. Gender expression is not necessarily always an accurate reflection of gender identity. People with diverse sexual orientation, gender identity or sex characteristics do not necessarily have a diverse gender expression. Likewise, people who do not have a diverse sexual orientation, gender identity or sex characteristics may have a diverse gender expression.

Gender Non-Conforming:

Behavior or appearance that does not align with prevailing cultural expectations of a particular gender. The term can apply to all individuals, regardless of SOGIESC.

Transition:

The process of changing one's external gender presentation to be more in line with one's gender identity. Transition typically occurs over a long period. It may include telling one's family, friends and co-workers, using a different name, pronoun or title, dressing differently, changing one's name or sex on legal documents, and undergoing hormone therapy or other treatment. In some countries, surgery is a requirement for legal gender recognition, which is a violation of UN human rights norms.

Gender Confirmation/Affirming-Treatment:

Gender confirmation, or gender-affirming, treatment refers to medical interventions that may be part of the transition. Not all people choose or can afford medical interventions such as hormone therapy or surgery. The terms "pre-operative" (or pre-op) or "post-operative" (or post-op) should be avoided because they can imply that transgender people who do not undergo medical transition are less valid. The terms "sex reassignment surgery" and "sex change operation" are outdated and should be avoided.

IV Sex Characteristics

Sex Characteristics:

Each person's physical features relating to sex, including chromosomes, gonads, sex hormones, genitals and secondary physical features emerging from puberty or post-puberty.

Sex:

The classification of a person as having female, male and/or intersex sex characteristics. While infants are usually assigned the sex of male or female at birth based on the appearance of their external anatomy alone, a person's sex is a combination of a range of bodily sex characteristics.

Assigned Sex At Birth:

The sex that is assigned to a person at birth, typically based on the infant's external anatomy; also referred to as birth sex or natal sex. The phrases "assigned female at birth" (AFAB) and "assigned male at birth" (AMAB) refer to people with typical male or female sex characteristics, regardless of their gender identity or gender expression. The phrase "coercively assigned female [male] at birth" (CAFAB and CAMAB) refers to intersex people assigned a binary sex, often via non-consensual surgeries.

Intersex:

Intersex people are born with sex characteristics that do not fit typical definitions of male and female bodies. Intersex is an umbrella term used to describe a wide range of natural bodily variations. Some of these variations may be apparent before or at birth, while others are not apparent until after puberty or later or may not be physically apparent at all. There are more than 40 intersex variations; experts estimate that between 0.5% and 1.7% of the population is born with intersex traits.

Because their bodies are seen as different, intersex people are at risk of human rights violations, including violence, stigmatisation and harmful practices. Intersex children may be subjected to surgeries and medical procedures in an attempt to align their appearance with societal expectations about male and female bodies. Surgery and other treatments carried out on children, by definition, cannot be premised upon informed consent, and there is rarely a medical need for such interventions. Surgery is typically irreversible and can cause a wide range of severe, adverse physical and psychological health effects and result in sterilisation. Some intersex people feel the procedures forced them into sex and gender categories that did not fit them.

Intersex people use many different terms and sometimes use different terms with different people to avoid stigma, misconceptions, discrimination and violence. Common language includes "being"

intersex, "having" an intersex variation, difference or trait, clinical diagnostic terms, "differences of sex development," and innate "variations of sex characteristics." The outdated and stigmatising term "hermaphrodite" is generally rejected by intersex people today. However, some have chosen to reclaim it. Intersex people may have any sexual orientation, gender identity or gender expression.

V Sexual Orientation

Sexual Orientation:

Each person's enduring capacity for profound romantic, emotional or physical feelings for, or attraction to, others. Encompasses hetero-, homo-, bi-, pan- and asexuality, as well as a wide range of other expressions of sexual orientation. This term is preferred over sexual preference, sexual behaviour, lifestyle and way of life when describing an individual's feelings for or attraction to other people.

Sexual Preference:

Indicates a greater liking for particular characteristics over others about an individual's romantic, emotional or physical feelings for or attraction to others. For instance, this can be for tall, short, dark-haired, brown-eyed or other traits of a partner.

Sexual Behavior:

What we do sexually and with whom is not always an accurate indicator of sexual orientation.

Homosexual:

A person whose romantic, emotional or physical attraction is to people of the same gender. Note that, in English, homosexual may be considered an outdated clinical term that should be avoided, and gay and lesbian may be preferred. The term remains acceptable in many non-English-speaking contexts[1].

Heterosexual (Also "Straight"):

A person whose romantic, emotional or physical attraction is to people of a different gender.

[1] Men who have sex with men" (MSM) is a term commonly used in the public health context, and particularly in terms of the HIV response, to refer to men who engage in sexual activity with other men, regardless of their sexual orientation or identity. However, in recent years, the term has been criticised for being overly clinical and reductionist. Critics argue that it reinforces a narrow and stigmatising perspective by reducing the complex and multifaceted nature of human sexuality to a set of behaviours. The use of the term also sidesteps issues of identity, self-perception, and the emotional aspects of relationships, contributing to a lack of nuance in understanding the experiences of individuals within the MSM category. Moreover, it may perpetuate stereotypes and marginalisation by implying that these men are defined solely by their sexual activities rather than acknowledging their diverse identities and relationships. Therefore, this framework has deliberately chosen to not use this term.

Bi/Bisexual:

A person who has the capacity for romantic, emotional or physical attraction to people of more than one gender. Bisexual+ and Bi+ are sometimes also used as umbrella terms for non-monosexual identities.

Pansexual:

A person who has the capacity for romantic, emotional or physical attraction to people of any gender.

Asexual:

A person who may experience romantic or emotional attraction but generally does not experience sexual attraction. Demisexual and greysexual/grey-asexual describe people with varying degrees of sexual attraction. Asexual may be used as an umbrella term encompassing demisexual, greysexual and other terms.

Gay:

Men whose enduring romantic, emotional or physical attraction is to men; also, women who are attracted to other women.

Lesbian:

A woman whose enduring romantic, emotional or physical attraction is to women.

Queer:

Traditionally a negative term, queer has been reclaimed by some people and is considered inclusive of a wide range of diverse sexual orientations, gender identities and expressions. It may be used as an umbrella term for people with diverse SOGIESC or as an alternative to the phrase "people with diverse SOGIESC" or the acronym LGBT. Queer is used by many people who feel they do not conform to a given society's economic, social and political norms based on their sexual orientation, gender identity and gender expression.

VI Agency and Toxic Masculinity

Agency:

In sociology, agency pertains to individuals' ability to act independently, shaping their lives and the social systems around them. It emphasises that people are not merely passive recipients of societal

or structural influences but active participants who can make decisions and act.

Agency involves several key aspects highlighting the complex link between individual autonomy and societal structures. Firstly, agency centres on individual autonomy, emphasising people's capacity to make self-directed choices aligning with their values and aspirations. This autonomy is evident in everyday decisions like career paths and personal relationships. Secondly, choice-making is central to the agency, enabling individuals to influence their lives and others. Thirdly, power is integral to agency, denoting the capacity to act, impact, and effect change stemming from various sources such as economic resources and social connections. However, while agency focuses on individual action, it operates within broader social structures encompassing institutions and cultural norms. The interaction between agency and social structures underscores the interplay between individual actions and societal influences (Scholarly Community Encyclopaedia, 2024).

Toxic Masculinity:

Masculinity encompasses attributes, behaviours, and roles typically associated with boys and men, shaped by socio-cultural influences and varying across countries, religions, classes, and historical contexts. Distinct from biological factors, masculinity is a socially constructed gender expression. On the other hand, "Toxic" masculinity refers to cultural norms and harmful behaviours historically linked to masculine stereotypes. For instance, the suppression of emotions stems from societal teachings that crying is unmanly, sensitivity is feminine, and displaying emotions is perceived as weak (Barr & Javed, 2021; Smith, 2021).

The glossary (I to V) is adapted from the International Organization for Migration. (2020a). Introducing SOGIESC information into Pre-Departure Orientation Curriculums. International Organization for Migration. https://www.iom.int/resources/introducing-sogiesc-information-pre-departure-orientation-curriculums

Section I

GENDER AND SEXUAL ORIENTATION AS DETERMINANTS OF TB: INTRODUCTION

1.1 Introduction

Tuberculosis (TB) remains a significant public health issue in the 21st century. In 2022, Tuberculosis affected an estimated 10.6 million people globally, of which around 3.5 million were adult women (age 15 years and above). In addition, 1.3 million people died from TB in 2022. Further, an estimated 3.1 million people with TB were not reported to health systems across the world. India contributed to approximately 27% of the global burden of TB.

The TB response in India is implemented through the National TB Elimination Programme (NTEP). The National Strategic Plan for Tuberculosis Elimination (NSP 2017–2025) outlines India's ambitious vision of a TB Mukt Bharat by reducing TB incidence and mortality due to TB through comprehensive, multisectoral action that responds to the clinical and social needs of people affected by the disease.

In keeping with the vision outlined in the NSP, this National Framework for a Gender-responsive Approach to TB (Framework) in India acknowledges and aims to respond to the unique needs of cis women, LGBTQIA++ persons, and cis men affected by TB, building on the central understanding that gender and sexual orientation impact the experience of TB and access to TB care. In 2023, of the over 25.5 lakh TB cases notified to the NTEP, 61% were male, 39% were female, and <1 % were transgender. At this point, information on the TB burden among Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and Other Identities (LGBTQIA++) communities is not available. This is a significant gap. If the global tuberculosis epidemic is to be ended, no one should be left behind, irrespective of their sexual orientation, gender identity, expression, and sex characteristics (SOGIESC).

Box 1: Usage of the term "Gender-responsive"

Throughout this framework, the term 'gender-responsive' is used to refer to the diverse health needs of cis women, LGBTQIA++ persons, and cis men. In principle, gender-responsive care means providing available, accessible, affordable, quality (AAAQ) care to all persons irrespective of their sexual orientation, gender identity and expression and sex characteristics (SOGIESC).

This gender-responsive framework is the first step towards providing equitable and inclusive care that takes into account the gender and sexual orientation-specific needs of all persons affected by TB.

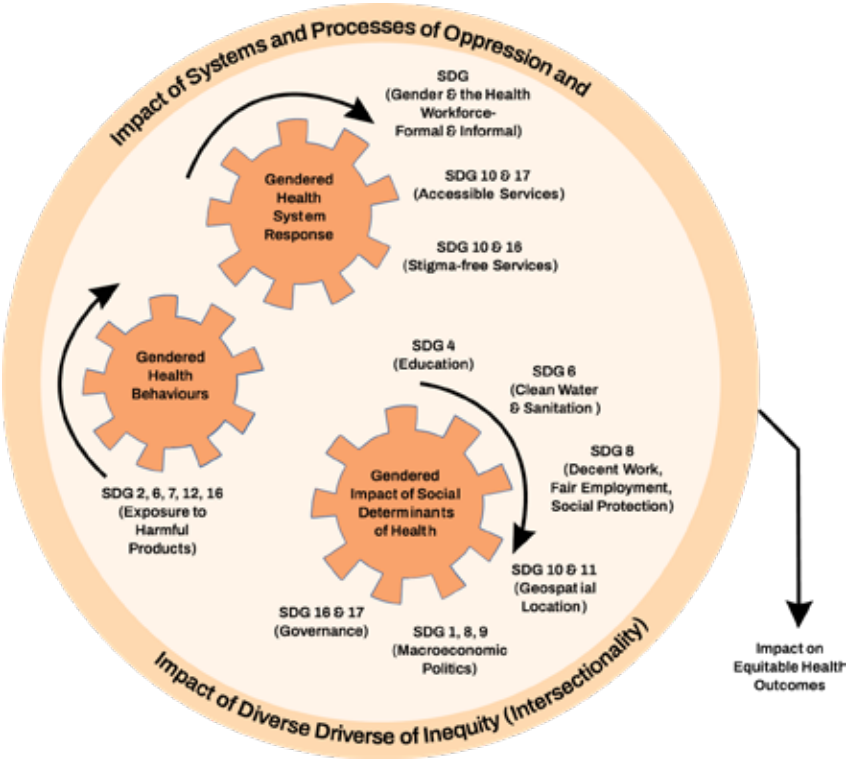
1.2. Gender and Sexual Orientation as Determinants of TB

Gender, sexual identity and associated inequities are powerful and cross-cutting determinants of health, in conjunction with other factors such as age, socioeconomic status, ethnicity, and sexual orientation. (World Health Organisation, 2011). Globally, gender inequities place the health of millions of cis women, girls and LGBTQIA++ persons at risk. Addressing gender inequities is the first step towards countering the historical burden of inequality and deprivation of rights faced by cis women, girls and LGBTQIA++ persons in households, communities, workplaces and healthcare settings.

Figure 1 below illustrates the impact of gender as embedded within other systems of oppression and domination, such as, but not limited to, class, caste, religion, ethnicity and sexual identity, on the following aspects of health: (1). Social determinants; (2). Health Behaviour; (3). Response of the health system.

Gender differences and inequalities play a significant role in how cis women, LGBTQIA++ persons and cis men access and receive healthcare in the public and private sectors. For instance, considerable evidence shows that smoking, alcohol use and substance use are factors affecting TB among men; the burden of undernutrition is higher among women, making them vulnerable to TB (International Institute for Population Sciences (IIPS) and ICF, 2021).

Figure 1: Gender As A Key Determinant of Health



Source: Manandhar et al., 2018; Gender, health and the 2030 agenda for sustainable development

However, evidence is limited on vulnerability to TB for other gender and sexual identities. While studies have shown that sexual minorities have significantly high unmet needs for healthcare and experience impediments to care at both structural and individual levels (Gonzales & Blewett, 2014; Dahlhamer et al., 2016; Jackson et al., 2016; Hsieh & Ruther, 2017; Tabaac et al., 2020), there are few studies specific to TB, particularly in the Indian context. What is known is that stigma and discrimination due to sexual orientation and gender identity also engender health inequities and impede access to dignified care within the public health system (SATB Interviews and studies in other contexts). In the past decade, despite the protections offered by the Government of India based on sexual orientation and gender identity, due to deeply ingrained stigma and societal mores, LGBTQIA++ persons continue to experience health disparities and worse health outcomes than heterosexual individuals (Bradford et al., 2013; Safer et al., 2016). The full extent of health disparities faced by LGBTQIA++ persons in TB is yet to be quantified.

1.3. About This Framework

This framework demonstrates how sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) are social determinants for TB and impact health-seeking behaviour and access to quality healthcare. The framework outlines a vision for TB care that is people-centred, rights-based and gender-responsive.

Box 2: Aim of The National Framework for a Gender-responsive Approach to TB

This framework aims to:

- Highlight the available evidence, gaps and challenges in providing gender-responsive TB care;
- Define an inclusive approach towards gender-responsive TB care;
- Identify and recommend potential actions for a people-centred, rights-based and gender-responsive approach to TB.

The framework is intended for programme managers and healthcare providers at the district, state, and national levels in the NTEP, as well as civil society and community representatives, involved in providing and evaluating TB care services in the not-for-profit and private sectors.

This framework takes cognisance of the laws in the Indian context that apply to marginalised communities, including but not limited to the Medical Termination of Pregnancy Act, 1971; The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013; The Equal Remuneration Act, 1976; the Transgender Persons (Protection of Rights) Bill, 2019; the Mental Health Care Act, 2017; Rights of Persons with Disabilities (RPwD) Act, 2016; the Scheduled Castes and the Scheduled Tribes (Prevention of Atrocities) Act, 1989 and relevant provisions in the Indian Penal Code. A detailed discussion on socio-legal issues related to TB, gender and sexual orientation is beyond the scope of this framework. The framework is intended for programme managers and healthcare providers at the district, state, and national levels in the NTEP, as well as civil society and community representatives, involved in providing and evaluating TB care services in the not-for-profit and private sectors.

The framework is expected to initiate dialogue and interventions at all levels within the TB programme and among key stakeholders, strengthening the collective understanding of TB and gender. Once implemented, the framework envisages a gender-responsive programme to catalyse and accelerate efforts to End TB in India.

1.4. Key Definitions

Sex is assigned at birth and refers to a person's biological, anatomical, and physiological characteristics, including internal and external reproductive organs, hormones and chromosomal composition. However, "Biological sex" is not binary, stable, or uniform" (Clarke, 2022).

Gender refers to the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender-diverse people. It influences how people perceive themselves and each other, how they act and interact, and the distribution of power and resources in society (Canadian Institutes of Health Research, n.d.). Gender also defines the relationships between people and reflects the power distribution within those relationships. Gender intersects with other drivers of inequities, discrimination, marginalisation and social exclusion, which affect health and well-being (WHO, 2018).

Gender Identity is each person's internal and individual experience of gender. It is a person's sense of being a woman, a man, neither, or anywhere along the gender spectrum. A person's gender identity may be the same as or different from their birth-assigned sex. However, a person's gender identity is fundamentally different from and not related to their sexual orientation (Ontario Human Rights Commission, n.d.). Gender identity is not confined to a binary (girl/woman, boy/man), nor is it static; it exists along a continuum and can change over time. There is considerable diversity in how individuals and groups understand, experience and express gender through the roles they take on, the expectations placed on them, their relations with others and the complex ways that gender is institutionalised in society (Canadian Institutes of Health Research, n.d.).

Gender Expression is how a person publicly expresses or presents their gender. This can include behaviour and outward appearance such as dress, hair, make-up, body language and voice. A person's chosen name and pronoun are common ways of expressing gender (Ontario Human Rights Commission, n.d.).

SOGIESC: An acronym for sexual orientation, gender identity, gender expression and sex characteristics.

Transgender Persons: As per Indian law, a Transgender person is a person whose gender does not match with the gender assigned to that person at the time of birth, and includes trans-men, trans-women, persons with inter-sex variations and gender-queer persons.

Transgender is, therefore, an umbrella term used to capture the spectrum of gender identity and gender-expression diversity. It covers a range of gender identities and expressions that might fall outside the idea that all people can be classified as only one of two genders — male or female (gender binary) (Transgender Facts, 2021).

People who are transgender include:

- Those who have a gender identity that differs from the sex assigned to them at birth.
- Those whose gender expression — the way gender is conveyed to others through clothing, communication, mannerisms and interests — and behaviour do not follow stereotypical societal norms for the sex assigned to them at birth.
- Those who identify and express their gender fluidly outside of the gender binary, which might or might not involve hormonal or surgical procedures.

"Trans" is sometimes used as shorthand for "transgender." While transgender is generally a good term to use, not everyone whose appearance or behaviour is gender-nonconforming will identify as a transgender person (What does transgender mean? 2014).

LGBTQIA++: An evolving acronym that stands for lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual ++' suggests inclusivity of myriad other identities. LGBTQIA++ are not a monolithic group, and they encompass diverse communities with varying health needs. The Framework employs the acronym as an umbrella term only for ease of reference.

Cisgender: This term is used when a person identifies in a way that the gender identity, or performance in a gender role, corresponds to the assigned sex at birth. This includes cis men and cis women.

Intersex Persons: Intersex people are born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies. Intersex is an umbrella term used to describe a wide range of natural bodily variations, including varying biological sex characteristics.

Affected Community: Affected communities refer to TB-affected communities, which include TB survivors, persons with TB, their families, and caregivers.

People-Centred Care: "The overall vision for people-centred health care is one in which individuals, families and communities are served by and are able to participate in trusted health systems that respond to their needs in humane and holistic ways… People-centred health care is rooted in universally held values and principles which are enshrined in international law, such as human rights and dignity, non-discrimination, participation and empowerment, access and equity, and a partnership of equals (World Health Organization, 2007)."

Rights-based Approach to Health: "The rights-based approach to health is… based on principles of participation, equality and non-discrimination, transparency, and accountability… guiding health policy so as to provide for the highest attainable level of health for all (Bustreo & Doebbler, 2020)."

Culturally Competent Care: Cultural competence in healthcare refers to the "ability of systems to provide care to patients with diverse values, beliefs and behaviours, including the

tailoring of healthcare delivery to meet patients' social, cultural and linguistic needs" (Betancourt et al., 2002). In the realm of the Indian healthcare system, the term "cultural context" encompasses factors such as age, gender, sexual orientation, religion, caste, ethnicity, race, religion, caste, disability, or economic standing that can shape personal choices regarding health and medical treatment (Carrillo, 1999; Einbinder & Schulman, 2000; Betancourt et al., 2002).

Chosen Family: Chosen families refer to "nonbiological kinship bonds, whether legally recognised or not, deliberately chosen for the purpose of mutual support and love." Chosen families are essential for LGBTQIA++ persons who often do not have support from their biological families on account of their gender identity or sexual orientation (Laderer, 2023).

1.5. Gender Analysis Tools

Undertaking a systematic gender analysis in health can help identify specific factors that influence health outcomes. The WHO's Gender Analysis matrix is used globally to help countries and programmes understand health differences and disparities among and between people of different sexual orientations, gender identity, gender expression and sex characteristics. The tool identifies six factors influencing outcomes from the health-related perspective, as seen in the table below.

Box 3: Role of Gender Analysis in Programme Effectiveness

Each of these factors can be analysed vis-a-vis the gender-related considerations - biological factors, socio-cultural factors and access to/control over resources. A gender analysis can increase the effectiveness of the programme by:

- Identifying practical and strategic needs related to SOGIESC in health;
- Recognising and mitigating the vulnerabilities that cis women, LGBTQIA++ persons, and cis men face in protecting and promoting their health;
- Considering and addressing how patriarchy and toxic masculinity may harm the health of men and boys and those around them;
- Reviewing inappropriate, ineffective services, programmes or policies that ignore the realities of gender identities and sexual identities;
- Identifying and reducing bias and discrimination within the health system;
- Developing and implementing gender-responsive policies, laws and services (primary, secondary and tertiary) and programmes.

Table 1: Gender Analysis Matrix for Health Programmes

Factors that influence health outcomes: Health-related considerations	**Factors that influence health outcomes: Gender-related considerations**		
	Biological factors	**Socio-cultural factors**	**Access to and control over resources**
Risk factors and vulnerability			
Access and use of health services			
Health-Seeking behaviour			
Treatment options			
Experiences in healthcare settings			
Health and social outcomes and consequences			

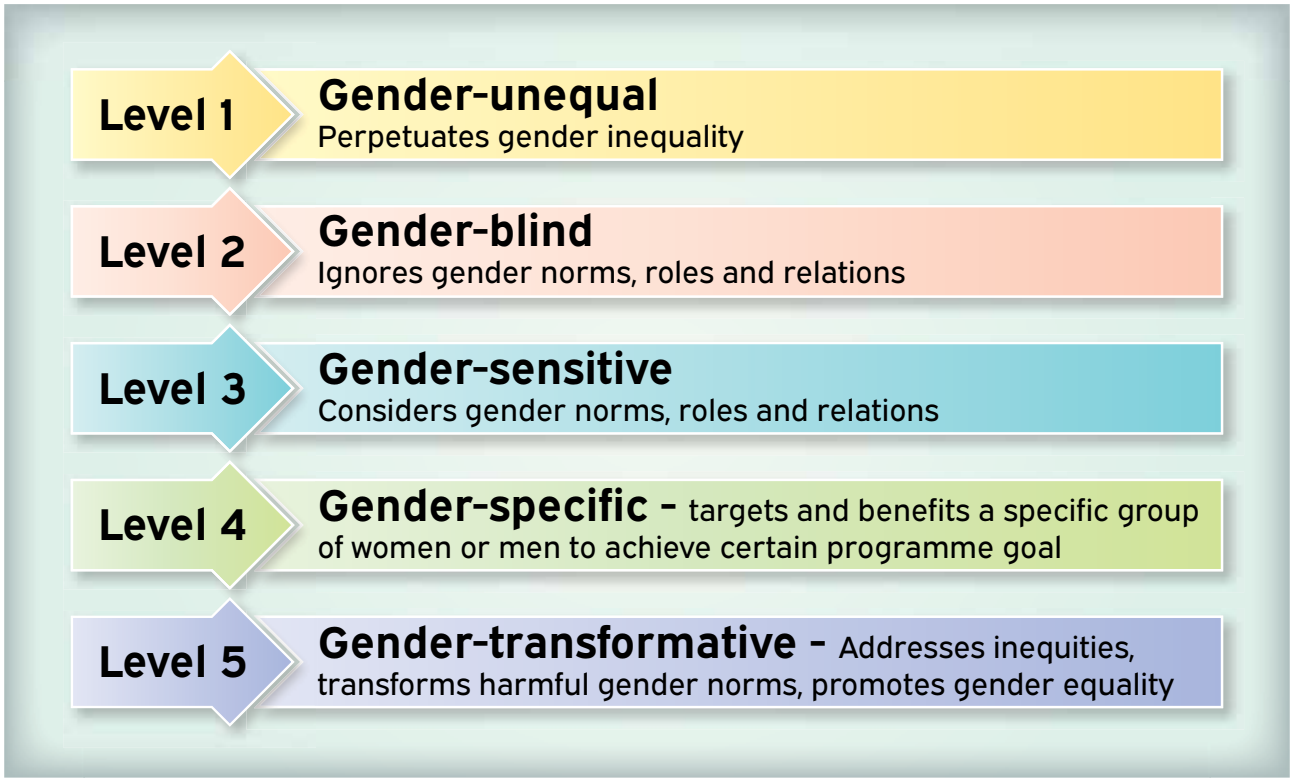
Source: (WHO, Gender Mainstreaming for Health Managers: A Practical Approach, 2011)

1.6. Moving Towards Gender-responsive Programming

A gender-responsive TB programme must acknowledge different, diverse needs; address the causes and impact of gender and sexual identity-based health inequities; identify ways to transform harmful gender norms, roles and relations; promote gender equity and include strategies to foster equal power relationships among cis women, LGBTQIA++ persons, and cis men (WHO, Gender mainstreaming for health managers, 2011).

Figure 2 below outlines the different levels of recognition for 'Gender' in health programmes. Gender-unequal health programmes perpetuate gender inequities; gender-blind programmes ignore gender norms, roles and relations; and gender-sensitive programmes may consider norms, roles and relations but do little to respond to these considerations. On the other hand, gender-specific and gender-transformative health programmes together add up to a gender-responsive approach in a health programme.

Figure 2: Gender-Responsive Assessment Scale



Source: WHO, Gender mainstreaming for health managers, 2011.

This framework aspires to enable a gender-responsive TB programme, as outlined in this document. A gender-specific TB programme would take cognisance of gender differences and develop specific strategies to fulfil the healthcare needs of cis women, LGBTQIA++ persons and cis men.

A gender-transformative TB programme would strive to go beyond this to identify harmful gender norms that affect TB and play a proactive role in countering these norms and promoting gender equity.

Section II

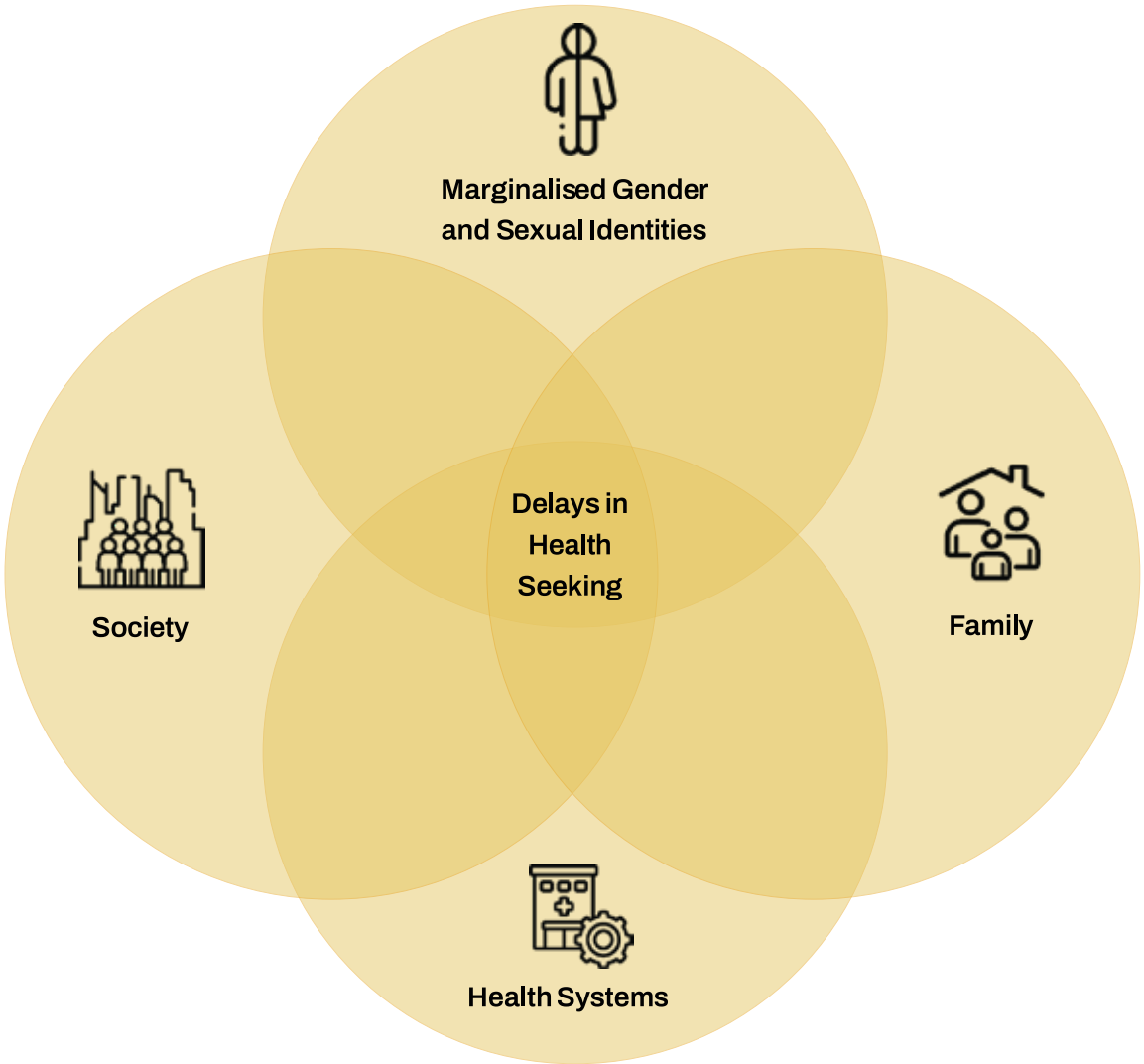
GENDER, SEXUAL ORIENTATION AND TB: INTERACTIONS

INTERPLAY BETWEEN GENDER, SEXUAL ORIENTATION, AND TB

Gender and sexual orientation are social determinants affecting health-seeking behaviour and healthcare access. Cis women often hesitate to seek healthcare given their socialisation to prioritise their family's needs above their own. Marginalised gender and sexual identities, such as LGBTQIA++ persons, are even more socially and structurally vulnerable, given the oppression, violence, stigma and discrimination they face within society and health systems. They are more likely to be ridiculed, denied access to healthcare, and stigmatised, thus making it difficult for them to access health settings. Cis men are more likely to delay health seeking because any admission of discomfort is often viewed as "weak" in a culture of toxic masculinity.

This chapter examines the interactions between gender, sexual orientation and TB. It further describes how different identities are biologically and socioeconomically vulnerable in different ways in the context of TB and TB care, given their gender or sexual orientation.

Figure 3: Health Seeking Delays: Types of Interactions



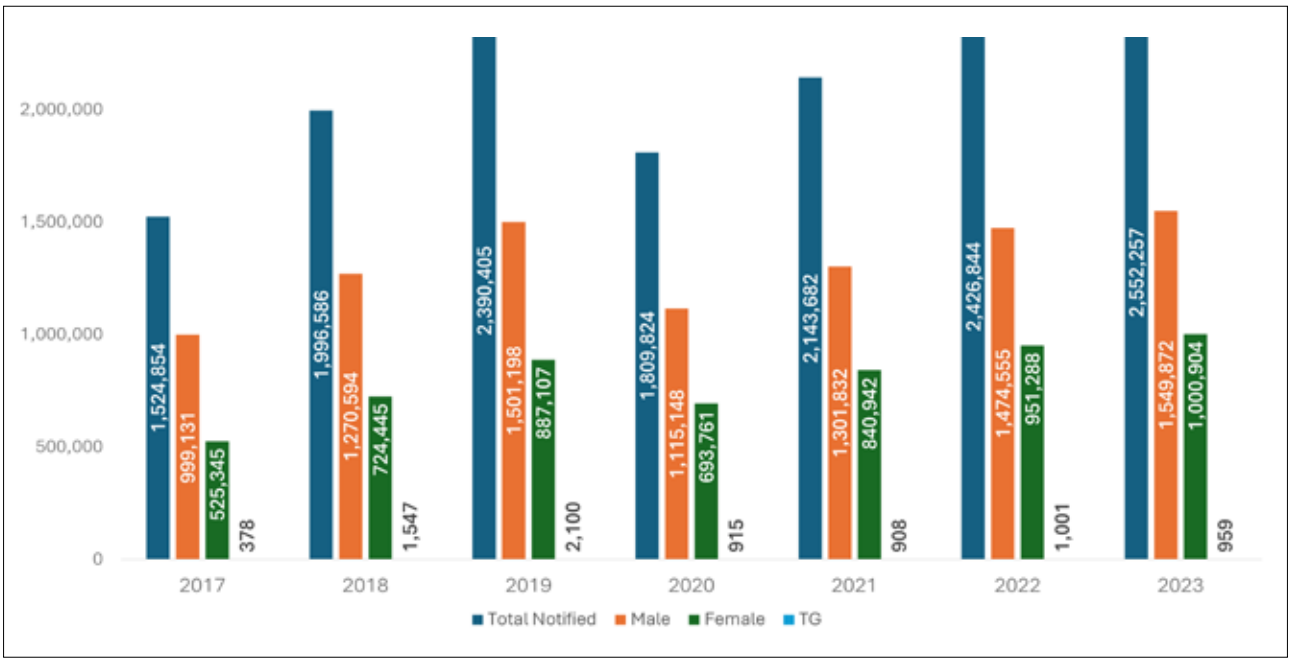
2.1. Biology and Epidemiology of TB

Burden of TB

As per the Global TB Report, 2023, the burden of TB was higher in adult men (55% of all TB cases in 2022) than in adult women (33%). Although in absolute numbers, TB disease affects men more than women, the number of women with TB globally and in India is significant. In addition, as per the findings of the National Prevalence Survey of India (2019-2021), the prevalence of microbiologically confirmed pulmonary TB (PTB) among 15 years and above in India was 312/lakh population. The prevalence in men was three times higher than in women (472/lakh population in men and 154/lakh population in women). Higher PTB Prevalence was also observed in geriatric persons, malnourished persons, people who use tobacco (smoking) and alcohol, and those with diabetes. While a few studies suggest that the difference in prevalence between men and women can be attributed to epidemiological factors such as smoking, alcohol consumption and occupational risks, other studies point to an innate biological susceptibility in men owing to hormonal, genetic and immunological factors.

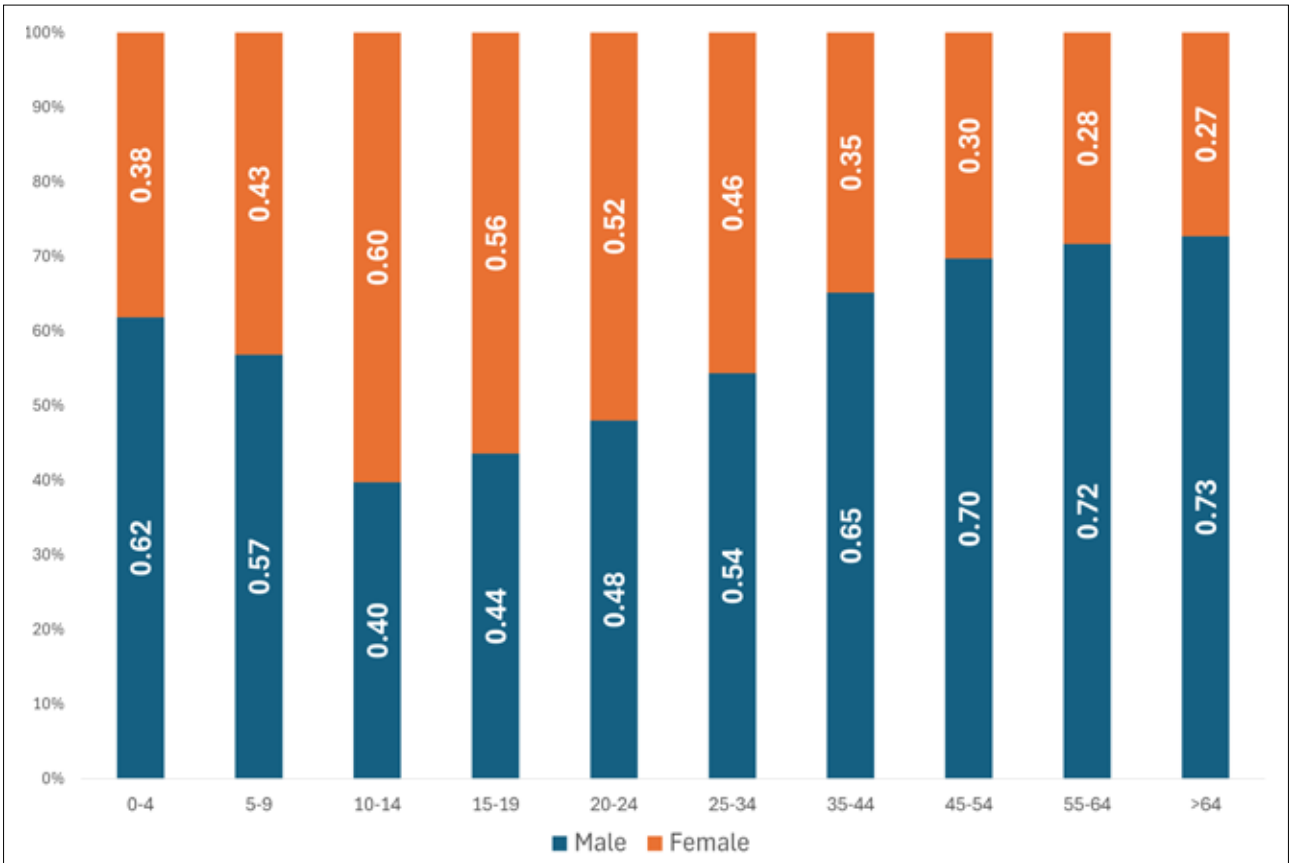
Historically, studies on health issues have excluded LGBTQIA++ persons. This is true in the case of TB as well, where there is a paucity of data on the burden of the disease in LGBTQIA++ persons, which needs to be addressed. The NTEP records the gender of those accessing services under three categories – women, men and transgender. In the year 2022, 1001 transgender persons were notified to the NTEP. Nevertheless, in a community-based TB and HIV screening among transgender women and male sex workers (MSW) in Pakistan, 1.5% of people screened had TB, 1.7% among MSW and 1.1% among transgender women (Shah et al., 2023). Figure 4 depicts the gender-disaggregated TB notification in the last five years.

Figure 4: Gender-disaggregated TB notification (2017-2023)



The NTEP data shows higher TB notifications in girls between 10 and 14 years. Further, the data also shows nearly equal TB notifications in both sexes in the age group of 20 to 24. In addition, the age group between 25 to 34 accounts for the highest notifications for both women and men. After this age, the gap between TB notifications among men and women steadily rises with age.

Figure 5: Proportion of TB Notifications Disaggregated by Age and Sex in 2023



Age/ Sex	Number of TB Notifications Disaggregated by Age and Sex in 2023									
	0-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	>64
Male	22,148	21,098	27,892	95,810	1,41,553	2,67,964	2,57,087	2,67,072	2,43,634	2,05,614
Female	13,651	16,028	42,269	1,24,088	1,53,213	2,25,021	1,37,435	1,15,919	96,234	77,046

The age and sex distribution, as outlined in Figure 5, has remained similar over the last three years (2022, 2021, 2020).

Multiple studies on the incidence of TB across the country indicate that more men report microbiologically confirmed pulmonary TB, and women are more likely to have clinically diagnosed pulmonary TB and extrapulmonary forms of TB (Balasubramanian et al., 2004; Dandona et al.,2004; Mukherjee et al., 2012; Weiss et al., 2006). There is also evidence that the presentation of pulmonary TB among women may differ somewhat from men, contributing to delays and making it difficult to diagnose TB in women. While men generally present with fever, haemoptysis and night sweats, women could present with typical symptoms or non-specific findings such as fever, body aches, loss of appetite and fatigue (Long et al., 2002; Weiss et al., 2006).

In Asia, younger women are affected by Extrapulmonary TB (EPTB) and female genital TB (20 to

30 years) compared to the high-income countries, thus putting younger women in the productive age group at higher risk for these forms of TB (Sharma et al., 2018). Research from India has also found menstrual dysfunction among adolescents and young women in more than 90% of pulmonary and extrapulmonary TB cases, which may be one of the earliest manifestations of TB in this age group. The dysfunction was in proportion to the severity of the disease, including MDR-TB (Sharma, 2003).

People with HIV are more vulnerable to TB. The NTEP and National AIDS Control Programme (NACP) have made substantial progress in addressing HIV-TB co-infection, including active case finding for TB in HIV care facilities, providing HIV testing to a majority of people with TB, integrated HIV-TB care and prevention of TB among PLHIV. However, HIV remains a substantial risk factor for TB. Furthermore, recent studies confirm that the prevalence of HIV-TB coinfection is high among women and young adults aged 21-40 years in India (Shastri et al., 2013). TB-HIV co-infection is also high among transgender persons, given that they are 49 times more vulnerable to HIV than others because of their heightened socioeconomic vulnerability and difficulty accessing care (AVERT, 2018). Providing gender-responsive care is critical for socially vulnerable groups affected by TB and HIV.

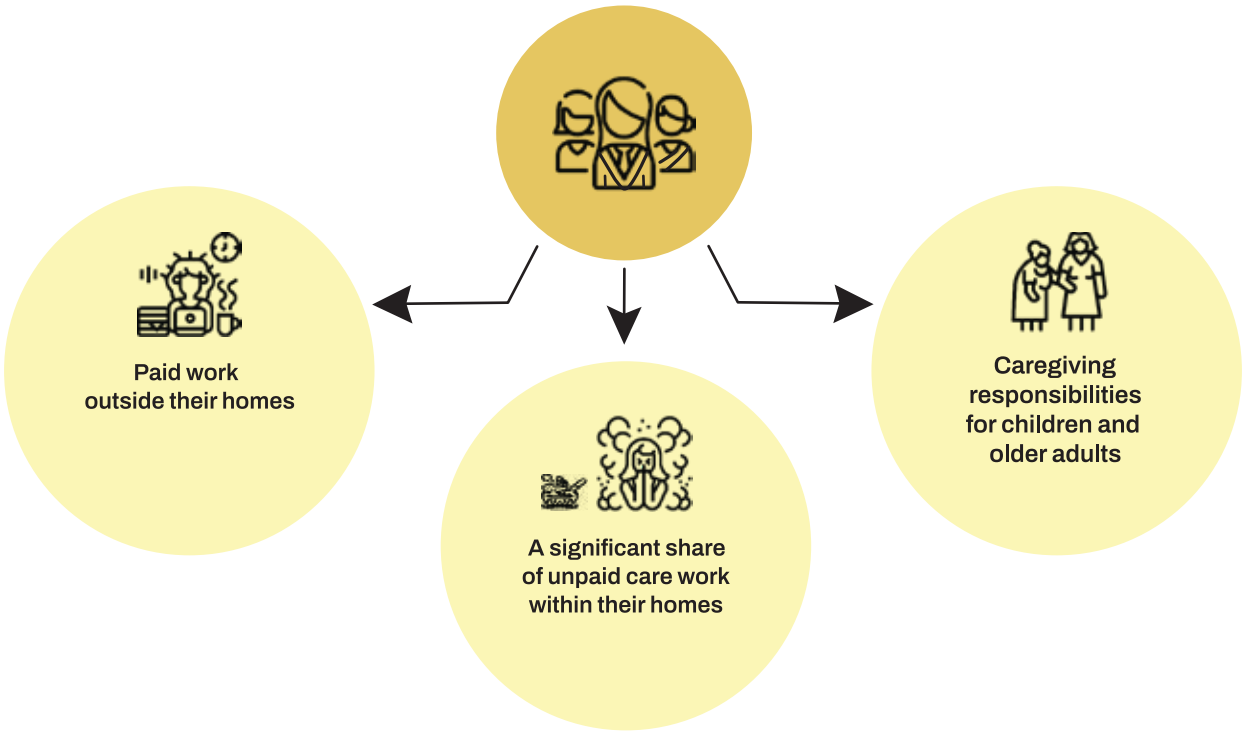
2.2. Exposure, Risks and Vulnerability to TB

Gendered roles, responsibilities and expected behaviours can place cis women, LGBTQIA++ persons and cis men at an increased risk for TB.

Gendered risks and vulnerabilities for cis women

Women across the world, generally, and in patriarchal cultures, particularly, face a triple burden: paid work outside their homes, a significant share of unpaid care work within their homes, and caretaking responsibilities for children and older adults. (Orthy, 2012). The gendered division of labour results in women being primarily responsible for domestic tasks (including water and fuel-related work), child caring and rearing, and caring for older adults and the sick, with usually little help from their male counterparts. Moreover, decisions that will impact their well-being are often made for them, where women often might not have a say. In cases where the man is the sole income earner in the house, women are also financially dependent on the men, further curbing their agency. These gendered roles and resulting power differentials make women vulnerable to TB in multiple ways.

Figure 6: Gender Roles and Triple Burden on Cis Women



Firstly, women are significantly constrained by social norms and internalised patriarchy, which prevent them from prioritising their nutrition, health and well-being. For instance, women are expected to be the last to eat after serving and feeding the household. Undernutrition is the most common, widely prevalent risk factor for TB in India, and it is responsible for the highest proportion of TB cases in India among women, men and transgender persons compared to any other risk factor. The Population Attribution Fraction (PAF) of undernutrition as a causal risk factor for TB is more than 55% in India (Cegielski et al., 2012; Bhargava et al., 2014). Unsurprisingly, the extent of undernutrition and the subsequent risk of TB is greater for women compared to men aged 20 to 39 years (Bhargava et al., 2014). For more information, please refer to the Guidance Document for Nutritional Care & Support for TB Patients in India.

Similarly, women also spend long hours at home and in the kitchen, increasing their exposure to smoke from the stove and resulting in indoor air pollution (Kurmi et al., 2014; Jindal, 2014). NFHS-4 points (Indian Institute of Population Sciences, 2015) to a much higher prevalence of self-reported medically treated TB in households that use solid fuels for cooking (566 per 100,000 persons) than in homes using non-polluting fuels (207 per 100,000 persons).

Further, as caregivers, women are vulnerable to exposure to TB either before or after the diagnosis of TB within the family. Women may be constrained from protecting themselves from the illness. They may hesitate to ask those with TB to practice cough hygiene, wear a mask or appropriately dispose of sputum. All of this can increase a woman's risk of contracting TB infection. This, coupled with the fear of being diagnosed with TB and poor attention within the family to women's health, may result in delayed attention to any symptoms and a late diagnosis.

Smoking, alcohol use and use of drugs pose additional risks for TB in women. According to NFHS-4, 45% of men and 7% of women aged 15-49 years reported use of any form of tobacco (Indian Institute of Population Sciences, 2015). Twenty-nine per cent of men and one per cent of women aged 15-49 reported consumption of alcohol. Although most studies identify substance use, including alcohol consumption among women, as lower than men, it is also acknowledged that this is changing, with an increasing number of women consuming alcohol and other substances globally and in India (Lal et al., 2015).

In terms of paid work, some industries in South Asia employ a high proportion of women. For example, up to 80% of workers in garment factories of Bangladesh (Zafar Ullah et al., 2012), more than 80% of beedi workers, and up to 50% of workers in tea gardens of Assam are women (Talukdar, 2016), the latter two in India. These workers are forced to live in overcrowded conditions and experience food scarcity, making them more vulnerable to TB (Chelleng et al., 2014; Islam et al., 2015; John, n.d.; Joshi et al., 2014; Talukdar, 2016). Consequently, a high proportion of tea garden workers, garment workers and beedi workers (Farz et al., n.d.; Hassan et al., 2005; Joshi et al., 2014; The Economic Times, n.d.) are found to be suffering from TB as compared to the general population.

Finally, studies also indicate that the reporting of fewer cases of TB among women may be due to

various other reasons, including poor access to healthcare services, poor diagnosis and poor reporting of cases among women (Uplekar et al., 2001). Studies have documented that the notification of TB among men and women, boys and girls, is similar up to 20 years of age (Mukherjee et al., 2012), with the gender gap widening subsequently.

Gendered risks and vulnerability for LGBTQIA++persons

The marginalisation and discrimination of LGBTQIA++ persons by family and society lead to social, educational, and economic exclusion and loss of socioeconomic advancement opportunities (Nadal et al., 2014). This vicious cycle of exclusion and marginalisation results in low education levels, discrimination in employment, poverty, and lack of access to safe housing and adequate nutrition. For instance, due to this cycle of marginalisation, many LGBTQIA++ persons are forced to live in overcrowded and poorly ventilated informal settlements.

Figure 7: Exclusion and Marginalisation of LGBTQIA++ Persons

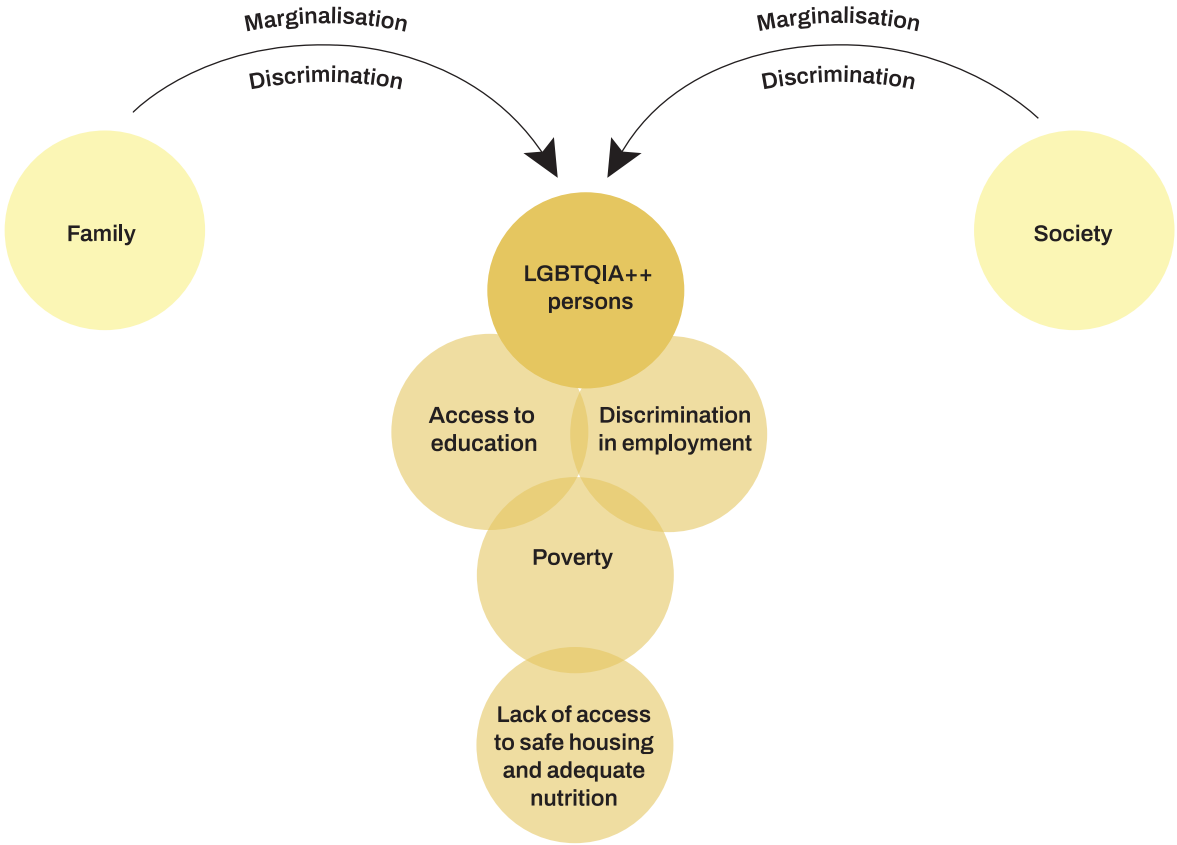
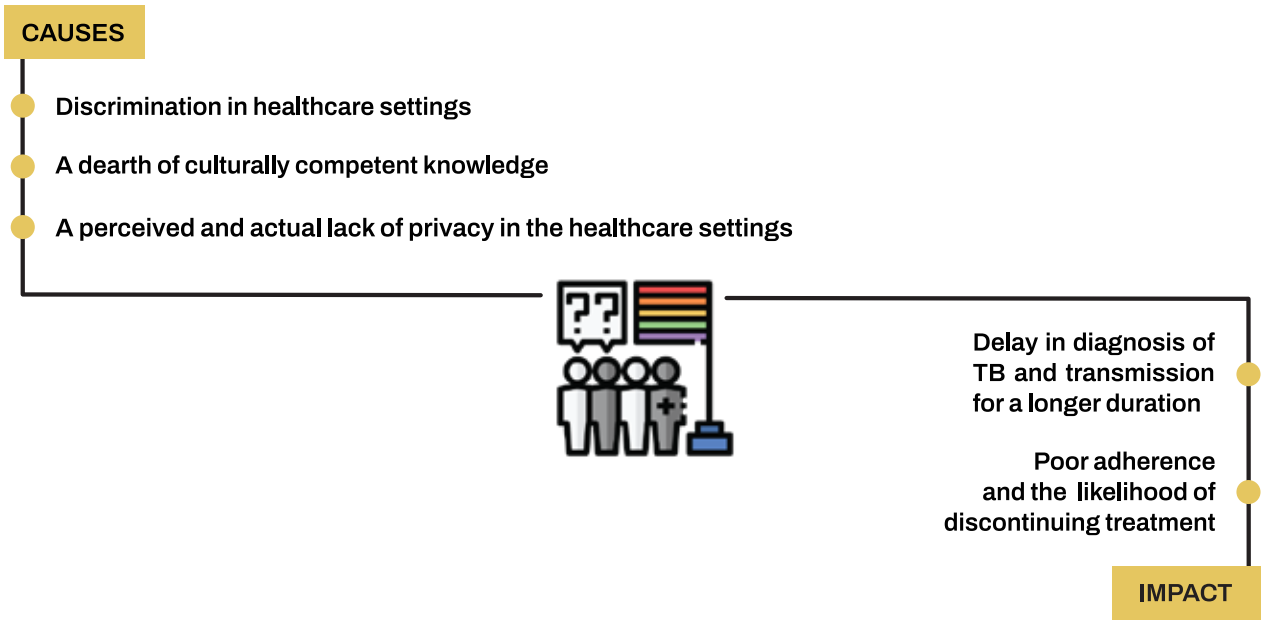


Figure 8: Marginalisation and Its Effect on Health Seeking Behaviour and TB Outcomes For LGBTQIA++ Persons



Similarly, given that employees are reluctant to hire LGBTQIA++ persons despite their skills and qualifications, LGBTQIA++ persons often have no stable income, hindering them from accessing housing, nutrition and preventive healthcare services. Furthermore, healthcare is inaccessible for LGBTQIA++ persons due to anticipated or experienced discrimination in healthcare settings (Kcomt et al., 2020), a dearth of culturally competent knowledge (Kattari et al., 2015), and a perceived lack of privacy in the health system leading to delayed not only diagnosis of TB and transmission for a longer duration, but also poor adherence, and likelihood to discontinue treatment. Evidence demonstrates that many LGBTQIA++ persons either delay seeking healthcare service or altogether avoid it (Grant et al., 2011; Stotzer, Kàopua, & Diaz, 2014; James et al., 2016). During the analysis of the 2015 U.S. Transgender Survey, it was found that approximately a quarter of the sample anticipated healthcare discrimination and, therefore, were forced to avoid seeking healthcare (Kcomt et al., 2020).

An ignored aspect of occupational hazard to TB is sex work done by cis women, LGBTQIA++ individuals and cis men (Nadal et al., 2014; Fisher et al., 2021). Evidence indicates that due to pervasive discrimination, many transgender women are compelled to resort to sex work as the only option for livelihood (Fisher et al., 2021). This includes a broad range of persons forced to trade sex for income or other items, including food, drugs, medicine, and shelter. Unstable access to preventive healthcare makes them more vulnerable to HIV, STIs (sexually transmitted infections) and TB. This framework is cognizant of the paucity of research on LGBTQIA++ identities' vulnerability to TB outside of the HIV context and the need for this to be addressed.

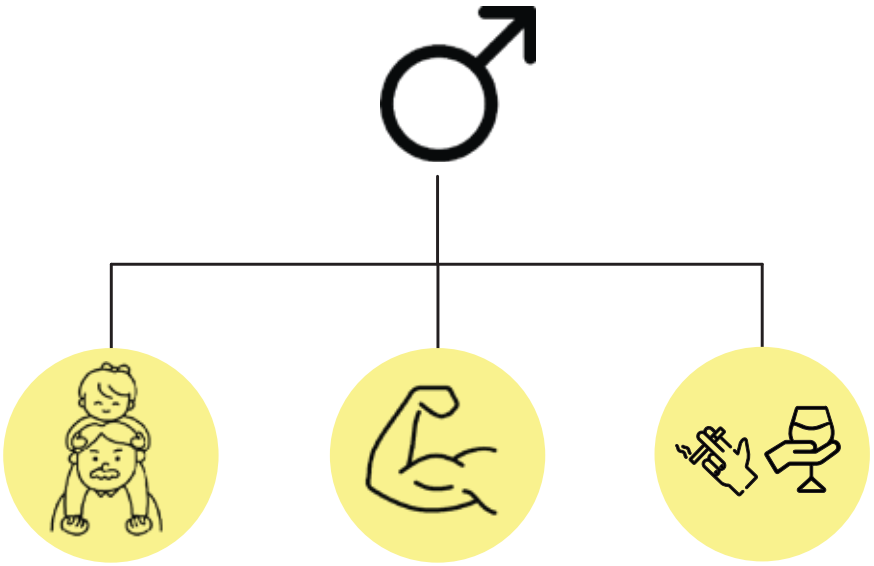
Lastly, social and economic marginalisation, physical and sexual violence, gaps in legal and protective frameworks, and minority stress make sexual minorities and gender minorities vulnerable to risk-

prone behavioural and substance use (Meyer, 2003; Burgess et al., 2007; Coleman et al., 2012), which in turn increases vulnerability to TB.

Gendered risks and vulnerability for cis men

Due to deeply entrenched gender roles, men of all sexual identities are expected to earn an income and run the household. Even though this is gradually changing, gender norms and expectations still pressurise men to appear strong, be masculine, hide feelings of vulnerability and be ready to take risks when required. This often translates into markers of masculinity such as smoking, drinking and taking risks regarding their health in order to be accepted by society at large. Therefore, while alcohol use and smoking among women are poorly accepted, these behaviours may be condoned or even encouraged due to the prevailing gender norms for men. Smoking and alcohol consumption are, therefore, specific gender-linked factors increasing vulnerability to TB and barriers to timely TB diagnosis and treatment for men.

Figure 9: Harmful Gender Stereotypes for Cis Men



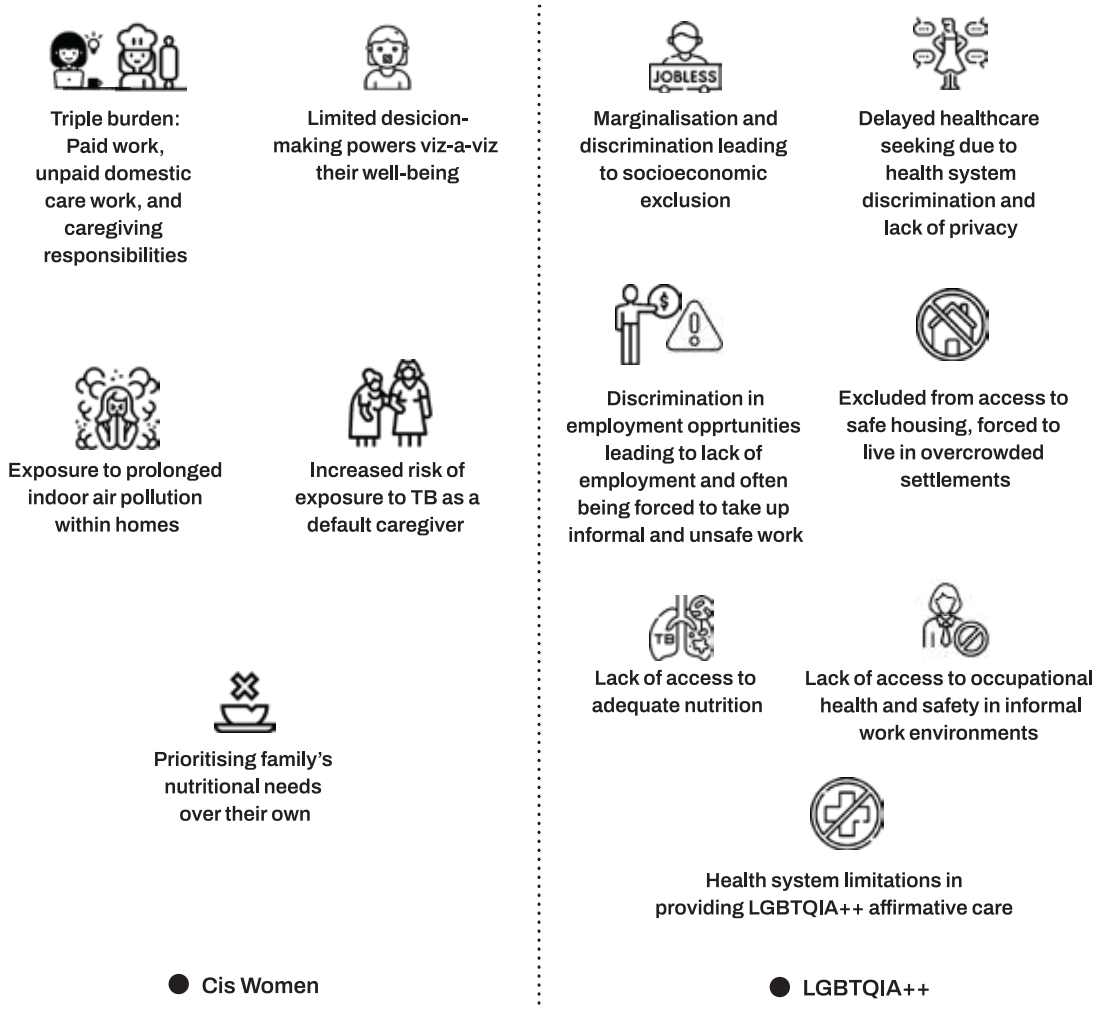
Smoking is linked to increased incidence of TB as well as TB-related morbidity and increased risk of mortality (Balasubramanian et al., 2004; Gajalakshmi et al., 2003; Jain et al., 2014; Kolappan et al., 2006; Lavigne et al., 2006). Men who have ever smoked are three times as likely to report having had TB as compared to non-smokers — this indicates a higher progression of chronic sub-clinical infection to TB disease (Gajalakshmi & Peto, 2000). TB mortality is four times higher among smokers than non-smokers (Gajalakshmi et al., 2003). Please refer to the National Framework for Joint TB-Tobacco Collaborative Activities for more information.

Similarly, heavy alcohol use is associated with increased incidence of TB, increased interruption of treatment, higher treatment failure rates and increased mortality (Cox et al., 2007; Dhanaraj et al., 2015; Imtiaz et al., 2017; Jain et al., 2014; Kliiman & Altraja, 2009; Kolappan et al., 2006). A meta-analysis of studies looking into alcohol consumption and the risk of TB found a strong link between the two and an increasing risk of TB with an increase in alcohol consumption (Imtiaz et al., 2017). Male smokers who consumed alcohol were 11 times more at risk of mortality than the general population because of TB (Kolappan et al., 2006).

A high proportion of people who use drugs were found to have TB in a study conducted in New Delhi, and most were men (quoted in REACH, 2018). People who use drugs are often excluded from mainstream society and experience stigma and discrimination. They are also at a considerably higher risk for HIV, increasing their TB vulnerability. Undernutrition is also a risk factor for this group. Supportive measures are required to ensure that people who use drugs access care and treatment services without fear of discrimination.

With regard to paid work, about 8.3 million people in India, primarily men, are estimated to be at risk of silicosis (Rastogi, 2018). They are employed in mining, quarrying, metals and construction industries. Their socioeconomic conditions may predispose them to TB, compounding the risk of TB secondary to silica-exposure. Besides, silicosis also makes diagnosis of TB challenging owing to similar radiological features and decreased chances of microbiological confirmation secondary to silicosis fibrosis.

Figure 10: Risks and Vulnerability to TB Due to Diverse Gender Roles and Dynamics



Risks and vulnerabilities to TB due to diverse gender roles and dynamics

2.3. Health-Seeking Behaviour and Access to Healthcare

People across Genders and Sexual orientations face delays in accessing health care. However, cis women, LGBTQIA++ persons and cis men are each affected differently. This section conceptualises differences and delays in accessing health care at the individual and systemic levels for cis women, LGBTQIA++ persons and cis men.

Table 2: Conceptual Mapping of Gendered Delays in Care Seeking for TB and Access to TB Services

	Individual-level Delays	Health System Delays
Women and Girls	• Lack of independent access to health information, including lesser exposure to media sources of health information. • Women's families prioritise marital prospects instead of early diagnosis and treatment for women affected by TB. • Lesser exposure to media sources of health information. • Mobility is more of a challenge for cis women, who often cannot step out unless accompanied by a man. This also delays healthcare seeking for women. • Treatment may be interrupted after marriage due to stigma. • Women neglecting their health to prioritise family needs. • Lack of money/financial independence to access services and mobility. • Lack of decision-making powers to decide about their health. • Fear of ostracisation due to TB-related stigma and internalised stigma. • There is a higher possibility of seeking care from an informal provider, pharmacist, or private doctor.	• Overall, there is an absence of a gender perspective in TB. • Women are more likely to access informal providers, pharmacists, or private doctors, which has been observed to delay the diagnosis of TB in women. • Lack of access to women doctors. • Lower index of suspicion for TB, including among pregnant and postpartum women. • Differential presentation of TB symptoms in women. • A higher proportion of clinically diagnosed, sputum-negative and extrapulmonary TB in women. • A lower incidence of microbiologically confirmed pulmonary TB and a higher incidence of clinically diagnosed pulmonary TB and EPTB make diagnosis among women difficult. • Limited understanding of how to provide the right quality sputum sample for testing. • Lack of private spaces for examination in the health system. • Lower diagnostic capabilities for paediatric TB affect girls, who are more vulnerable than boys.

	Individual-level Delays	Health System Delays
LGBTQIA ++ persons	• Lack of access to inclusive information on TB and TB services. • Delays in care seeking due to gender/sexual identity-based stigma, TB-related stigma and unsupportive work environments. • Lack of familial support to help initiate care and complete treatment. • Loss of pay due to taking days off to get diagnosed and for treatment. • History of erroneous criminalisation and associated violence that forces LGBTQIA++ persons to hide their gender and sexual identities and relevant medical history.	• Stigma, discrimination, and abuse in the health system. • Lack of capacity of health providers to provide gender-responsive, culturally competent care. • Lack of private spaces for examination and confidentiality. • Lack of access to information about free TB services or health system navigation. • Inadequate implementation of legal protective frameworks that percolate to ensure equity in healthcare access for LGBTQIA++ persons. • Delay diagnosis in PLHIVs due to health-system discrimination.
Men and Boys	• Anticipated loss of income and social standing as primary income earner. • Social pressures to support families. • Informal workers, including migrants, lack supportive work environments that could lead to delays in health-seeking benefits like leave to visit clinics. • Perceived and experienced TB-related stigma, particularly at the workplace and within the community. • Lack of access to TB-related and TB services information, similar to all genders.	• Difficulties accessing health care, e.g. inconvenient clinic timings and geographical distance. • Disrespectful or unwelcoming attitude of health staff towards people with TB. • High consultation charges for every visit to the private sector.

(Source: Weiss et al.,2008; Khan, 2012; Krishnan et al., 2014; Kulkarni et al., 2014; Thapa et al., 2014; Yang et al., 2014; IIPS, 2015; McArthur et al., 2016)

2.4. Experience of TB-related Stigma

Despite the gains made towards diagnosing and treating TB, the stigma and associated discrimination experienced by persons with or who are affected by TB is still pervasive. Although stigma associated with TB has multiple layers, whether perceived (or anticipated), experienced (or enacted), social (or internalised by one who is affected), it is detrimental to everyone affected by TB. Stigma is a fundamental barrier across the TB care cascade, affecting care-seeking behaviour, diagnosis, and treatment adherence (Kulkarni et al., 2013; Chakrabartty et al., 2018; Chakrabartty et al., 2019; Garg et al., 2020).

Moreover, shaped by social mores, beliefs, and interpersonal attitudes, TB-related stigma functions as a social determinant of health. Persons of all genders and sexual orientations experience stigma and discrimination. However, the experience and the impact of TB-related stigma varies for different genders and sexual identities.

Studies have shown that social isolation and job loss owing to TB-related stigma and reduced income are primary concerns reported by men (Nair et al., 1997; Long et al., 2001). Moreover, men have reported discrimination for TB in the context of high levels of alcohol consumption (Thapa et al., 2014). This could be because of reduced income and loss of status in the family.

For cis-women, the stigma is associated chiefly with marriage and marriage-related problems, harassment and differential treatment within the household. In contrast, men experience a sense of shame because they cannot work, income levels drop, and other women members of the household are required to work to augment the family income (Khan, 2012; Krishnan et al., 2014; McArthur et al., 2016). Young unmarried girls and their families fear that they will not be able to get married or that the marriage may end because of a TB diagnosis. There are also instances of marriages being called off (Weiss et al., 2006). This leads to hiding symptoms or illness, not seeking treatment or keeping the treatment secret and refusing home visits (Khan, 2012; McArthur et al., 2016).

For LGBTQIA++ persons, the effect of stigma is layered. Stigma for them can be threefold — the stigma of being socially discriminated against as an LGBTQIA++ person, as an LGBTQIA++ person with TB or presumed to have TB and as an LGBTQIA++ with HIV and TB or presumed to have HIV. LGBTQIA++ persons encounter discrimination across various spheres, such as education, employment and housing opportunities, and interpersonal relationships (Milburn et al., 2006; António & Moleiro, 2015). LGBTQIA++ youth, social stigma about their sexual choices or identities can be challenging. This puts LGBTQIA++ youth at increased risk for certain adverse health outcomes.

LGBTQIA++ persons experience stigma and discrimination within health systems and are thus deterred from accessing care early. Delays in seeking care due to stigma and unsupportive work environments; loss of pay due to having to take days off to get diagnosed and for treatment; lack of familial support to help initiate care and complete treatment; lack of access or means to caregiving

services. Studies on healthcare access and usage by lesbian, gay, and bisexual (LGB) demonstrate that sexual minorities have significantly high unmet needs for healthcare and experience impediments to care at both structural and individual levels (Gonzales & Blewett, 2014; Dahlhamer et al., 2016; Jackson et al., 2016; Hsieh & Ruther, 2017; Tabaac et al., 2020). The interaction of various aspects of social identity with sexual orientation and the potential role of stigma in influencing access to TB services and the quality of services for the LGBTQIA++ community cannot be ignored. It needs to be factored into designing stigma mitigation strategies explicitly addressing the multifold stigma the LGBTQIA++ community faces.

Stigma faced by older men and women and other vulnerable groups: The health of family members who are relatively powerless and subordinated is often neglected. This includes the elderly — cis men and cis women — and widowed, separated or divorced women. Studies show poor access to healthcare for older women and insufficient notification of TB cases in older women, though there is no evidence that the two are linked. Instances of harassment experienced by older women and isolation of older men and women with TB have been anecdotally documented (REACH, 2023).

2.5. Treatment Adherence and Completion

Adherence to TB treatment and completion of treatment are critical phases of the care cascade. TB treatment typically involves a combination of antibiotics taken over several months, and strict adherence is essential to prevent the development of drug-resistant strains and ensure the clearance of the infection. Adherence, therefore, refers to the extent to which a person with TB follows the prescribed treatment plan, takes the medication as directed, and completes the entire course. Completion, conversely, signifies that the person with TB has successfully finished the entire course of the prescribed treatment. Neither term necessarily means that the person with TB, albeit having adhered to treatment and completed it, is necessarily cured.

Factors influencing TB treatment adherence range from external conditions and systemic challenges that may affect a person's ability to adhere to treatment. These may include socioeconomic factors, such as poverty, loss of livelihood, discrimination and isolation, and logistical barriers like transportation issues or distance from healthcare facilities. In addition, mental health issues, substance use, the stigma associated with TB, gender-specific barriers and cultural beliefs about the disease can all impact treatment adherence. Additionally, the complexity and duration of TB treatment may pose challenges, leading some individuals to discontinue the medication prematurely.

Interrupted treatment in cis women:

Several studies show that women have a higher probability of completing treatment, with better treatment outcomes, while men face challenges on this front, including in the case of MDR-TB. However, incomplete and irregular treatment is a common problem in pregnant women. Further, married women may be unable to complete treatment for various reasons, including:

Box 4: Cited Reasons for Not Completing TB Treatment Among Women Treatment

- TB has not been disclosed to the in-laws, and the woman feels compelled to hide her TB diagnosis because of social stigma, self-stigma and fear of rejection.
- Adequate information might not be provided about the interference of Rifampicin with oral contraceptives, and proper counselling is not offered to the woman and her spouse for alternate forms of contraception.
- Information on the safety of first-line TB drugs in pregnancy is not adequately emphasised. Affected women and families end up prioritising the foetus's health over the mother's due to the unfounded fear that the medication will harm the foetus or a woman's fertility.

Interrupted treatment among LGBTQIA++ persons:

As outlined earlier, due to economic instability, social discrimination, internalised stigma and stigma

within the health system, LGBTQIA++ individuals are often hindered from completing treatment. As a result, in many cases, they reinitiate treatment in the private sector at an increased cost of care. Studies on the influence of stigma on adherence to TB treatment are limited. Nevertheless, an analysis of medication adherence among transgender and gender nonconforming (TGNC) people living with HIV (PLWH) from the 2015 U.S. Trans Survey (USTS) found that when compared to other studies on this population in medical care, the respondents reported lower adherence (Teti et al., 2019). In cases documented by Survivors Against TB (SATB), LGBTQIA++persons found it hard to continue treatment due to discrimination and stigma in healthcare despite having no behavioural risk factor. Nonetheless, LGBTQIA++ groups recommend increasing cultural competence, awareness and training of health personnel, providing counselling and support networks for LGBTQIA++ persons, and increasing LGBTQIA++ representation within the NTEP workforce.

Interrupted treatment among cis men:

Studies have demonstrated that men struggle to complete TB treatment, particularly the men who use alcohol (Das et al., 2014; Jain et al., 2014; Nair et al., 2017; Ramachandran et al., 2017; Veerakumar et al., 2016). In addition, studies have shown that a significant number of persons suffering from TB have reported depression and anxiety (Alene et al., 2018). Furthermore, people with multidrug-resistant TB, as well as TB with comorbidities, are at high risk of depression (Molla et al., 2019). In a cross-sectional, prospective and observational study conducted among people with TB at a tertiary care hospital in Bangalore, it was found that men have significant depression (Shyamala et al., 2018). Existing mental health issues, in turn, can contribute to treatment interruption.

The other principal attribute linked to not completing treatment is smoking (Jain et al., 2014; Veerakumar et al., 2016). Studies on MDR-TB show that adherence to treatment and treatment outcomes are worse and mortality higher for people with MDR-TB who use alcohol. Smoking and drinking are independently associated with poor treatment outcomes for people with MDR-TB (Jain et al., 2014).

Other reasons provided by affected persons for not completing treatment were (Jaggarajamma et al., 2007):

- Adverse drug reactions or toxicity to TB drugs
- Migration
- Feeling better, reduction in symptoms
- Taking medicine from other centres

Migrant workers — the majority of whom are men — often find it challenging to adhere to treatment because of poor mechanisms to support uninterrupted treatment in the face of their extreme poverty and daily survival issues. This struggle often leaves them unable to access continuous TB care. Migrant workers are often forced to discontinue treatment without giving a forwarding address. This is probably because they do not have a forwarding address to share, do not have adequate identity proof or are reluctant to provide the employer's address for fear of stigma and losing employment. The programme is working to strengthen the mechanism of care for migrant workers. Migration for

work among women is increasing, especially as domestic workers, but there is a paucity of studies and data. The possibility of interrupted treatment would be similar for both men and women.

Addressing both structural and socioeconomic factors is crucial for developing comprehensive strategies to enhance TB treatment adherence and completion, ensuring better outcomes for people with TB and reducing the risk of TB transmission and drug resistance[2].

[2] The framework takes cognisance that the term "treatment adherence" has been criticised for its inherent paternalistic undertones, as it implies a passive role for the individual in simply following medical directives. The term can be stigmatising, implying that individuals who struggle with adherence are "non-compliant" or or to be blamed, overlooking the complex interplay of factors that influence a person's ability to follow a prescribed treatment plan. A more people-centric and empowering alternative to "treatment adherence" is the term "treatment concordance." This alternative emphasises a collaborative approach between healthcare providers and those affected, recognising that successful treatment outcomes depend on mutual understanding, trust, and shared decision-making. By reframing the narrative around care partnership, healthcare professionals can foster a sense of agency and responsibility in people with TB, acknowledging their active role in the treatment process. Moreover, healthcare systems should address the structural barriers hindering treatment adherence. This includes improving access to healthcare services, addressing socioeconomic disparities, and implementing support systems to help individuals navigate the challenges associated with their treatment.

2.6. Socioeconomic Impact of TB

The socioeconomic impact of TB varies across cis women, LGBTQIA++ persons and cis men. For instance, though studies of catastrophic expenses on TB pertain to both men and women, most studies underline that the costs incurred by men were more than those by women (Ananthakrishnan et al., 2012; Muniyandi et al., n.d.; Rajeswari et al., 1999). The reasons for this are not clear. Expenses incurred for extrapulmonary TB were also higher among women and more significant than those for pulmonary TB. Nevertheless, psychosocial impacts, including anxiety and stress of loss of income, depletion of savings, indebtedness, and mortgaging ornaments, have all been documented.

The loss of income or employment affects men economically and socially, given the culture's ingrained expectation that men should be primary or sole income earners and provide for their families. On the other hand, women, including older women, face the brunt of stigma, harassment and rejection much more than men. Women who become infertile due to genital TB face added stigma.

Studies on TB's socioeconomic and psychosocial impact on the lives of LGBTQIA++ persons in the region are scarce. However, given the existing marginalisation, health inequities, and socioeconomic exclusion experienced by LGBTQIA++ identities, it could be safely concluded that TB's socioeconomic and psychosocial impact is not only magnified for LGBTQIA++ persons but adds to the layer of multiple oppression. In a set of interviews conducted in 2021, SATB found that many trans and queer individuals reported debt and other economic impacts, including loss of income. The socioeconomic effect of TB is further compounded for LGBTQIA++ persons as they often do not have the social safety nets of families and structured communities. Therefore, research focusing on LGBTQIA++ persons to assess the impact of TB across various spheres is critical for the NTEP to formulate interventions to mitigate the impact of the disease.

2.7. Psychosocial Impact of TB

The psychosocial impact of TB is well documented. In recent years, several studies have shown the correlation between TB and mental illnesses. People on treatment for TB, as well as TB survivors, have reported mental health issues like depression, anxiety disorders, and low self-esteem at some point in their TB journeys. The treatment for TB is lengthy, and some anti-TB medications, such as cycloserine, can lead to severe mental health issues like depression, anxiety, or psychosis. Studies have shown that the prevalence of depression can be as high as 70% in people with TB. Additionally, TB remains highly stigmatised. Research indicates that these factors can result in people with TB discontinuing their treatment, heightened isolation, and extreme self-harm, including suicide (Ashesh & Mehra, 2019).

Psychosocial impact on cis women

A TB diagnosis and seeking treatment is traumatic for women, given the stigma and fear of rejection by families. Women face rejection, especially in joint families they were married into, and sometimes from their parental families (Weiss et al., 2006). Rajeshwari and others (1999) document that approximately 15% of rural and 11% of urban women with TB faced discrimination and rejection by their families. The reduction of self-worth for the women themselves stemming from their inability to care for their children and perform routine household activities further exacerbates the family dynamics. Some extreme forms of rejection reported by women include being sent away to the maternal home (Khan, 2012), facing domestic violence, being deserted by husbands (Singh, 2005), being instigated to commit suicide by the husband and in-laws and the fear of being killed (Weiss et al., 2006). Furthermore, it also affects their ability and motivation to function. Before their illness, 79% of women carried out household activities such as cooking, cleaning, washing and serving food. After diagnosis, this fell to 38%. Child care decreased from 69% to 34% (Rajeswari et al., 1999).

Psychosocial support and supportive counselling can be essential in removing misconceptions, providing accurate information, protecting from infection and negotiating power relationships within the family.

Psychosocial impact on LGBTQIA++ persons

There is a paucity of studies on the psychosocial impact of TB on LGBTQIA++ persons. The interaction of discrimination, stigma, and minority stress endured by LGBTQIA++ persons with TB severely affects their mental health. Additionally, evidence demonstrated that stigma is a critical determinant of a person's mental well-being and affects health-seeking behaviour (Safer et al., 2016). Studies on TB and stigma should prioritise the collection of gender and sexual orientation-disaggregated data, a crucial step to understanding the psychosocial impact of TB on LGBTQIA++ persons. Financial instability, the cost of TB, and the lack of familial support, given that families often disown them, all significantly impact the mental health of LGBTQIA++ persons.

The need for psychosocial support systems is heightened for LGBTQIA++ persons as their interpersonal relationships may be affected due to stigma, and there may be rejection from the family. Participatory research shows the unmet healthcare needs of LGBTQIA++ persons (SATB, 2021).

Psychosocial impact on men

Studies also point to men being impacted due to the diagnosis of TB, the impact being more in terms of their inability to work, support the family and employment loss. Sometimes, there is also rejection from the family. A 40-year-old man working as an office assistant said, "I told my employers that I had TB and wanted some leave. Immediately, they told me that I should discontinue the job and come back only after the doctor gives me a certificate that I am cured." (Ananthakrishnan et al., 2012)

While men also suffer the psychosocial impact of TB, instances of rejection by families are fewer than women. The economic impact, impact on employment and impact on their families causes the maximum psychosocial trauma for men. However, men have the freedom and mobility to travel for work and live independently. Such options are often closed to women.

Privacy, anonymity and confidentiality are essential for gender and sexual identities, including but not limited to cis men, cis women, and LGBTQIA++ persons. Young unmarried girls and their families fear that they will not be able to get married or that the marriage may end because of a TB diagnosis. There are also instances of marriages being called off (Weiss et al., 2006). This leads to hiding symptoms or illness, not seeking treatment or keeping the treatment secret and refusing home visits (Khan, 2012; McArthur et al., 2016).

2.8. Gender, Sexual Orientation, and Healthcare Systems

Just as society is organised along the lines of gender binaries resulting in gender inequalities, the health system is also a gendered institution. This document acknowledges the need for a gender-responsive lens to understand various aspects of TB, including its epidemiology, risks and vulnerabilities to TB, strategies, policy design, and access to TB care and services. Therefore, building capacity for a gender-responsive approach of staff in the public health system to equip them with the knowledge and skills to understand gender and sexual identity and apply it effectively in their work is critical.

Still, some of the barriers linked to gender which affect the understanding of TB and the provision of effective services are described below. Firstly, most staff of the NTEP, including the State TB Officers (STOs), District TB Officers (DTOs), other Medical Officers and supervisory staff (STS, TB-HIV Coordinator, PPM Coordinator) are male. This reinforces the image of TB as a predominantly male disease. On the other hand, most community health workers, i.e. ASHAs (Accredited Social Health Activists), Sahiyas, etc., are women. This can pose challenges, such as potential discomfort in establishing rapport with or counselling people with TB who use alcohol, drugs or smoke. A model of overwhelmingly male supervisory staff and overwhelmingly female field staff will not result in gender-equitable and inclusive services.

Similarly, the representation of TB survivors from cis women and LGBTQIA++ persons is crucial for an inclusive approach because of their lived experience and insights into community needs. As we advance, the programme continues to aspire to work towards gender and sexual identity representation parity in staffing at all levels. Hence, cis women, LGBTQIA++ persons and cis men all feel comfortable accessing services.

Other challenges brought out by the literature review are:

- Inadequate information and guidance at health facilities to negotiate the system,
- The need for multiple visits before the diagnosis is confirmed,
- Difficulties in getting an appropriate referral and substandard attitudes of the staff.

Rights for people with TB as enshrined in NSP include providing essential information at each stage of treatment, including regarding medication side effects and effective communication by the health system. The NTEP proactively involves community members such as TB Champions and support groups to ensure adequate feedback regarding such challenges reaches the programme managers in real-time.

Section III

NATIONAL FRAMEWORK FOR A GENDER-RESPONSIVE APPROACH TO TB AND ITS PROGRAMMATIC IMPLEMENTATION

3.1. Goal and Guiding Principles

An effective and gender-responsive TB programme must incorporate elements of both programmatic and institutional mainstreaming (WHO, 2011). The programmatic approach ensures gender and sexuality mainstreaming in all aspects of implementing interventions and activities. At the same time, the Institutional approach ensures that institutions running the TB programme create an enabling environment that respects people of diverse sexual orientations, gender identities, gender expressions and sex characteristics. Moreover, it ensures that organisational procedures and mechanisms do not reinforce or reproduce societal inequities based on gender or sexual identity. For institutional gender mainstreaming, it is vital that the affected communities co-lead agenda setting, policy development and governance, recruitment, staffing, budgetary allocations and administration.

To that end, this section builds on the evidence presented in previous sections to outline the critical components of the National Framework for a Gender-responsive approach to TB. The section begins with the overarching goal, objectives and guiding principles that will not only govern the implementation of this framework but also be incorporated into all strategies and policies of the NTEP. The subsection delineates strategies and actions fundamental for gender-responsive TB care based on the four pillars of the NSP - Detect, Treat, Prevent and Build. Except for actions specific to the NTEP, most of the activities and actions laid out in the following chapters also apply to the private sector. Therefore, private health providers must be sensitised to recognise and incorporate gender-responsive care into their service provision.

Box 5: Goal and Objectives of The Framework

Goal: To adopt and implement a gender-responsive approach to TB in India.

Objectives:

- To aim to provide equitable, rights-based TB services for cis women, LGBTQIA++ persons and cis men by adopting a gender-specific programmatic approach at all levels.
- To mobilise, empower and engage cis women, LGBTQIA++ persons and cis men in the TB response at the policy, health system and community levels.
- To recognise and mitigate systemic stigma and discrimination towards all cis women, cis men and LGBTQIA++ persons.

Figure 11: Four Pillars of the NSP Detect, Treat, Prevent and Build

Overall Guiding Principles

Access for All: Make high-quality care and services available, accessible and affordable for all.

Respect For All: Ensure respectful care for people with TB of all genders and sexual orientations; they must be treated with respect and dignity.

Non-Discrimination: Provide equitable, quality care to people with TB irrespective of all ages, sexes, sexual orientations, gender identities, races, ethnicities, religions, classes, cultures, castes, occupations, or disability.

Promoting the Rights-based Care of Individuals and Groups: Provide people-centred, rights-based care to all persons with TB, particularly those most vulnerable.

Informed Consent: Provide sufficient and culturally appropriate information and options about TB-related diagnosis, treatment, side effects, and social support to ensure these are understood and respect the individual's autonomy in making fully informed decisions.

Informed Choice: Provide adequate support and an enabling socio-cultural environment to equip people with TB, particularly from vulnerable groups, to make informed, free and voluntary choices about their care.

Confidentiality: Ensure that all information and medical records, in digital and physical format, are confidential. Only healthcare professionals and community supporters with a direct role in managing care seekers or people with TB should have access to such records on a need-to-know basis.

Working in Partnership: Foster and strengthen partnerships between government and civil society, including community-based organisations, women's groups, TB Champions survivor-led networks and LGBTQIA++ community collectives.

Engaging Communities: Engage communities as equal partners in creating an enabling gender-responsive environment for people with TB.

Linking Prevention, Treatment and Care: Build decentralised, integrated, coordinated care programmes by linking TB prevention, treatment and care services, and other related health services needed by people with TB or those with TB symptoms.

Fostering Accountability: Ensure health system accountability for providing gender-responsive care through programmatic and community-led monitoring.

Adapted from "WHO: Integrating Gender into HIV/ AIDS programmes in the Health Sector 2009."

Table 3: National Framework on a Gender-responsive Approach to TB

NATIONAL FRAMEWORK FOR A GENDER-RESPONSIVE APPROACH TO TB IN INDIA

Core Values

Confidentiality

Non-discrimination and non-stigmatizing behaviour

Respect for all

Informed consent

Accountability

DETECT

Train providers (public and private) on gender-responsive provision of care.

Integrate screening for TB into maternal health services.

Gender-responsive.

Active Case Finding.

Improve gender and age-disaggregated notification for the public and private sectors.

Strengthen referral and feedback mechanisms between the programme and the community.

TREAT

Adopt comprehensive people-centric care.

Ensure respectful behaviour and confidentiality of identity.

Provide non-judgmental, safe space for all, especially women and LGBTQIA++ persons.

Enlist support of programme/private sector intervention for people with TB in the private sector.

Engage communities in community monitoring, peer psychosocial support and mitigation of stigma.

PREVENT

Institute air-borne infection control in health facilities, especially in MCH and ART clinics.

Prioritise screening for LTBI and management among LGBTQIA++ persons, women and children.

Enlist support for women and LGBTQIA++ persons for contact screening and chemoprophylaxis.

Screen caregivers for TB and educate them on cough hygiene.

Support cough hygiene drives by TB champions and community groups.

BUILD

Strengthen linkages between programme, private sector and communities.

Work towards gender-equitable planning and budgeting.

Assess and aim for gender parity in the workforce.

Ensure representation of women, men and LGBTQIA++ persons in all forums.

Promote participation of women's collectives in community response to TB.

Core Values

Access for all

Right-based approach

Empowered communities

Work in partnership

The Framework aims to apply the gender lens to the existing and new strategies, programme functioning, and implementation at all levels.

3.2. Training on Gender-responsiveness for NTEP Staff

Building the health system's capacity to provide gender-responsive care is a critical first step in creating a national TB elimination programme that acknowledges and responds to diverse needs across gender identities and sexual identities. This chapter details the training curriculum and relevant content to be emphasised to ensure the NTEP staff at the national, state, district and sub-district levels are trained to gain a conceptual understanding of gender and its relationship with health and TB, thereby supporting the programme to become more gender-responsive.

All NTEP staff at the national, state, district and sub-district levels will be trained to understand the concepts of sex, gender and SOGIESC (Sexual Orientation, Gender Identity/Expression, and Sex Characteristics) and how gender and TB interact. The main objectives of the training will be to bring about a change in the knowledge, attitudes and practices of all staff, thereby equipping them with the cultural competencies and skills to provide gender-responsive care to people with TB and implement this Framework.

Through interactive activities and role-plays, the training will emphasise actions that can be taken to make the TB programme gender-responsive at all levels. Moreover, such training will strengthen the capacity of all state and district TB programme staff, including counsellors, treatment supporters, and community health workers, to provide gender-responsive care at every step of the TB care cascade.

The training curriculum can be adapted for different cadres of NTEP staff from different regions, focusing on key action points. The following are some key steps for capacity building:

- Appoint focal persons for gender at the national and state levels to handhold and oversee strategies for a gender-responsive TB programme.
- Create a pool of diverse trainers through 'Training of Trainers' workshops at the national and state levels. This pool should have a proportionate representation of cis women, LGBTQIA++ persons and cis men across genders and sexual orientations.
- Provide gender-responsiveness training to all NTEP staff at the national, state and district levels on an incremental basis, including medical officers, service providers, healthcare workers, counsellors, treatment supporters, and managers, as well as staff responsible for ACSM and monitoring the programme. To account for attrition and newly appointed staff, these trainings must be held regularly, preferably at least twice a year. The training must be participatory, involving gender experts and experts from LGBTQIA++ communities for a hands-on demonstration of gender-responsive care.
- Involve civil society organisations and LGBTQIA++ persons working on gender and sexual

identity as resource persons in training with proportionate representation of trainers across genders and sexual orientations.

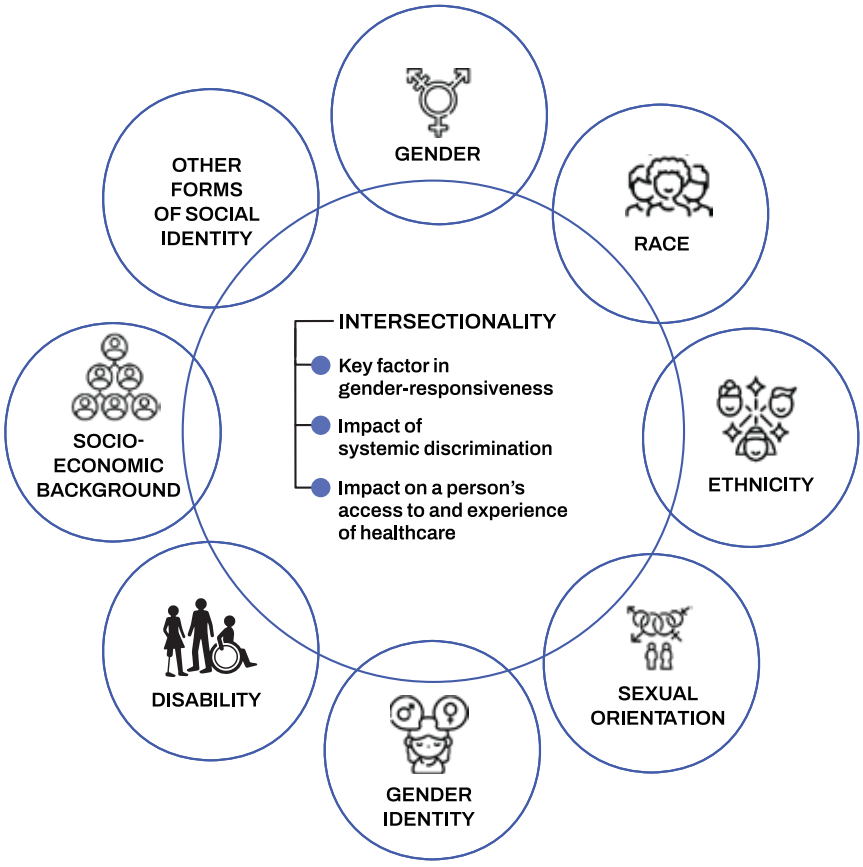
- Integrate strategies for a gender-responsive TB programme in all existing training modules on TB. Review and adapt existing training materials and tools to make them gender-responsive.
- Adapt the gender-responsive training curriculum as required for different audiences.

Box 6: Curriculum on Gender-responsiveness

Include, at a minimum, the following key areas in a standardised gender-responsiveness training curriculum:

- Concepts of patriarchy, gender and sexual orientation, gender identity/expression, sex characteristics (SOGIESC), gender-based violence, and intersectionality.
- Gender inequity relating to power differentials in relationships, gendered division of labour, and access to education, finances, property, mobility, etc.
- Gender as a social determinant of health.
- Age and gender-specific epidemiology of TB in India.
- Gender and sexual orientation as factors that affect a person's access to healthcare and experience of the TB care cascade.
- Gender and sexual identity-related power dynamics within the health system.
- Implementing strategies and actions for a gender-responsive TB programme.
- Enabling participants to recognise and address any inherent biases.

Figure 12: Gender and Intersectionality



Box 7: Intersectionality

Understanding intersectionality is integral to gender-responsiveness. "The concept of intersectionality describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination "intersect" to create unique dynamics and effects" (Center for Intersectional Justice; n.d.).

Each of these aspects of a person's social and political identity potentially impacts their access to and experience of healthcare. For example, a transgender person with a disability may be discriminated against in a health facility, given the stigma associated with their gender identity and disability. This would adversely affect their access to care and the quality of care they receive.

The training should incorporate a session on intersectionality through a power walk exercise described in the curriculum. Further, the training should build the capacity of NTEP staff to provide care that recognises and mitigates the impact of intersectionalities on access to and healthcare experience.

3.3. Gender-Responsive Approach to Detecting TB

Essential Actions for gender-responsive diagnosis of TB:

At the Health-system Level:

1. For conducting community-level mapping, screening and active case finding among vulnerable groups, ensure representation of those affected. For example, engage with organisations and collectives led by women and LGBTQIA++ persons. Ensure representation of those affected. Ensure that those involved from the community are adequately compensated for their work, not just given a token honorarium.
2. Ensure that Active Case Finding (ACF) efforts are gender-responsive in terms of the following, at a minimum:
   a) *Participation:* These activities are designed to incorporate an understanding of local communities to identify and prioritise vulnerable groups. This is important for LGBTQIA++ communities, who must be engaged where relevant to understand the varied health needs of the different groups in LGBQTIA++ communities.
   b) *Composition of team:* There should be adequate and proportionate representation of people of all genders and sexual identities within ACF teams. An adequate representation must be ensured - for example, having just one woman or LGBTQIA++ person will not be a substantial representation. At least 30% of the team should be people of marginalised gender identities and sexual identities (including cis women and LGBTQIA++ persons).
   c) *Timing:* ACF should be conducted when an adequate number of diverse people across genders and sexual orientations are likely to be available at home. If this is not feasible, this should be balanced through multiple ACF drives in the same locality. In other words, it is vital to ensure that ACF or door-to-door screening takes place at a time when the maximum number of household members of varied gender identities and sexual identities are available. Such a gender-responsive approach, in turn, will also give better insights during data analysis and avoid the pitfall of incomplete inferences.
3. Train healthcare providers to understand and acknowledge varied clinical presentation of symptoms for cis women, LGBTQIA++ persons, and cis men for both pulmonary and extrapulmonary TB. For example, as mentioned in previous sections, while men typically exhibit symptoms like fever, haemoptysis, and night sweats, women may manifest typical signs or present with non-specific findings such as fever, body aches, loss of appetite, and fatigue.
4. Be mindful of the specific needs of cis women, pregnant women (cis and trans), LGBTQIA++ persons and cis men in sputum collection and transportation by ensuring privacy and safe spaces for collecting sputum samples and X-rays. For example, as changing rooms may not be available for cis women or transgender persons, they may be uncomfortable. Similarly, they

may feel inhibited about bringing out sputum in public and may need private spaces to do so.

5. Ensure screening of all pregnant and postpartum women for TB using the four symptoms complex through integration with maternal health services across all levels.
6. Create gender-inclusive health facilities such as toilets for people of all genders, private spaces for breastfeeding, adequate private rooms for counselling or examination, diaper changing stations in all restrooms (and not just the women's toilet), display multi-lingual, easy-to-understand information in audio-visual and print format, etc.
7. Provide counselling for families, including partners and chosen family, with the informed consent of the person with TB while acknowledging gender dynamics within families. This is particularly important in the case of contact screening within families and in instances when those diagnosed with TB specifically request that their families not be informed for fear of isolation, stigma, etc.
8. Ensure gender-responsive counselling for people with symptoms of TB and those seeking a diagnosis that considers gendered needs and challenges. For example, a transwoman with symptoms of TB may hesitate to return to collect the test result if she has experienced any discrimination while providing the sample. Provide them with a supportive environment that encourages them to return.
9. Respect the privacy and confidentiality of people of all genders and sexual orientations while disclosing diagnostic test results or conducting house visits. Do not reveal their diagnosis without their consent, even to their families, including partners and chosen families.
10. Develop culturally appropriate and gender-inclusive TB education campaigns to improve access to information on TB and the availability of free diagnostic services. For example, ensure participation and representation of people of diverse gender and sexual orientations in such campaigns.
11. Track and analyse access to diagnostics across people of diverse genders and sexual orientations, including mapping access for those in remote areas. For example, an analysis of gender-disaggregated Universal Drug Susceptibility Testing (UDST) data could reveal gender differences in access to testing via smear microscopy vis-a-vis upfront testing via Nucleic acid amplification tests (NAAT).
12. Pay special attention to analysing age and gender-disaggregated data to improve understanding of TB diagnosis trends among cis women, transgender persons, cis men and children of different age groups. For example, in the 0-6 age group, more girls than boys are diagnosed with TB. This analysis should ideally be done at the district level to establish local patterns and needs.

Except for the actions specific to the NTEP, all other activities apply to the private sector, where providers must be sensitised and trained to recognise and incorporate gendered dimensions into their service provision.

At the Community Level:

1. Strengthen the participation of TB Champions, survivor-led networks and LGBTQIA++ collectives in reaching out to the community to sensitise them about the symptoms of TB and facilities available for testing.
2. Strengthen the involvement of communities in identifying and referring people with symptoms of TB to nearby health facilities.
3. Engage TB Champions, local community leaders and LGBTQIA++ collectives in ACF drives to sensitise and mobilise the community on upcoming ACF to improve acceptance among people of all genders and sexual orientations.
4. Strengthen feedback from the community regarding diagnostic facilities and their accessibility through community monitoring.
5. Foster collaboration for TB screening with other community structures such as the National Livelihood Mission, Jan Aarogya Samiti, Mahila Aarogya Samiti, Integrated Child Development Services centres, etc.
6. Compensate involved community members fairly and adequately, not limiting this compensation to a token honorarium.

3.4. Gender-Responsive Approach to Treating TB

Key Actions for gender-responsive treatment of TB:

At the Health-system Level:

1. Ensure the NTEP staff are well-trained to recognise and respect gender-specific needs during treatment initiation. For example, cis women may not be the decision-makers on matters related to their health and may not be allowed to start treatment, even if diagnosed. Cis men may hesitate to initiate treatment, fearing loss of livelihood and the subsequent adverse impacts on their families. Addressing these issues is critical to ensure pre-treatment loss-to-follow-up, particularly for drug-resistant TB.
2. Ensure that health staff do not practice gender stereotyping. For example, it should not be assumed that all cis men will be stigma-free, that all LGBTQIA++ persons are sex workers, or that all cis women are homemakers. Based on cultural context, states can collate a list of simple Do's and Don'ts to address stereotypes and develop IEC material to disseminate.
3. Ask respectful, medically relevant and non-intrusive questions. For example, while providing care to a gay person affected by TB, while it is advisable to ask them whom they live with or come in contact with, do not ask intrusive questions about sexual activities or other intrusive questions about their personal life.
4. Provide a private and non-judgemental safe space for all people with TB to enable them to speak freely. For example, cis women may hesitate to seek help for side effects due to limited mobility. Ensure their treatment literacy, access to information and the necessary support services. It is vital not to be dismissive of suffering from side effects.
5. NTEP to progressively work towards providing comprehensive psychosocial support to people with TB within the programme and in collaboration with relevant ministries. This should also include gender-responsive counselling, treatment literacy through survivor-led initiatives, peer support through trained counsellors, survivor-led networks, and TB Champions. This is crucial to ensure that affected people have the support they need to complete treatment and enhance their quality of life.
6. Identify and address the specific needs of trans persons diagnosed with TB and are on hormone therapy or during gender-affirmative procedures.
7. Prevent systemic discrimination of cis women and LGBTQIA++ persons and cis men at all health facilities. All healthcare providers must be trained to understand the diverse needs of people of various genders and sexual orientations and practice respectful, empathetic, inclusive, and consistent communication to build rapport.
8. Adopt a non-judgemental approach in supporting people with TB who smoke and use drugs or alcohol by emphasising the health risks, dangers, and potential impact. They may not disclose

their habits because of the judgemental attitudes they face from providers, which could have a detrimental impact on their TB outcomes and overall health. Be sure to enlist family support for de-addiction and link people with TB to de-addiction services wherever possible.

9. Counsel families, including chosen families, to mitigate any stigma or discrimination, particularly towards cis women, older women, pregnant women and LGBTQIA++ persons.
10. Identify varying needs and facilitate access to social support schemes for cis women, LGBTQIA++ persons and cis men. For example, older or widowed women may require enhanced access to nutritional support, for which families may need to be counselled. Information on state-specific social welfare schemes may be provided. Alternatively, the nearest Anganwadi Centres could be contacted to provide underweight women with specialised diet and nutrition counselling. Similarly, persons with disabilities diagnosed with TB may need personalised support - such as information on TB in braille or closed captions support to access specific disability schemes.
11. Ensure gender-inclusiveness in access to new treatment regimens in programmatic settings. Based on the available evidence, this is especially important for pregnant women and LGBTQIA++ persons, and ensuring informed consent, privacy and confidentiality.
12. Please do not assume a person's gender identity based on physical appearance.
13. At the time of enrolment in Ni-kshay, ensure enquiry of preferred gender pronouns. Explicitly ask every person with TB or symptoms of TB which gender box they would like selected - male, female, transgender.
14. Be cognizant that LGBTQIA++ persons may not have identity cards corresponding to their chosen name or pronoun. Explore ways to respect their gender identity in such instances by, for example, asking them what their preferred pronoun is - 'he', 'she' or 'they'.
15. Ensure that the identities of people with TB, including their gender identities or sexual orientation, are not revealed without their consent to their families or communities. For example, this is critical when offering access to STI testing for a person with TB who is also living with HIV.
16. In the case of children on treatment for TB, be cognisant of gender-specific challenges. For example, girl children may be permanently withdrawn from school if diagnosed with TB. In such instances, families and school authorities must be counselled.
17. Where relevant, provide information on the importance of contraception for cis women on treatment for TB. Reiterate the safety of first-line anti- TB drugs in pregnancy and emphasise the importance of completing TB treatment to ensure better outcomes for the mother and child. Involve families in this conversation as much as possible and with consent. In the case of cis women with drug-resistant TB, emphasise the importance of preventing pregnancy and facilitate access to abortion services if the period of gestation is less than 20 weeks. For more information, refer to NTEP and Maternal Health Collaborative Framework for Management of Tuberculosis in Pregnant Women.
18. Provide clear, non-judgmental information, without violating privacy, on when and how to engage in sexual activities with partners for people with TB of all genders and sexual identities. For example, do not ask a gay man with TB how many sexual partners he has, or do not

assume that a cis woman has only one sexual partner.

19. Facilitate integrated services for all to the greatest extent possible. For example, pregnant women need to access ANC and PNC services along with TB treatment; people living with HIV may need to access care for HIV and TB; pregnant women with HIV may need all three services. Planning and providing integrated TB services is vital to ensure that multiple visits to different clinics are avoided as far as possible. This can be done through efficient coordination and alignment of services of various departments.
20. Facilitate access to support services for people with TB who may experience gender-based violence. Train healthcare providers to be vigilant of this possibility and accordingly support linkages with relevant support services. For example, helpline numbers of relevant departments may be provided to them for reporting an incident.

Several of the above actions also apply to the private sector, where providers must be trained to recognise and incorporate gendered dimensions into the treatment of TB.

At the Community Level:

1. Identify and facilitate training and capacity-building of TB survivors and Champions to provide gender-responsive peer support to people with TB who are on treatment.
2. Adequately compensate community workers, TB Champions and members of LGBTQIA++ collectives for their skills, time and input in working with the TB programme.
3. Ensure representation of women and survivors who identify as LGBTQIA++ as TB Champions in regular patient-provider meetings (with prior intimation to participating persons with TB). Also, provide targeted outreach to engage these members; for example, have a specific LGBTQIA++-led campaign encouraging LGBTQIA++ survivors to be involved as TB Champions.
4. Enlist the support of TB forums and survivor-led networks for community monitoring and feedback on the quality of treatment services. When seeking feedback, ensure the participation of cis women and LGBTQIA++ persons and representatives of vulnerable communities through mixed and separate groups, ensuring engagement with vulnerable groups is not tokenistic.
5. Ensure that TB Forums are constituted at the district, state and national levels, with adequate and proportionate representation of affected community members of all genders and sexual identities, and that concerned programme officials will ensure that meetings are convened at regular intervals as required, to identify and flag treatment-related challenges to the NTEP, in keeping with the mandate of Forums.

3.5. Gender-Responsive Approach to Preventing TB

Key actions for gender-responsive prevention of TB:

At the Health-system Level:

1. Adopt a gender-responsive lens in ensuring contact screening of people with TB of diverse genders and sexual identities. For example, in the case of LGBTQIA++ persons, ask about chosen families and those who may be sharing their living environments. Allow people with TB to define their households and ensure that family members who go to school, college or work, or are travelling are not missed out.
2. Identify those particularly vulnerable within families and ensure that they are screened, including but not limited to women who are caregivers of people with TB, women who use solid fuels for cooking, pregnant and postpartum women in contact with people with TB, people of all genders and sexual identities who smoke, use drugs or alcohol and LGBTQIA++ persons and their contacts who are forced to live in crowded communities and have limited access to healthcare.
3. Wherever possible, information must be asked through respectful questions and not assumed. For example, the appropriate question for a young woman in her 20s would be, "Whom do you live with?" rather than "Are you married; do you have children, etc."
4. Provide counselling and information for infection control for formal and informal settlement housing and the need to practice cough hygiene to people of all genders and sexual identities. For example, speak directly to a woman with TB rather than address this information to her husband or partner.
5. Ensure that TB Preventive Treatment (TPT) is provided to all children, irrespective of gender. For example, families with multiple children, including boys and girls, ensure that girls are not excluded from access to TPT.
6. When counselling families on TPT, be sure to sensitise them that it does not affect reproductive health or fertility to ensure that families do not prevent young girls or women from taking TPT.
7. For any future rollout of vaccines, counsel the entire family and household, and not necessarily the person who is assumed to be the decision-maker. For example, if a household has both cis men and cis women, counsel both of them and not just the cis man.
8. Devise evidence-based, gender-responsive public health communication strategies and content on TPT or future vaccines that address the community's hesitancy about safety and efficacy. For example, there are often concerns about adverse impacts on reproductive health that must be addressed to ensure that girls and young women are not denied access to preventive healthcare.

Sensitise private providers about the above gender dimensions of preventive actions for TB and encourage them to adopt the updated guidelines.

At the Community Level:

1. Train and engage TB Champions, survivor-led networks, and LGBTQIA++ collectives to provide appropriate counselling to promote the uptake of TPT. For example, identify and engage trained counsellors/treatment supporters from the LGBTQIA++ community to improve understanding of TPT.
2. Adequately compensate and incentivise community workers, TB Champions and members of LGBTQIA++ collectives for their skills, time and input in working with the TB programme. Ensure that travel and related costs are covered for all community workers attending programme meetings.
3. Ensure the availability of TPT beyond clinical settings by providing homes or community dwellings through trained health workers.
4. Ensure that all people with TB and caregivers of diverse sexual orientation, gender identity, gender expression and sex characteristics are counselled on the need to practice cough hygiene and take the lead in sharing the message among their communities.
5. Seek feedback from people with TB, TB Champions, and survivor-led networks about common socio-cultural problems faced by people with TB, particularly cis women and LGBTQIA++ persons, in maintaining cough hygiene within households and accessing preventive care.

3.6. Building A Gender-Responsive Health System

Essential actions for building resilient, gender-responsive health systems:

At the Health-system Level:

1. Invest in sustained and long-term capacity building of NTEP staff at all levels, from national to sub-district and facility level, on gender responsiveness. These training sessions should ideally be held at least twice a year to account for attrition and newly appointed staff. TB survivors must co-lead these trainings, particularly cis women and LGBTQIA++ persons.
2. Additionally, discussions on gender issues must be incorporated into all routine programme meetings and reviews, not limited to a one-time training.
3. Incorporate gender-responsive care provision into Continuous Medical Education programmes for public and private providers.
4. Aim for gender parity in the health system workforce to achieve nearly equitable participation of people of all genders and sexual orientations in the long term. However, in the short-term, ensure adequate and proportionate representation, focusing on making hiring practices inclusive to enable increased representation of cis women and LGBTQIA++ persons in the workforce.
5. Adopt a gender-diverse and inclusive approach in selecting treatment supporters in the community, ensuring appropriate representation of people of all genders and sexual orientations.

In tandem with the above actions, it is also critical to build and strengthen the capacity of the private healthcare sector to provide gender-responsive services for all people with TB and their families.

At the Community Level:

1. Identify and invest in learning from the experiences of affected communities. This can be done by having TB survivor-led networks and LGBTQIA++ collectives sensitising the NTEP and its staff at all levels on varied affected community needs to improve the overall quality of gender-responsive care.
2. Build advocacy capacity of TB survivors and Champions, ensuring appropriate representation of people of all genders and sexual identities.
3. Facilitate or support the formation of support groups for people with TB, ensuring appropriate representation of people of all genders and sexual identities. In some cases, gender-specific groups, i.e., only women or LGBTQIA++ persons, may be required, rather than mixed groups with people of all genders and sexual identities.

4. Ensure proportionate and appropriate representativeness of affected community representatives of all genders and sexual orientations in leadership roles and participation in TB Forums. They must be given opportunities to share their feedback on the availability and quality of person-centred and gender-responsive TB services. The programme must provide a mechanism for grievance redressal if the input is not factored in or acted upon within a reasonable period.

3.7 Advocacy, Communication and Social Mobilisation Activities

Advocacy, Communications and Social Mobilisation (ACSM) around gender-responsive TB care are critical to ensuring meaningful community engagement and mobilisation for awareness and advocacy on gender-responsive TB care and services. This chapter outlines the strategies the NTEP will adopt to ensure that advocacy, communications and social mobilisation are inclusive and gender-responsive. The TB-affected community, including TB survivors, should be engaged as co-creators and equal partners in designing, planning and implementing gender-responsive ACSM activities. All ACSM committees and subcommittees should have adequate and proportionate representation of TB survivors of diverse genders and sexual identities, particularly those underrepresented, such as cis women and LGBTQIA++ persons. All ACSM training, materials, and campaigns should be diverse, equitable and inclusive, featuring people of diverse genders and sexual identities and ensuring the content is accessible and locally relevant. The messaging of ACSM content is to be differentiated and targeted as per the varied messaging needs of different genders and sexual identities. For instance, a campaign that seeks to improve TB screening in intersex persons should be developed with inputs from intersex persons and tailored with messaging relevant and specific to intersex persons instead of being a generic TB screening campaign.

The following are potential interventions to make ACSM more gender-responsive:

- Use a gender and sexual identity lens in planning, defining, implementing and reviewing the advocacy, communications and social mobilisation strategies.
- Strengthen NTEP's capacity building on gender and sexual identity and how ACSM can be used to drive strategic behavioural change by involving subject experts from TB-affected communities. Ensure equal representation among these experts of cis women, LGBTQIA++ persons, and cis men to train the NTEP staff.
- Develop and operationalise a Standard Operating Procedure (SOP) for providing comprehensive gender-responsive TB care. Ensure that this design, sensitisation and implementation process is co-led by affected community members, including cis women and LGBTQIA++ persons.
- Ensure that all job aids for health staff include messages about providing respectful, gender-responsive care and support.
- Provide platforms for recognising and appreciating role models from all genders and sexual orientations, particularly women and LGBTQIA++ persons, for their exemplary advocacy work.
- Ensure periodic meetings between NTEP and affected community groups, survivor-led networks and others to discuss access to and quality of gender-responsive services and get feedback.

- Engage and strengthen civil society and community collectives to advocate for gender-responsive care and co-create similar awareness campaigns with the NTEP.
- Support affected communities and TB survivors, including LGBTQIA++ persons, to lead all public communication, including media roundtables with state-level IEC officers to enhance the media's understanding of TB, gender and sexual identity.
- Ensure equal representation of TB survivors of diverse genders and sexual identities, including cis women and LGBTQIA++ persons in all ACSM committees, mass media, mid media, social media and traditional media about TB.
- Adopt communication strategies aimed at:
    - o Contextualised, culturally competent communication tailored to care-seekers about the availability of gender-responsive TB care and services.
    - o Developing audio-visual communication materials and using innovative new media options, including mobile technology, to communicate everyday gender issues. Involve cis women and LGBTQIA++ TB survivors to co-produce, direct, and approve the messages and visual representation.
    - o Increasing awareness about TB and various forms of TB with specific, culturally sensitive, accessible messaging at all levels and for all stakeholders that considers gender identities, sexual identities, and vulnerabilities among cis women, LGBTQIA++ persons and tribal communities.
    - o Conveying the importance of contact screening and screening members of the biological or chosen family across all genders and sexual orientations.
    - o Co-develop stigma mitigation strategies with affected communities to address discrimination based on SOGIESC.
    - o Ensuring that people with TB, mainly persons from LGBTQIA++ communities and cis women, are aware of their rights and responsibilities.
    - o Focusing on progressive messaging through multiple campaigns for cis men as caregivers for cis women, LGBTQIA++ persons and children affected by TB.
    - o Increasing awareness of social support schemes for people with TB with a particular focus on LGBTQIA++ persons.

3.8 Supervision, Monitoring and Evaluation with a Gender Lens

Conventionally, monitoring and evaluation revolve around interpreting and instituting corrective mechanisms to address gaps in case finding and treatment outcomes. Based on current evidence on TB epidemiology, the NTEP does not collect data on the sexual orientation of people with TB, nor is it recommended to do so. Therefore, disaggregation and analysis of LGBTQIA++ persons (except for transgender persons) will not be possible. However, this is prioritised in research on TB.

In implementing the gender-responsive framework, monitoring and evaluation should also focus on the convergences and divergences in impact across all genders. It should focus on recording, interpreting and applying gender-disaggregated data to devise mechanisms that ensure gender-responsive interventions. Evaluation of gender-responsive programming should be incorporated into the existing evaluation framework used by the programme at all levels and should not be undertaken as a standalone activity. This chapter details how the programme can undertake monitoring and evaluation through a gender-responsive lens.

A. Use of Gender/Age-Disaggregated Data

Ensuring that all data published in national and state reports are disaggregated by sex, gender and age, to the greatest extent possible, will enable a better understanding of the epidemiological profile of TB in India.

- Use gender and age-disaggregated data for active programme monitoring, trend analysis and decision-making at national, state and district levels. Every single data point and variable must be disaggregated and analysed. Age and gender-disaggregated data can reveal the following:
    - The epidemiological profile of TB in a state and district, including age and gender distribution
    - Comparison with national figures and local trends can reveal if there are any difficulties in access to services for some sub-populations. For example, limited diagnosis of TB among the following groups indicates poor access to TB services:
        - Girls and women below the age of 35 years.
        - Transgender persons (in all districts).
        - Pregnant and postpartum women.
        - Analyse ACF data by gender regularly to increase understanding of local trends.
        - Overall, the study of differences in age and gender disaggregated data can call attention to disparities or unusual trends in certain geographic areas. Further qualitative investigation would be required to identify the causative factors and tailor measures to address these differences.

B. Feedback from Service Users

- Ensure that State and District TB forums seek feedback from survivor-led networks and TB Champions on various aspects of programme performance, including providing gender-responsive care, which should be used for suitable modifications in programme implementation.
- Seek regular feedback to understand the acceptance of TB services and the problems people face in accessing services.
- Assess and identify successes and challenges in implementing the framework.

C. Gender-Responsive Monitoring and Evaluation

All monitoring and evaluation components will consider gender an essential criterion at all levels.

- Incorporate measurement of gender responsiveness across the TB care cascade as a parameter in the TB Index.
- Ensure that all monitoring and evaluation processes, including Joint Supportive Supervision, Central Internal Evaluation (CIE), and Annual Reviews, incorporate a review of gender dimensions, including the provision of gender-responsive care across the TB care cascade.
- The gender-responsive review should be co-led by members from the affected community, including LGBTQIA++ persons.
- Ensure proportionate representation of people of all gender identities, including but not limited to cis women, LGBTQIA++ persons, and cis men, as part of the monitoring and evaluation teams to the greatest extent possible. Moreover, monitoring and evaluation are best co-led by CBOs through the community accountability framework, and evaluators from the community should have proportionate representation of all gender and sexual identities.
- Evaluate staff gender and sexual identity training and gender mainstreaming in all programme components.
- Teams constituted for Joint Supportive Supervision, CIE, Annual Reviews, etc., should be sensitised to be gender-responsive in their reporting mechanisms. For example, visits to homes of people with TB should include cis women and LGBTQIA++ persons when possible, with adequate representation of vulnerable groups (cis men with disabilities, transwomen from tribal communities, cis women who are undernourished etc).
- Some routine indicators for the monitoring of a gender-responsive TB programme include:
    - Age (0-4, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, >65) and gender-disaggregated data among total TB cases notified
    - Age and gender-disaggregated data among TB cases initiated on treatment among those notified
    - Age and gender-disaggregated data for TB cases notified in the previous year and successfully treated (<15 years, 15 - 24 years, 25-34 years,>34 years need to be specifically included)
    - Age, and gender-disaggregated data on number of deaths during treatment
    - Age, and gender-disaggregated data on the number of people with TB who were lost-to-follow-up before and after initiation of treatment

- Age and gender-disaggregated data on the proportion of household members undergoing contact screening for TB and the number of household members started on chemoprophylaxis according to prevailing guidelines
- Proportion of cis women, transgender persons and cis men among people with DR-TB
- Proportion of pregnant and postpartum women diagnosed with TB
- Proportion of pregnant and postpartum women initiated on treatment among those diagnosed
- Proportion of cis women, transgender persons, and cis men with microbiologically confirmed, clinically diagnosed and EPTB
- Proportion of cis women, transgender persons, and cis men initiated on treatment from among those diagnosed with microbiologically confirmed, clinically diagnosed and EPTB
- Proportion of NTEP programme staff who have undergone training on the Framework Proportion of cis women, transgender persons, and cis men among NTEP staff at various levels
- Proportion of children by sex who received BCG vaccination

3.9. Roles and Responsibilities of Various Stakeholders

Building a gender-responsive response to TB in India is a joint process that requires the understanding and sustained efforts of everyone within the programme and other stakeholders outside the programme.

The following table lists the roles and responsibilities of key institutions and stakeholders who are part of the TB response:

Table 4: Roles and Responsibilities of Key Institutions and Stakeholders

INSTITUTION	RESPONSIBILITIES
Central TB Division	• Making policy decisions and formulating guidance essential for implementing the Framework. • Promoting and approving activities outlined in the Framework will make the NTEP more gender-responsive in the state Programme Implementation Plans (PIPs). • Planning and provision for training on the Framework and its implementation. • Guiding and promoting inter-departmental coordination (Refer to National Framework for inter-ministerial Collaboration). • Ensuring collection and gender-disaggregated data analysis for active programme monitoring, trend analysis and decision-making at the national level. • Ensuring publication of gender-disaggregated data in all reports and documents. • Prioritising and implementing research along the natural history of the disease and the care cascade on differences across varied Sexual Orientations, Gender Identities, and Sex Characteristics.

INSTITUTION	RESPONSIBILITIES
State TB Cell	• Adopting a gender-responsive lens in all programmatic activities along the TB care cascade as outlined in the Framework. • Providing districts with guidance on integrating a gender-responsive lens in all programmatic activities along the TB care cascade and requisite budgeting. • Compiling district budgets on integration of the Framework and inclusion of the same in the state PIP. • Ensuring all state and district-level teams are trained using the TB-gender curriculum. • Training and engaging the private sector in implementing the Framework through dialogue with relevant medical bodies such as IMA, IAP, FOGSI, etc. • Establishing TB forums with adequate and proportionate representation of all gender and sexual orientations. • Liaising with relevant departments such as DHS and DME for coordination to implement the Framework. • Ensuring gender-responsive recruitment at all levels. • Ensuring that all behavioural change strategies and IEC materials are being co-developed inclusively with affected communities and are gender-responsive. • Consolidating and disseminating good gender practices regularly. • Ensuring compilation and publication of gender-disaggregated data in all reports and documents.
District TB Cell	• Implementing the Framework through day-to-day activities. • Engaging and training the private sector on the Framework. • Forming and sustaining TB forums at the district level that are representative of all gender identities and sexual identities. • Ensuring that all peripheral health workers are trained in the Framework. • Reporting gender-disaggregated data and relevant observations to the State TB Cell and CTD. • Establishing and fostering linkages between the private sector, TB survivors and people with TB for sustained and comprehensive TB response. • Conceptualising, implementing and sharing good gender practices at all levels of implementation.
Medical Officers - MOTC and Medical officers of Peripheral Health Institutions	• Understanding gender differences in vulnerabilities, health-seeking, treatment adherence, outcomes and socioeconomic determinants. • Handholding of peripheral health workers in understanding and implementing the Framework. • Ensuring and nurturing a friendly and respectful ethos devoid of stigma in the health facility for people of all genders and vulnerable populations. • Regular review of facility-level gender-disaggregated data. • Monitoring and providing feedback to the district on implementing the Framework.

INSTITUTION	RESPONSIBILITIES
Peripheral healthcare workers	• Understanding gender and sexual orientation differences in vulnerabilities, health-seeking, treatment adherence and outcomes. • Treating people of all gender identities and sexual identities with respect and dignity. • Ensuring the generation of gender-disaggregated data. • Seeking and enlisting the support of people with TB and social influencers to address harmful gender norms in the community and families. • Providing access to gender-responsive, person-centric quality TB care services, including detection, prevention and treatment.
Civil Society Organisations and community groups, including but not limited to TB survivor-led networks, women-led groups, LGBTQIA++ community collectives	• Co-developing gender-responsive initiatives with the CTD and State TB Cell. • Supporting the national, state, and district TB cells and peripheral institutions in implementing the framework. • Leading the capacity building of medical officers/health workers and affected communities on gender dimensions with support from the National programme/ District/State TB call. • Advocating for integrating TB in Reproductive, Maternal, Newborn and Child Health Programme or women's health programmes and projects.
TB Champions and Survivor-led Networks	• Co-developing, implementing and monitoring gender-responsive initiatives with the CTD and State TB Cell. • Applying the gender-responsive lens to community-based monitoring of TB care services. • Ensuring adequate and proportionate representation and participation from all genders and sexual orientations as members of survivor-led networks and other community groups.

Section IV

RESEARCH PRIORITIES AND COLLABORATION

4.1. Research and Knowledge Building with A Gender-responsive Lens

Cis women and LGBTQIA++ persons are inadequately represented in TB research. Further, research on TB often ignores social determinants like gender and sexual orientation and their impact on access to TB care. Research must focus on marginalised and socially vulnerable groups to understand better their health needs and interventions suited for these. Persons affected by TB from marginalised and socially vulnerable communities, including cis women or LGBTQIA++ individuals, persons with disabilities, or persons from marginalised castes, classes, and groups must be involved by the government, and public and private research institutions as equal partners in identifying research priorities, and in designing and conducting research in keeping with the principles of participatory research. It is also essential to ensure adequate, proportionate participation of all genders and sexual orientations and socially vulnerable groups, including but not limited to cis women, LGBTQIA++ persons, older persons, persons with disabilities, girls, and boys. Further, all research data must be disaggregated by age, gender, sexual orientation, class, caste, disability, ethnicity, religion, occupation and other relevant socio-demographic indicators for analysis. Finally, an ethics committee must review all research protocols, and such committees, in turn, should have adequate and proportionate representation of persons affected by TB across all genders and sexual orientations. At least 30% of the committees should comprise cis women and LGBTQIA++ persons with relevant expertise.

Drawing on the 'Research in Gender and TB' document (World Health Organization, 2004)', the following approach and critical areas of research on gender-responsive dimensions of TB are proposed:

A. Sex and Gender Equity in Research Design, Implementation and Participation

- Ensuring equity in TB research participation and receiving research benefits across all gender and sexual orientations, including but not limited to cis women, LGBTQIA++ persons, and cis men.
- Ensuring equal and equitable opportunities for persons of all SOGIESC in leading and coordinating the TB research programme.
- Ensuring adequate and proportionate gender and sexual orientation representation in research, ethics and community advisory board committees at national and sub-national levels.
- Developing guidelines, strategies and best practices to ensure equitable representation of gender and sexual identities.
- Understanding the factors that lead to inequitable representation of gender and sexual identities in TB research.
- Undertaking implementation research to understand health-seeking behaviour and, in turn, develop

strategies and best practices to ensure equitable representation of gender and sexual identities.

- Focusing on how different social stratifiers interact to create different experiences of privilege, vulnerability and marginalisation among the gender and sexual identities.
- Considering gender within the design and development of research: data disaggregation and gender frameworks.
- Advocating with the Indian Council of Medical Research (ICMR) and the Indian Council of Social Science Research (ICSSR) to provide guidelines for this purpose.
- Developing a research analysis framework that will allow maximum data segregation by gender and sexual identities.
- Dissemination of research findings by segregating data on gender and sexual identities.

B. Biology and Epidemiology of TB

- Understanding how intersectional social determinants like gender, sexual orientation, disability, religion, caste, class, etc., interact with TB and comorbidities like HIV, diabetes, and mental health.
- Understanding how intersectional social determinants like gender, sexual orientation, disability, religion, caste, class, etc. interact with TB-related morbidity.
- Psychosocial and socioeconomic impact of TB on cis women, LGBTQIA++ persons, and cis men.
- The progression of TB infection to TB disease in different genders and sexual orientations.
- Clinically diagnosed TB and EPTB in different genders and sexual orientations.
- Undertaking research through an intersectional gender-responsive lens to better understand TB disease's aetiology, prevention, control and management, including vulnerability, exposures, disease experiences, health-related decision-making, responses to treatment, and the extent of impact on individuals or social groups.
- Bridging gaps in understanding the biology and epidemiology of TB, including TB presentations and natural course across different gender and sexual identities, including but not limited to cis women, LGBTQIA++ persons, and cis men, as well as their interaction with sexual identity and gender and socio-cultural factors.

C. Diagnosis, Treatment and Treatment Adherence

- Ensuring gender-responsive community-based case finding by planning, implementing and monitoring relevant activities with participation of gender and sexual identities.
- Incorporating gender-responsive screening and assessment tools to identify vulnerabilities for TB and mental health issues among people with TB, which could vary widely across gender and sexual identities.
- Developing evidence-based gender-responsive interventions to address the varied substance use and mental health issues across genders and sexual orientations.
- Implementing evidence-based differential care, which includes flexible treatment options and support systems for the treatment needs of gender and sexual identities.
- Undertaking research to assess the gender dimensions of family caregiving and informal

caregiving for people with TB during and post-treatment.

- Undertaking implementation research to develop effective and equitable family caregiving for people with TB in households and communities.
- Ensuring equity in patient support systems appropriate for gender and sexual identities and developing gender-driven leadership in TB advocacy.
- Evidence-based intervention for addressing gender-related and LGBQIA++-related stigma (enacted and internalised/perceived stigma) and discrimination, which affects an individual's willingness to seek TB diagnosis and treatment.
- Developing guidelines and training models for healthcare providers to orient and sensitise them to the unique needs of people with TB of all genders and sexual orientations and to equip them with the skills to communicate effectively and respectfully with gender-diverse populations.
- Undertaking research to study provider-level delays in diagnosis and its impact on treatment outcomes of people with TB of all genders and sexual identities, including but not limited to cis women and men and LGBTQIA++ persons and study factors helping women and LGBTQIA++ persons in better treatment adherence.
- Comparative study of innovations in community and facility-based treatment support and impact on treatment adherence.

D. Health Seeking Behaviour

- Designing and implementing operational and implementation research to understand social vulnerabilities which create barriers to seeking care for persons across SOGIESC, particularly LGBTQIA++ persons and cis women.
- Identifying the provider-level barriers and facilitators for delivering services for persons of all SOGIESC.
- Studying and understanding gender and sexual identity-specific reasons for TB-related stigma, provider and individual-level delays and treatment outcomes.
- Designing and implementing operations, interventions and qualitative research agenda that focuses on gaps in understanding gender dimensions of care-seeking and access to TB services.
- Undertaking gender, sexual identity, and age-group-wise analysis of healthcare-seeking behaviour among people with symptoms of TB, especially in girls, women, pregnant and postpartum women and LGBTQIA++ persons, with a specific emphasis on pathways to health services, access to diagnosis and care, delays in diagnosis and treatment initiation, treatment adherence, completion and disease-free survival.
- Assessing reasons to opt for public sector, private sector, private/public mix sector, AYUSH providers or tribal healers/informal care among women, men and transgender persons.
- Analysing gender and sexual orientation-specific outcomes and developing appropriate policies to counter their effects.

E. Quality of Care

- Designing and implementing qualitative, quantitative and mixed-method studies to understand gender and sexual identity dimensions in quality of care.
- Co-creating quality care tools and metrics with affected communities with representation from persons of different genders, sexual orientations, and disabilities.
- Ensuring gender-responsive quality of care in the health system, from diagnosis to the completion of treatment.
- Developing gender-responsive quality of care tools and best practices to measure and assess perceptions and experiences of the quality of care in public, private and private/public mix settings.
- Studying gender and sexual identity-specific feedback on service delivery in public and private health institutions.
- Undertaking research on the quality of life in people with TB for different forms of TB (PTB, EPTB, DRTB, DSTB) across genders, sexual orientation, and disabilities.
- Determining factors leading to favourable outcomes for cis women and LGBTQIA++ communities on TB treatment.

F. Undernutrition and TB

- Undertaking research studies on the relationship between undernutrition in cis women, adolescent girls, pregnant and postpartum women and TB.
- Undertaking research on undernutrition and TB in LGBTQIA++ populations with gender and sexual identity disaggregated data.
- Undertaking research studies on different state—or community-based nutrition support interventions to identify best practices for nutrition support in TB.
- Developing nutritional counselling intervention for family caregivers of different gender and sexual identities and enhancing their skills in providing/delivering balance and sufficient nutrition for people with TB during the treatment.
- Undertaking research studies to understand the comparative impact of supplementary nutrition in various forms (e.g. food supplies, conditional cash transfers, provision of supplementary meals) on TB treatment and outcomes with a focus on LGBTQIA++ communities.
- Understanding differences and barriers in nutritional support equity across different genders and sexual orientations, focusing on cis and trans women.

G. Other Areas for Qualitative and Implementation Research

- Social, psychological and economic implications of TB in cis women, LGBTQIA++ persons, and cis men.
- Innovations, new technologies, and medicines suitable for cis women and LGBTQIA++ persons.
- Comparative research on gender-responsive care best practices from other states and countries

on TB-related comorbidities' impact on persons of different genders and sexual orientations.

- Developing best practices for adolescent and geriatric TB care.
- Developing best practices for culturally competent care.
- Developing gender-responsive social support systems and livelihood mechanisms.
- Evaluating barriers to accessing TB care for LGBTQIA++ persons.
- Study on the health needs of different groups within the LGBTQIA++ community.
- Evaluating utilisation of TB services among LGBTQIA++ persons with gender and sexual identity disaggregated data.
- Evaluate utilisation of TB services, especially for tribal communities in geographically remote areas.
- Enhancing social and communication skills for healthcare personnel.

4.2. Inter-Ministerial Collaboration and Multi-Stakeholder Engagement

TB requires a multisectoral response as a socioeconomic disease with consequences beyond the clinical. This involves building and strengthening collaboration with ministries and departments beyond health at national and state levels to achieve a gender-responsive approach to TB. A detailed National Multisectoral Action Framework is available. This chapter outlines some key areas of focus for addressing the social determinants of TB.

Ministry	Action	Benefit	Timeline
Ministry of Women and Child Development	Ensure 100% coverage of supplementary nutrition schemes for people with TB at the central and state levels.	It helps address nutrition as a social determinant of TB.	
	Strengthen linkages to existing gender-based violence support services for persons with TB who experience gender-based violence.	Reduces discrimination experienced by people with TB.	
	Include TB as a cause for gender-based violence in training on gender-based violence.	Increased sensitisation for government and people with TB on TB-related gender violence.	
Ministry of Minority Affairs and Ministry of Tribal Affairs	Ensure that marginalised communities affected by TB have access to information on TB-related social support schemes, including nutrition.	Increased access to social support schemes for marginalised communities, including tribal communities affected by TB.	
Ministry of Panchayati Raj	Sensitise Panchayats on the gender dimensions of TB. Strengthen monitoring mechanisms to ensure elected Panchayat representatives are undertaking TB awareness campaigns and sensitisation sessions for the community on TB and gender-responsive care.	Panchayats begin to adopt a gender-responsive approach to TB. Increased health literacy, reduced stigma, and better health-seeking behaviour for TB testing.	

Ministry	Action	Benefit	Timeline
Ministry of Social Justice and Empowerment	Design a social support scheme for TB-affected persons, focusing on women and LGBTQIA++ persons, given the multiple forms of marginalisation they experience. This could be disability benefits (travel, pension, other support, and offsetting wage loss during treatment).	Providing social support to persons affected by TB improves their quality of life.	
Ministry of Law and Justice	Design a rights-based and gender-responsive care policy for TB along the lines of the HIV legislation.	Protecting the rights of people with TB and ensuring the rights are realised. Reducing discrimination and stigma.	
Ministry of Petroleum and Natural Gas	Provide alternative smoke-free fuels in homes for cooking.	Better respiratory health outcomes for cis and trans women in tribal and rural areas where hazardous solid fuels are predominantly used.	
Ministry of Skill Development and Entrepreneurship	Include persons recovered from TB as target groups that need to be covered in existing programmes to provide vocational training, including the Skill Acquisition and Knowledge Awareness for Livelihood Promotion ("SANKALP").	Providing social support to persons affected by TB improves their quality of life. Will ease post-recovery entry into the workforce for TB survivors.	
Ministry of Road Transport & Highways and Ministry of Railways	Provide travel concessions for people with TB through their diagnosis, treatment and follow-ups.	Social support for people with TB.	
Ministry of Labour and Employment	Develop labour policies to support those affected by TB, such as those getting special medical leave, rejoining the workforce after a gap, reimbursement of medical expenses, etc. Incorporate social protection for informal workers, including gig economy workers affected by TB, and corresponding obligations for employers in the informal sector in the Social Security Code 2020.	Social Protection for People with TB in the Formal Workforce. Social protection for people with TB in the Informal Workforce.	

Ministry	Action	Benefit	Timeline
Ministry of Housing & Urban Affairs	Include persons affected with TB as part of the marginalised group in all schemes focused on housing support.	Well-ventilated housing for people and families affected by TB.	
Ministry of AYUSH	Ensure gender-responsive care training for AYUSH providers.	Indigenous systems of medicine integrates a gender-responsive approach to care.	

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ANNEXURE

Checklist to Assess Implementation of the Gender Framework at the State, District, Sub-district and Facility levels

Note: This checklist is intended for NTEP teams to assess the current implementation status of the Gender Framework. The checklist can be used at the state, district or facility levels and at multiple time points. The checklist should ideally be used once in 2024 to establish a baseline.

S. No.	Question	Yes (Score = 1)	In progress (Score = 0.5)	No (Score = 0)
Gender-Responsive Training for NTEP Staff				
1.	Has the programme developed a module for gender and sexual identity sensitisation of its officers, programme managers and health staff?			
2.	Has the programme undertaken gender-responsive training for all its officers, programme managers and health staff?			
3.	Has the gender module been incorporated into the induction training curricula for all staff?			
4.	Has the programme made provisions to ensure the gender module is included in the refresher training held annually?			
5.	Has the programme invested in building the capacity of NTEP staff at all levels, from national to sub-district and facility-level, on gender-responsiveness?			
6.	Is gender-responsive care provision incorporated into Continuous Medical Education programmes?			
Gender-Responsive Approach to Detecting TB				
7.	Are gender differences in diagnosing TB clearly understood in the state/district context?			
8.	Have healthcare providers been trained on the varied clinical presentation of TB symptoms among people of diverse gender and sexual orientations?			
9.	Are ACF drives gender-responsive, considering the composition of the ACF team, participation of diverse communities, timing of ACF and any other local priorities?			
10.	Are diverse communities engaged in the mapping and screening of vulnerable groups?			
11.	Are sputum collection mechanisms, both facility and community-based, cognisant of gender and sexual identity-specific needs?			
12.	Are all pregnant and postpartum women screened for TB?			

S. No.	Question	Yes (Score = 1)	In progress (Score = 0.5)	No (Score = 0)
13.	Are health facilities with diagnostic services gender-inclusive with: • toilets for people of all genders • private spaces for breastfeeding • adequate private rooms for counselling and examination • diaper changing stations in all restrooms (and not just the women's toilet), • display multilingual, easy-to-understand information in audio-visual and print format, etc.			
14.	Does the programme provide sputum collection and transportation facilities to communities to increase access to services for cis women, LGBTQIA++ persons, and cis men?			
15.	Does the programme sensitise private providers to gender-responsive provision of TB diagnostics?			
16.	Is gender-responsive counselling provided to people with symptoms of TB and their families to support them through the diagnostic cascade?			
17.	Are all health staff trained to ensure the privacy and confidentiality of TB test results and not disclose results without consent to families or others in the community?			
18.	Is feedback routinely obtained from the community regarding diagnostic facilities and their accessibility?			
Gender-Responsive Approach to Treating TB				
19.	Are all NTEP staff well-trained to recognise and respect gender-specific needs during treatment initiation?			
20.	Are all NTEP staff guided/trained to not practice gender stereotyping in the provision of TB services?			
21.	Are all newly diagnosed people with TB asked which gender pronouns they prefer at the time of entry in Ni-kshay?			
22.	Do all people diagnosed with TB and on treatment receive gender-responsive counselling, ideally provided in a private and non-judgemental safe space, by well-trained counsellors?			
23.	Do all people on treatment for TB receive comprehensive psychosocial support, including gender-responsive counselling, treatment literacy and peer support through trained counsellors, survivor-led networks and TB Champions?			
24.	Are all NTEP staff equipped with the knowledge and skills to identify and address the specific needs of transgender persons diagnosed with TB on hormone therapy or during gender-affirmative procedures?			
25.	Are all NTEP staff trained to ensure that TB treatment is provided free of stigma or discrimination of any sort?			

S. No.	Question	Yes (Score = 1)	In progress (Score = 0.5)	No (Score = 0)
26.	Do all families, including chosen families, receive counselling and support to mitigate any stigma or discrimination, particularly towards cis women, older women, pregnant women and LGBTQIA++ persons?			
27.	Are all cis women provided information on the importance of contraception while on treatment for TB?			
28.	Are all people with TB counselled, in a respectful manner, on when and how to engage in sexual activities with partners while on treatment for TB?			
29.	Are all new treatment regimens rolled out ensuring access to cis women, LGBTQIA++ persons, and cis men?			
30.	Are all people with TB provided access to peer support through trained TB Champions and survivor-led networks?			
31.	Are patient-provider meetings held at regular intervals, with adequate representation of women and survivors who identify as LGBTQIA++?			
32.	Is regular feedback obtained on TB services through TB Forums and survivor-led networks? Is this feedback used to improve the quality of TB care and services?			
Gender-Responsive Approach to Preventing TB				
33.	Is a gender-responsive lens adopted while ensuring contact screening for all people with TB, including identifying those most vulnerable within families?			
34.	Were all health workers — cis women, LGBTQIA++ persons, and cis men screened for TB in the last year?			
35.	Are those most vulnerable in families - caregivers, children, etc., identified?			
36.	Is gender-responsive counselling provided for infection control within households?			
37.	Is TPT provided to all children, irrespective of gender?			
Building A Gender-Responsive Health System				
38.	Do health facilities have the provision of staggered timings to consider the convenience of the cis women, LGBTQIA++ persons, and cis men the facility caters to in the context of geographic and occupational conditions?			
39.	Are discussions on gender issues incorporated in all routine programme meetings and reviews?			

S. No.	Question	Yes (Score = 1)	In progress (Score = 0.5)	No (Score = 0)
40.	Is the programme actively ensuring gender parity in the health system workforce by making hiring practices inclusive to enable increased representation of cis women and LGBTQIA++ persons in the workforce, particularly as programme managers?			
41.	Is the programme actively ensuring proportionate and appropriate representation of affected community representatives of all gender and sexual identities in leadership roles and participation in TB Forums and CTD committees?			
42.	Are there treatment supporters of all gender and sexual identities within the community for people with TB?			
43.	Is the programme facilitating the formation of support groups for people, with appropriate representation of people of all gender and sexual identities?			
44.	Has the programme established feedback mechanisms and grievance redressal from community representatives of all gender and sexual identities on the availability and quality of person-centred and gender-responsive TB services?			
45.	Is the programme actively investing in learning from the experiences of affected communities by having TB survivor-led networks and LGBTQIA++ collectives sensitising the NTEP and its staff at all levels on varied affected community needs and interventions to improve the overall quality of gender-responsive care?			
	ACSM			
46.	Does the facility engage with the community to popularise services available for TB and influence gender norms affecting diagnosis and outcomes in TB?			
47.	Does the programme engage cis women and LGBTQIA++ among TB survivors and caregivers in designing IEC materials to ensure that IEC materials on TB reflect the views and realities of people with TB and caregivers?			
48.	Does the programme promote the use of gender and LGBTQIA++ inclusive and culturally-sensitive IEC materials to deconstruct negative stereotypes about women, men and LGBTQIA++persons? For example, negative stereotypes that are factually incorrect and discriminatory are: a) Women will not be able to marry because they acquired TB. b) Men should be terminated from their jobs if they develop TB. c) LGBTQIA++ individuals get TB because of their "lifestyle".			

S. No.	Question	Yes (Score = 1)	In progress (Score = 0.5)	No (Score = 0)
49.	Does the programme ensure parity in visual representation that counters stereotypes of gender roles? E.g., A husband taking care of a woman with TB, A transgender health worker providing counselling to a person with TB, A woman doctor attending to a person with TB.			
50.	Does the programme promote equal involvement of male, female and LGBTQIA++ persons as role models in TB awareness campaigns?			
51.	Does the programme encourage equal participation of women, men and LGBTQIA++ persons (including community leaders and traditional healers) in all community-based mobilisation campaigns to increase knowledge and understanding of disease prevention measures?			
52.	Does the programme encourage open discussions in communities on stigma and discrimination due to TB?			
53.	Do IEC materials and sessions target different groups of people, including mothers, fathers, pregnant women, single cis women or LGBTQIA++ persons, adolescent girls and boys, and school children, with a significant focus on prevention and early treatment-seeking?			
	Monitoring and Evaluation			
54.	Does the programme collect, analyse and utilise gender and age-disaggregated information on: - Diagnosis - Health-seeking - Access to health services - Treatment adherence - TB Comorbidities - Treatment Outcomes - TB-related mortality rates			
55.	Is the routine analysis of gender and age-disaggregated data undertaken at the facility/district/state levels for all key indicators in the diagnostic cascade, including presumptive testing, use of X-ray, use of upfront NAAT, etc.?			
56.	Has the programme employed the use of gender and age-disaggregated data that reflect the differential impact of TB on cis women, LGBTQIA++ persons, and cis men for active programme monitoring, trend analysis and decision-making? • At national level • At state level • At district level • At facility level			
57.	Has the programme developed or reviewed M&E systems to routinely capture gender- and sex-disaggregated information?			

S. No.	Question	Yes (Score = 1)	In progress (Score = 0.5)	No (Score = 0)
58.	Do quarterly/annual reports have data disaggregated by sex, gender, and age to the greatest extent possible? • At national level • At state level • At district level			
59.	Has the programme built the capacity of relevant staff in gender-sensitive M&E?			
60.	Is the programme ensuring that State and District TB forums seek feedback from survivor-led networks and TB Champions on various aspects of programme performance, including the provision of gender-responsive care, which should be used for suitable modifications in programme implementation?			
61.	Is the programme ensuring that all monitoring and evaluation processes, including Joint Supportive Supervision, Central Internal Evaluation (CIE), and Annual Reviews, incorporate a review of gender dimensions, including the provision of gender-responsive care across the TB care cascade?			
62.	Is the gender-responsive review being co-led by members from the affected community, including an adequate number of LGBTQIA++ persons?			
63.	Is the programme ensuring proportionate representation of people of all gender identities, including but not limited to cis women, LGBTQIA++ persons, and cis men, as part of the monitoring and evaluation teams to the greatest extent possible?			

S. No.	Question	Yes (Score = 1)	In progress (Score = 0.5)	No (Score = 0)
Research **(Note: This section is not specific to the NTEP and can be used by researchers working on TB)**				
64.	To ensure sex and gender equity in research design, implementation, and participation, does the programme promote/encourage the following? - Equity in TB research participation and receiving research benefits across all genders and sexual orientations, including but not limited to cis women, LGBTQIA++ persons, and cis men. - Equal and equitable opportunities for persons of all SOGIESC in leading and coordinating the TB research programme. - Adequate and proportionate gender and sexual orientation representation in research, ethics and community advisory board committees at national and sub-national levels? - Develop a research analysis framework that will allow maximum data segregation by gender and sexual identities.			
65.	Does the programme ensure that all biomedical research and surveys consider the sociocultural issues of cis women, LGBTQIA++ persons, and cis men?			
66.	To inform policy development about cis women and LGBTQIA++ persons, is the programme researching gender-responsive dimensions of TB, for example: • Biology and Epidemiology of TB • Diagnosis, Treatment and Treatment Adherence • Health Seeking Behaviour • Quality of Care • Undernutrition and TB			
67.	Does the programme ensure an intersectional gender-responsive lens to understand better TB disease's aetiology, prevention, control and management, including vulnerability, exposures, disease experiences, health-related decision-making, responses to treatment, and the extent of impact on individuals or social groups?			
68.	Does the programme ensure that all research commissioned by the programme generates and publishes sex, gender and sexual orientation-disaggregated data?			
69.	Is the programme actively engaged in developing gender-responsive quality of care tools and metrics with affected communities with representation from persons of different genders, sexual orientations, and disabilities to measure and assess perceptions and experiences of quality of care in public, private and private/public mix settings?			

S. No.	Question	Yes (Score = 1)	In progress (Score = 0.5)	No (Score = 0)
	Inter-Sectoral Coordination Mechanisms			
70.	Are there functional coordination mechanisms with relevant stakeholders in the following sectors to achieve a gender-responsive programme: • Ministry of Women and Child Development • Ministry of Minority Affairs and Ministry of Tribal Affairs • Ministry of Panchayati Raj • Ministry of Social Justice and Empowerment • Ministry of Law and Justice • Ministry of Petroleum and Natural Gas • Ministry of Skill Development and Entrepreneurship • Ministry of Road Transport & Highways and Ministry of Railways • Ministry of Labour and Employment • Ministry of Housing & Urban Affairs • Ministry of Skill Development & Entrepreneurship • Ministry of AYUSH • Any other			
71.	Has the programme formed strategic partnerships with the stakeholders mentioned above who can influence policy change concerning gender-responsive programming?			
	Budgeting			
72.	Does the programme conduct sensitisation on gender-responsive budgets for anyone involved in the preparation of sub-district, district, state or national budgets?			
73.	Does the programme provide adequate financial resources to support gender-responsive M&E systems?			

Adapted from: Checklists for Measuring Implementation of the Gender Mainstreaming Guidelines in HIV and AIDS, Tuberculosis and Malaria Programmes, Southern African Development Community (SADC) Secretariat.

Central TB Division
Ministry of Health and Family Welfare,
Jeevan Vihar, Sansad Marg, New Delhi-110001
http://www.tbcindia.gov.in