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Stop **TB** Partnership
TB REACH

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WOMEN'S EMPOWERMENT THROUGH TB PROGRAMMING:

LESSONS FROM TB REACH WAVE 7 PROJECTS

EXAMPLES OF CHANGE CASE STUDIES

These case studies were developed by Anna Versfeld, Amera Khan, Elsbet Lodenstein, Olive Mumba and Evgenia Maron

CASE STUDY:

COUNTERING WOMEN'S DIGITAL EXCLUSION THROUGH TB PROGRAMMING

Case study: Countering women's digital exclusion through TB programming

The work environment increasingly requires digital literacy and use, even for lower-tier work functions. This increased with COVID-19, as physical distancing requirements included reliance on digital communication systems. Decades of data overwhelmingly show that women and girls both have less access to digital resources, and are less proficient at using digital resources, especially in developing countries.[1] Digital illiteracy is being entrenched as another frontier of exclusion for women and girls.

The problems compound each other: lack of access discourages proficiency and lack of proficiency reduces access. Three TB REACH Wave 7 funded projects actively undertook and reported on digital training for a total of 500 women working in community health worker (CHW) roles.[2] This case study focuses on the experiences and lessons of two organizations that responded to digital exclusion of women and girls through the development and use of accessible technology as well digital literacy training.

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1   Antonio, A & Tuffley, D, 2014. "The Gender Digital Divide in Developing Countries" Future Internet 6(4): 673-687.

2   Organizations and projects tend to have different names for women providing frontline community-based TB services. Here they are collectively referred to as community health workers.

Featured organizations

ZMQ Development, India[3] is an international non-profit organization that provides health information and care linkages to communities through technological solutions that are appropriate to women. ZMQ works on the principle that technology accessible to women must be designed in line with women's needs. In the TB REACH Wave 7 project, ZMQ India sought to improve TB case finding and treatment adherence in women through the integration of two existing digital tools. The MIRA channel, an integrated mobile phone channel that provides health information to rural women and connects them with public health services was combined with Freedom TB, a TB treatment adherence support channel.[4]

The **Resource Group for Education and Advocacy for Community Health (REACH)**[5] India is based in Tamil Nadu, India. REACH is a TB focused organization providing support, care and treatment for TB patients as well as research, advocacy, public education and communication. REACH has a history of leading gender-based approaches to TB in India. The Wave 7 TB REACH project increased case detection through the women-led processes of community education along with household and facility-based and contact screening. Women involved in the programme were trained through an innovative method of audio modules shared through cell phones.

3   https://www.zmqdev.org/
4   ZMQ is also featured in the case study "Developing and disseminating gender-responsive TB education media".

5   https://reachindia.org.in/. The REACH project report is accessible here: https://img1.wsimg.com/blobby/go/52cad3d5-1167-465b-8f13-e419aeaee141/REACH%20Wave%207%20Impact%20Report%202021.pdf

Interventions and impact

ZMQ develops all their technological devices and applications through a series of inclusive design processes in which the needs of all people who will use the technology – including healthcare providers and service users –are taken into account. This includes discussions and engagement about information needs, as well as technology access and use requirements. In the Wave 7 project, technological solutions were used to assess and track women's health and provide health information. People affected by TB were also provided with devices that assisted them with health tracking and information. ZMQ trained 50 community health workers and volunteers on using the technology developed. ZMQ India also went through a participatory process of developing TB education stories, which were shared through the devices. Further, through the MIRA mobile phone channel women were able to access information and get connected to public health services through micro messages in local languages accessible on their mobile phones.

For the Wave 7 project REACH partnered with a technology organization[6] for the development of training through an Interactive Voice Response System (IVRS). This is a training approach that allows people to access training modules through any mobile phone (a smart phone is not needed) without incurring calling costs. Topics were selected through a preliminary community needs assessment and added as new training needs arose. Dramatized, colloquial audio stories were developed on TB and other topics including diabetes, hypertension, nutrition, common childhood illnesses and financial literacy. Trainees could choose to listen to any of the five to seven modules that are broadcast at any point in time by navigating through a numerical selection system. Listeners could also record their questions and feedback on the content. Back-end data were collected about which modules the women listened to and for what duration.

There are a number of similarities in the ways these organizations worked and their outcomes. In both cases digital tools were developed based on needs assessments and engagement with the target audiences. The technology used was designed with women's prior technological exposure in mind; the content developed was shaped by and based on local interests and needs, and education content was accessible through phones at times chosen by the listener. Both used vernacular languages.

Both ZMQ and REACH also undertook generalized digital and mobile phone use training for their female community health workers. REACH further provided training on use and etiquette for WhatsApp, online meeting platforms, email, and digital data collection.

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6   The partner organization was Gram Vaani ¬ an organization that works on enabling communities to use technologies and share information that can equip them to bring about positive changes in their lives.

The approach has been very successful in supporting women. REACH noted that the easy access to training through the IVRS system has enabled community health workers to undertake training at times and in places that suit them. This has resulted in the inclusion of women who would normally be excluded from training processes due to childcare responsibilities. The audio approach also allowed for comprehensive modules, which improved care provision practice, as well as the women's confidence when conducting community meetings. It also allowed others to access the information. Though designed for their community health workers, health workers shared the content with their social networks, resulting in 1230 people accessing the training.

Both organizations noted how simple technology training created confidence and encouraged general technology use. REACH noted that their staff team was motivated to buy and use mobile phones. ZMQ noted that the demystified technology encouraged women to further self-train themselves in other areas of digital use, access other areas of information, and self-organize into support groups. Digital training in standard work technologies also allowed continuation of work through COVID-19 lock down regulations, real-time reporting, and capturing and sharing of impact stories.

Lessons learned

- TB projects should recognise and respond to digital exclusion of women and girls as a key facet of women's empowerment.

- Digital upskilling should be considered a core component of on-the-ground TB workers' training for women's improved work efficiency and capacity.

- Basic digital training and access can demystify technology and encourage women to access and use other technology, improving their general digital inclusion.

- Technology design and content should take women's previous digital exposure into account, be designed through participatory processes that reveal local interests and needs, and be presented in vernacular languages.

CASE STUDY:

ACCESS TO FINANCIAL AND INCOME GENERATION RESOURCES FOR MARGINALIZED WOMEN

Case study: Access to financial and income generation resources for marginalized women

As a disease commonly associated with poverty, tuberculosis (TB) is most prevalent in conditions of social marginalization. Yet TB programming and international concerns related to TB tend to focus on biomedical responses to the disease and the epidemiological burden of disease. It is well documented that women generally (though not always) face lower disease burden rates, but often more severe – or at least different – socio-economic consequences of TB disease.[1]

Successful TB treatment and staying healthy after treatment are supported by adequate life conditions, yet gender inequality means that women often have worse life conditions than men. This includes lower rates of formal employment, less access to resources (financial and other), and greater care burdens when they, or someone in their family, gets sick. Noting all of this, five of the Wave 7 TB REACH projects sought to improve life conditions of women affected by TB, through vocational training and/or linking women to local savings groups.

This case study draws on details from three projects that highlight some of the approaches and benefits of a broader approach to TB treatment that recognizes women's financial vulnerability.

Wave 7 TB REACH project summary achievements

5 projects sought to improve women's financial stability through access to vocational training and/or linking women to savings groups

197 women received vocational training

1793 women participated in savings groups

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1   For a fuller description of this see the Stop TB Partnership updated Gender and TB paper refer to
https://www.stoptb.org/prioritise-people-human-rights-gender/support-gender-equity-tb

Featured organizations

Infectious Diseases Institute (IDI), Uganda[2] is an institute based at Makerere University. IDI aims to strengthen health systems in Africa, with a particular focus on research and capacity development related to infectious diseases. The Wave 7 project developed a network of private pharmacies serving to diagnose and refer people affected by TB in Kampala, Uganda. This was in response to the low rates of TB diagnosis by private pharmacies in the city despite pharmacies being the first point of care for most individuals experiencing a cough. The project further responded to the psychosocial vulnerabilities of women affected by TB through identifying and incorporating vulnerable women in skills and income generation training.

PLAN International, Nigeria[3] seeks to promote children's rights and equality for girls. This includes a focus on safe education access, the reduction of maternal and child mortality, nutritional support, violence prevention, and advocacy training. The TB REACH Wave 7 project, sought to take a gender-responsive approach to improve detection, referral to treatment and reporting of tuberculosis, especially for women and girls, along with improved participation and decision-making for women and girls. A key area of work was the formation, training and support of voluntary savings and loans associations (VSLAs) for community health workers and people affected by TB.

BRAC Uganda, a country branch of BRAC International, runs a number of projects related to a range of programmatic areas including health, education, and financial inclusion. The Wave 7 BRAC Uganda project improved TB case detection through community-based screening and linkage to care. The women's empowerment aspects of the project were led by NACWOLA Uganda, an HIV positive women's organization. Women's empowerment work included training of women's groups and health facility staff on gender, women's empowerment and TB; linking women affected by TB and providing care to established microfinance forums; and conducting TB screening and care linkage in micro-finance forums.

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2   https://idi.mak.ac.ug/
3   https://plan-international.org/nigeria/

Interventions and impact

IDI, Uganda, identified and engaged 60 women affected by TB (either directly, or as a close relative) facing challenging socio-economic conditions. These women were connected to income generating skills building training provided by UDI. Skills covered included baking, tailoring, home crafts and hairdressing. Courses ran for up to ten sessions. The women were also provided financial literacy training, and two market days were implemented to set up opportunities to sale their wares. By the end of the project period 60 were successfully implementing their micro-enterprises. This assisted them with general household income, individual financial freedom and skills sharing with other family members, amongst other things.

During the project implementation period **PLAN Nigeria** set up 61 new VSLA groups. These associations serve as a place where individuals meet, place their savings and – after a period – can access saved income and related interest. The VSLAs also provide loans based on group assessment of need, including for the catastrophic costs of TB care and treatment. Initially the VSLAs were planned to include only women affected by TB, but the stigmatized nature of TB in Nigeria undermined group participation. PLAN Nigeria then changed the groups composition to include high performing male and female community health workers providing TB care. The groups flourished – with approximately 1226 people (1,151 women and 75 men) participating in the 61 VSLA groups by the end of the project period.

BRAC/NACWOLA similarly included an economic and financial inclusion program in the Wave 7 work. It also worked towards the strengthening of over 30 women's groups in TB education and symptom screening and worked directly with 22 women facing catastrophic costs because of TB disease, linking them to these groups. The project also introduced credit businesses in the groups that supported people affected by TB to cover essential welfare costs, improve nutrition in their families, and cover the costs of transport for treatment. By the end of the project a total of 23 accounts with BRAC Bank were opened and savings were going well.

PLAN Nigeria and BRAC/NACWOLA reported strikingly similar observations and findings related to the impact of the work with women and savings groups. Both organizations found that the savings groups were a productive platform for providing TB education and identifying people with TB signs and symptoms. The organizations also noted that group involvement encouraged the women to support health-seeking behavior in people in need of screening for and for those affected by TB (especially within their family networks), and reduced TB stigma. Both organizations noted that the available loans started to be used by group members to cover the catastrophic costs of TB care and treatment. Both organizations reported improved household financial management skills in women involved in the savings groups. PLAN Nigeria further noted that the women engaged reported increased financial and decision-making independence in a highly patriarchal context. BRAC/NACWOLA further noted that for some women, involvement in the savings groups provided additional motivation to get healthy.

Lessons learned

- Catastrophic costs continue to be faced by people affected by TB, perhaps especially women. Support mechanisms to minimize these costs can be an important aspect of holistic TB care provision. These can include income generation training and/or linking women to savings and loans groups.

- Linking TB programming interventions with groups supporting women's financial freedom can have a bi-directional positive impact: the groups can serve as a platform for TB education and screening, while also serving as a support mechanism for women affected by TB.

- Financial literacy, access to financial credit, and the skills to self-generate can be important steps towards independence and self-care in women affected by TB, especially in highly patriarchal communities. Empowering women in these ways can also positively impact on their families as they share the skills and knowledge they have gained and contribute towards the health of their families and broader communities.
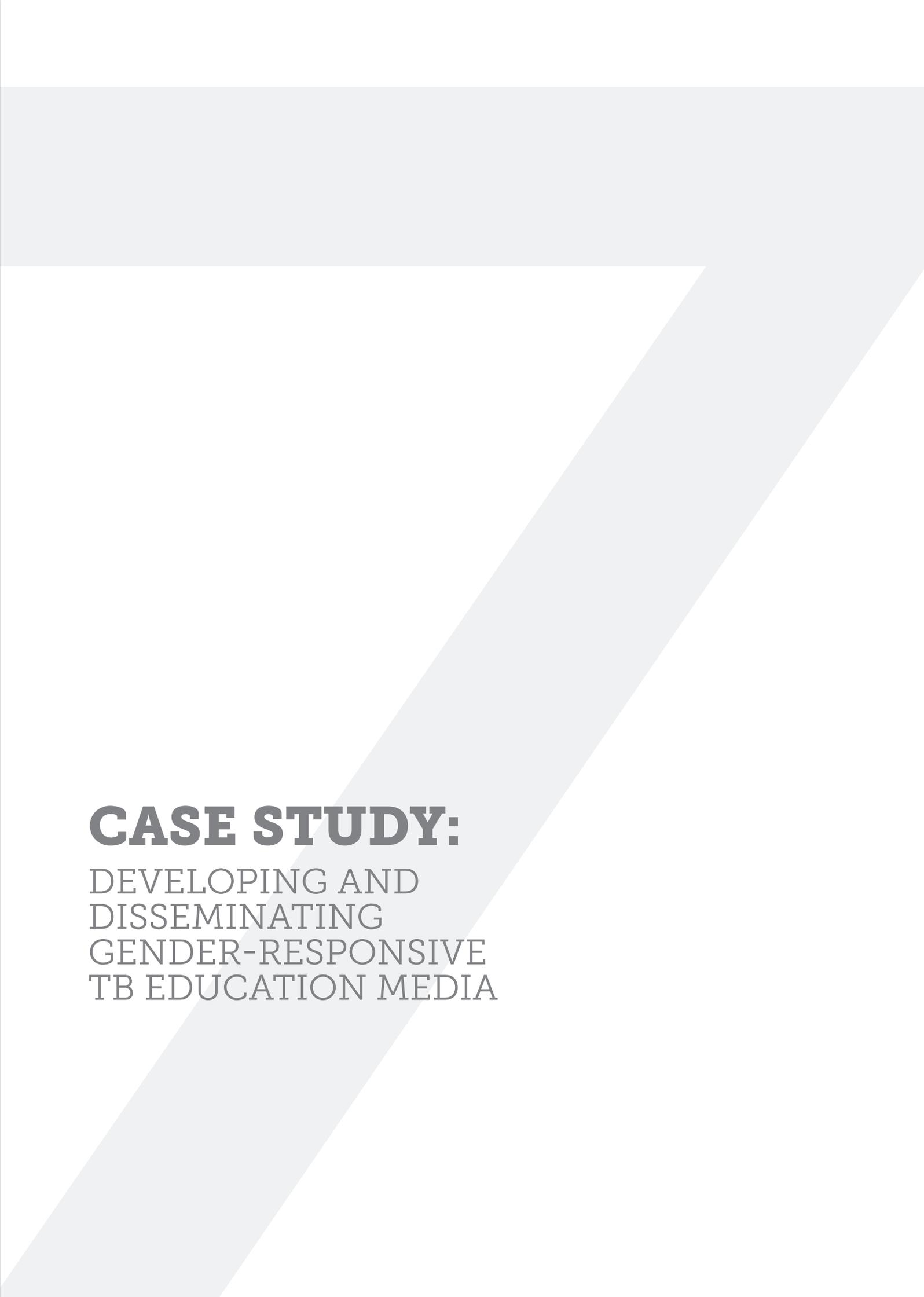
CASE STUDY:

DEVELOPING AND DISSEMINATING GENDER-RESPONSIVE TB EDUCATION MEDIA

Case study: Developing and disseminating gender-responsive TB education media

A lack of knowledge about TB disease, signs and symptoms, and treatment can serve as a key barrier to TB care access and treatment completion[1]. TB education is a fundamental component of any intervention designed to support treatment for people affected by TB. People affected by TB have a right to information about their illness and treatment.[2] TB REACH Wave 7 funded grantees – focused on women's empowerment – noted that historically, information and education materials often reproduced gender stereotypes. For example, women tend to be represented as lower-tier caretakers, and care providers in the home; men as patients or senior healthcare providers. Grantees also noted that materials used for the dissemination of information were also often not accessible to women, resulting in lower levels of TB knowledge in women.[3] These standard practices reinforce harmful gender norms.

Six TB REACH Wave 7 funded organizations took a gender-based approach to TB education product development. This ranged from the development of information, education and communication flyers and posters, to audio podcasts, public performances and mass media products. This case study draws on the lessons and experiences of two of these organizations.

1   de Vries, S. G., Cremers, A. L., Heuvelings, C. C., Greve, P. F., Visser, B. J., Bélard, S., & Grobusch, M. P. (2017). Barriers and facilitators to the uptake of tuberculosis diagnostic and treatment services by hard-to-reach populations in countries of low and medium tuberculosis incidence: a systematic review of qualitative literature. The Lancet Infectious Diseases, 17(5), e128-e143.
2   Stop TB Partnership and TB People, Declaration of Rights of People Affected by TB. https://stoptb.org/assets/documents/communities/FINAL%20Declaration%20on%20the%20Right%20of%20People%20Affected%20by%20TB%2013.05.2019.pdf
3   Habib, S. S., Jamal, W. Z., Zaidi, S. M. A., Siddiqui, J. U. R., Khan, H. M., Creswell, J., ... & Versfeld, A. (2021). Barriers to access of healthcare services for rural women—Applying gender lens on TB in a rural district of Sindh, Pakistan. International Journal of Environmental Research and Public Health, 18(19), 10102.

Featured organizations

ZMQ Development, India[4] is an international non-profit organization that provides health information and care linkages to communities through technological solutions that are appropriate to women. In the TB REACH Wave 7 project, ZMQ India sought to improve TB case finding and treatment adherence in women through the integration of two existing digital tools. The MIRA channel, an integrated mobile phone channel that provides health information to rural women and connects them with public health services was combined with Freedom TB, a TB treatment adherence support channel. In the context of illiteracy amongst women, exacerbated stigma experienced by women affected by TB, and exclusion of women from public activities and life in ways that reduces their access to TB information, ZMQ maintains the principle of developing information for women, by women, as a means of ensuring that it is relevant and relatable and distributing it in ways that are accessible and easy to consume.

Development Media International (DMI), Mozambique[5] is an international organization that uses story-based media campaigns to motivate health behaviour change. Campaigns are developed through extensive formative research; impact is supported by repeated message delivery to saturation and measured through randomised control trial methods. Operational through sub-Saharan Africa, DMI tackles a range of health education areas, including family planning, COVID-19, early childhood development, and nutrition. The TB REACH Wave 7 project – DMI's first TB project – responded to low levels of TB knowledge in Zambezia Province, Mozambique.

Interventions and impact

ZMQ India developed illustrated digital TB education comics that were disseminated though house-to-house storytelling sessions and through women's group sessions in communities, where they were used to generate discussion and awareness. Stories were also made available on YouTube (the first generating over a million views) and mobile applications for continued access.[6,7]

DMI implemented a radio campaign. The campaign included 12 radio "spots" – short stories about people affected by TB providing information on signs and symptoms and how to access care. Each of these spots was produced in Portuguese and the two most widely spoken local languages in Zambezia – Elomwe and Echwabu – and broadcast through the regional broadcaster and 11

4   https://www.zmqdev.org/

5   https://www.developmentmedia.net/
6   https://www.zmqdev.org/
7   Quraishi S, Quraishi H, Yadav H, Singh A, Fasih I, Vasquez NA, Huria L, Pande T, Mumba O, Kamineni VV, Khan A. Digital Story-telling and Community Engagement to Find Missing TB Cases in Rural Nuh, India. Tropical Medicine and Infectious Disease. 2022 Mar 11;7(3):49.

community radio stations 10 times a day every day for 6 months.

Both DMI and ZMQ undertook formative work to understand the gender dynamics of TB in their context and use this to inform the content they developed. DMI conducted a desk review and qualitative interviews with healthcare workers and community members in Zambezia Province, Mozambique. This provided information on the extent of gendered and stigmatising misconceptions about the cause of TB. This includes the understanding that TB is caused by having sex with a widow who has not been traditionally purified; with a woman who has had an abortion; or with a menstruating woman without using a condom. The radio campaign addressed these misconceptions, helped people recognise symptoms of the disease, and encouraged them to get tested. Radio spots also actively responded to research findings about lack of spousal support for women getting tested for TB and lack of health decision-making power in women.

ZMQ undertook participatory story-telling workshops with women and supportive men in their target communities. In these workshops women developed short stories about their experiences of tuberculosis. A selection of these stories were then turned into illustrated digital comics, supplemented with local text and voice-overs, often by the women who told the stories themselves. These stories presented real issues faced everyday by women, with an included focus on providing information on TB awareness,

signs and symptoms, screening and diagnostics, and treatment. Both DMI and ZMQ ensured that the means of information provision was accessible to women in their target area. Both also emphasised presentation of central female characters who are relatable women facing issues common in the community being served and taking control of their health.

The reach and impact of this work has been striking. DMI messaging reached an estimated two million people. Qualitative evaluation showed positive knowledge, attitude and behaviour change related to TB, including a shift towards seeking care for TB symptoms from the public healthcare system, rather than from traditional healers or by self-medication, at an earlier stage of symptom presentation. (See Box 1 below for a case study on the impact of the radio slots.)

Over 30,000 women have downloaded ZMQ's storyteller application, and YouTube versions of the stories have had over 10,000 views. ZMQ found substantial increases in knowledge and understanding about TB; 1% of the women participating in the story-telling sessions were diagnosed with TB and the number of women accessing care surged by 20% in the regions where the workshops were happening, ensuring a point of contact with the healthcare system not only for TB, but also for other healthcare concerns.

Finally, both organizations found that women who accessed their information reported sharing this information with friends and family.

Lessons learned

- TB information provision needs to consider gender, and actively work against entrenching gender-based stereotypes related to TB.

- Generating information to support women's TB knowledge and care access is best done by drawing on women's own experiences. This provides detailed, relatable information that allows for powerful messaging.

- Women's access to information must be assessed in the design and dissemination of TB education. Communication channels must be readily accessible to women and compatible with their everyday activities.

- Accurate information that tackles TB stigma is a key step towards generating demand for TB treatment, including by women facing additional challenges to treatment access.

- Women accessing information can act as an information conduit for family and friends. They are therefore a resource for broader community education processes.

Box 1:
DMI, Mozambique Radio Impact Case Study

I am Amina Francisco and I was my husband's third wife. Together we had five children, but unfortunately four lost their lives and I was left with only one child, the only living memory of my late husband. I very nearly wouldn't be here today either.

I say this because I was plagued by a disease called tuberculosis. At first, I didn't know what it was. I just coughed a lot and didn't stop even for a minute. This wen on until one day, while resting on my mat, I heard a messaged on the radio that spoke of precisely what I was going through.

It didn't take me long to act. I went to the hospital, did the test and it was positive for tuberculosis. I immediately started the treatment and it's been 5 months now. I feel so much better.

My main activity is agriculture, which for a long time I couldn't do because of the disease. But today, thanks to the radio, I've started farming again. The messages really are good and if I hadn't heard them, I would have already died.
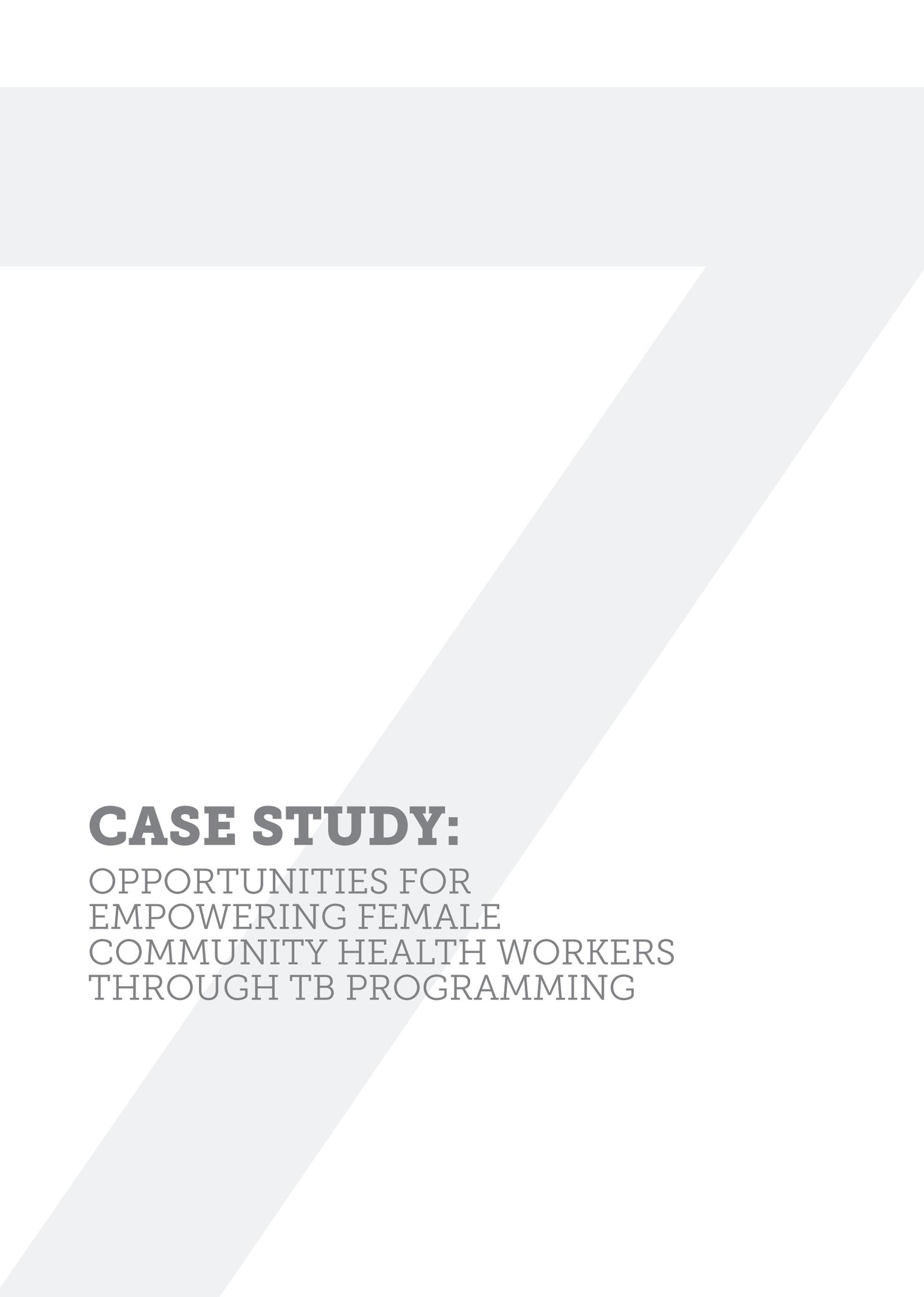
CASE STUDY:

OPPORTUNITIES FOR
EMPOWERING FEMALE
COMMUNITY HEALTH WORKERS
THROUGH TB PROGRAMMING

Case study: Opportunities for empowering female community health workers through TB programming

Active case finding within the TB response tends to rest on the labor and capacities of community health workers (CHWs). CHWs are often women living in the communities they serve who have had limited access to formal education. Their roles include TB education and sensitization; identification and registration of individuals with TB signs and symptoms; and/or referrals for testing, treatment supporters or follow-up care. Familiarity with local context and socio-cultural norms mean that CHWs are assets for active case-finding activities and their involvement can lead to increased uptake of case-finding services.[1] CHWs are often assumed to be filling gender-appropriate care roles or serving their communities in ways expected of women. This can justify poor, or no remuneration for the work they do. Women fill and stay in these roles (that – to an extent – men tend not to) due to a lack of other remunerated opportunities.

TB programming that draws on women as inexpensive labor supports disempowerment and perpetuates gender inequality. Counter to this, TB programming can empower engaged women by providing access to medical knowledge; a formal link to the health system; opportunities to do meaningful work; and opportunities to be fairly paid for the work they do.[2] However, empowerment objectives are often frustrated by a lack of trvaining, inadequate working conditions and equipment, and lack of stakeholder buy-in. This can lead to poor morale and high rates of attrition, adversely affecting health outcomes and leading to disempowerment.[3] Drawing on four TB REACH Wave 7 projects that took an active approach to empowerment in engaged CHWs, this case study presents lessons on the possibilities and challenges of women's empowerment through TB programming. We note that CHW engagement can lead to women's empowerment, but also risks reinforcing gender inequality. Care must be taken in the ways that CHWs are engaged.

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1   José B, Manhiça I, Jones J, Mutaquiha C, Zindoga P, Eduardo I, et al. (2020) Using community health workers for facility and community based TB case finding: An evaluation in central Mozambique. PLoS ONE 15(7): e0236262. https://doi.org/10.1371/journal.pone.0236262
2   Kane, S., Kok, M., Ormel, H., Otiso, L., Sidat, M., Namakhoma, I., Nasir, S., Gemechu, D., Rashid, S., Tae-gtmeyer, M., Theobald, S., & de Koning, K. (2016). Limits and opportunities to community health worker empowerment: A multi-country comparative study. Social science & medicine (1982), 164, 27–34. https://doi.org/10.1016/j.socscimed.2016.07.019
3   Lukman, M., Ibrahim, K., Yani, D. I., Sari, S. P., & Juniarti, N. (2019). Exploring Strategies to Improve the Performance of Community Health Volunteers for Tuberculosis Care and Prevention: A Qualitative Study. International journal of community based nursing and midwifery, 7(4), 270–278. https://doi.org/10.30476/IJCBNM.2019.81353.0

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Wave 7 TB REACH project summary achievements

8 grantees provided TB service provision to female community members, collectively training a reported **5308** women in TB care skills.

13 grantees worked on upskilling women already working in the healthcare sector. These women ranged from community care workers to doctors.

633 women already working in the healthcare sector received training towards the improvement of their TB care provision.

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Featured organizations

The **Burnet Institute**.[4] in partnership with the **Centre of Tropical Medicine, Universitas Gadjah Mada**[5] in Yogyakarta, Indonesia, implemented the Zero TB Initiative. The project sought to reduce the burden of TB in Yogyakarta through provision of mobile chest X-ray services, integration of TB screening into current community-based health services and TB prevention treatment provision, and to empower women to improve TB detection, TB treatment outcome, and access to TB preventive treatment.

OGRA Foundation[6] in Kisumu, Kenya, seeks to promote and improve health and emergency response in pursuing economic and cultural development in the fight against poverty and social exclusion in communities. The Wave 7 project implemented an active case finding project partnering with 100 small private healthcare facilities working with 100 out of school adolescent girls and young women (AGYW) to support TB screening and case follow up.

Yayasan KNCV Indonesia[7] is an organization that provides technical assistance to governments and NGOs and develops effective, efficient, innovative and sustainable TB control strategies. Yayasan KNCV Indonesia implemented the WOW-TB program to create TB free working conditions in factories in Yogyakarta and Yakarta. In the Yayasan KNCV project women working in manufacturing factories were engaged and trained to become TB Warriors: to conduct cough surveillance and deliver mobile TB screening for staff; and refer them to internal clinics or external health centers.

Association des Volontaires pour Lutter contre la Tuberculose[8] (AVLT) in Burundi, is a student-based organization that fights TB in university settings. The Wave 7 case finding project, implemented in 30 universities in Burundi, sought to strengthen early and active TB screening via student Stop-TB clubs. Usually led by men, the project sought to shift club leadership to 60% female.

Interventions and impact

All the included projects engaged CHWs, the majority, or all of whom were women. All implemented training and capacity strengthening related to community-based TB care and treatment to support the engaged women to undertake TB education and case-finding work. In addition, Zero TB and Yayasan KNCV Indonesia also incorporated training on the role of community support in TB

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4   https://www.burnet.edu.au/
5   https://centertropmed-ugm.org/
6   https://www.ografoundation.org/
7   https://yki4tbc.org/

8   https://m.facebook.com/Association-des-Volon-taires-pour-Lutter-contre-Tuberculose-Branche-Gite-ga-1685507051663734/

care and on gender and TB; and the OGRA Foundation included life skills training such as financial management, entrepreneurship, communication and personal leadership. The OGRA Foundation also incorporated a longer-term program of training and supporting engaged young women in developing income generation skills and putting these into action. Other than the OGRA Foundation (which supplied a $50 stipend to engaged women), the other organizations relied on volunteer labor.

Several key themes emerged regarding the empowerment impacts of this work at the individual, collective and societal levels. Firstly, all the projects (as expected) indicated reports of knowledge and skills gains related to TB. All the projects also indicated that the engaged women reported a sense of pride and increased self-worth due to the recognition they received from colleagues and as role models in the community. The women also reported an increased confidence in their own capacities. For example, women engaged in the Zero TB project reported increased confidence to go out into their communities for TB mobilization and screening; led community meetings previously led by men; and women engaged as leaders by AVLT reported increased confidence in public speaking.

Increased financial independence was reported as a key aspect of life improvement by the women in the OGRA Foundation project, and women in the AVLT project set up a savings association to improve their own financial status as their relative lack of access to funds was experienced as disempowering.

Three projects further found that the women's engagement was related to increased ambitions to pursue future work opportunities. Becoming a CHW, then, opened up a sense of possibilities for the engaged women's futures. In the case of the OGRA Foundation, this was supported by possibilities of generating their own livelihoods through the skills learned through the project.

" I am now recognised as a TB Ambassador within my community. I get phone calls whenever there is a TB [person with presumptive TB] and I am able to do the screening and link them to Ministry of Health."

Reported by one of the engaged young women, OGRA Foundation, Kenya.

All the organizations noted that the engaged women reportedly experienced or exhibited changes to their sense of leadership and their decision-making capacities. The women in the AVLT project reported a sense of collective health leadership that had developed amongst themselves. In the Zero TB project, the youth leaders developed and implemented innovative ways to respond to the daily challenges of their work, for example, by developing social media messaging or using theatre. This included the development of a prize-winning social media campaign on TB and COVID-19 that drew on the local context of Javanese culture "wayang". Women in the OGRA Foundation project noted that they had increased decision-making powers within their own households.

The organizations also noted shifts in the ways that women were viewed by others. AVLT noted that male leaders of the TB clubs came to perceive female leaders as their peers, acknowledge their management skills and express ambition to vote for women in other positions of responsibility in their respective universities. In the KNCV Yayasan project, factory management acknowledged the key role of TB Warriors in workers' well-being and health promotion; the OGRA Foundation noted that District Leaders recognized the opportunities of engaging young women as CHWs in the TB response.

These important gains were, however, also compromised by some negative events and impacts. In the AVLT project, the work was entirely voluntary, and the engaged women noted that standing socio-economic differences between male and female students meant that costs of work (such as phone calls, printing and transport) weighed more heavily on them than on male students. Zero TB found that the women involved faced challenges related to the added responsibilities they were carrying, for example, conflicting schedules with study or office hours, and challenges introduced by COVID-19. In Kenya, fears of COVID-19 infection meant that some women and girls were not allowed to enter the health facilities or were simply threatened or humiliated.

Lessons learned

- Many TB programs can be more intentional about empowerment goals in which empowerment is defined by CHW themselves and which can include opportunities for work after the project ends, economic and physical security, and work to address social norms change in communities[9].

- Women's empowerment can result from engaging women as CHWs, even without remuneration. However, we caution that this should not be seen as a justification for relying on volunteer work.

- Work skills and confidence gained can support women in changing their perceptions of themselves and developing their ambitions to undertake other work in their communities.

- The work undertaken by CHWs can change the perceptions others hold of them. This can be in the home, in the workspace, and in the broader community. These societal shifts should be supported.

- Programs engaging CHWs risk replicating and reinforcing inequitable gender norms that lead to disempowerment, especially when they do not sufficiently take into account socio-economic differences between women and their male colleagues. Remuneration and income generation is important for changing women's status and opportunities in homes and communities.

- If remuneration is not being offered, assessment should be undertaken of the expected benefits and burden on volunteers and the possible impact on gender/community dynamics to determine whether the engagement of CHWs is likely to be ethical and not exploitative.

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9   CHW Central (2021) Gender and Community Health Workers: Three focus areas for program managers and policy makers. https://chwcentral.org/twg_article/gender-and-community-health-workers-three-focus-areas-for-programme-managers-and-policy-makers/

CASE STUDY:

BRINGING WOMEN'S EMPOWERMENT INTO COMMUNITY HEALTH ORGANIZATIONS

Case study: Bringing women's empowerment into community health organizations

TB institutions and structures too often unwittingly perpetuate or reinforce harmful gender norms. For example, decision-making tends to lie with men, while women carry the bulk of the less protected, and often poorly remunerated ground level care work. Women are not always able to move about freely and safely as they do their work and often their basic needs – such as access to safe toilets – are not met in workspaces. Systems are not always in place for ensuring equity or responding to harassment in the workplace.[1]

TB REACH Wave 7 funded projects were encouraged to take on women's empowerment at an organizational level. Key areas of intervention across all the grantees included the development or amendment of gender equity policies; staff training on women's empowerment and gender equity; and a proportional employment target for women, including in leadership positions.

Wave 7 TB REACH project summary achievements

8 organizations developed or amended their gender equity policies

6 organizations emphasized increases in leadership and decision-making roles for women

11 organizations maintained at least 50% female staffing

This case study presents the changes that happened in two organizations as a consequence of their women's empowerment efforts at an institutional level.

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1   For more, see the updated Stop TB Partnership Gender and TB paper, accessible at
https://www.stoptb.org/prioritise-people-human-rights-gender/support-gender-equity-tb

Featured organizations

Innovators in Health (IIH)[2] is a rural health organization based in Bihar, India working in TB, maternal and newborn health, and mental health. The Wave 7 TB REACH project sought to improve TB diagnosis and care through linking private healthcare providers with public sector TB resources to improve diagnosis and care. ASHAs (community health workers) served as essential links between health systems, while also undertaking in-community active case finding.

Friends for International TB Relief (FIT)[3] focuses on TB elimination through piloting, evaluation and scale of person-centered TB prevention and care strategies in Vietnam. The Wave 7 project focused on improved diagnostics for people seeking care in an extensive network of private providers and the official reporting of private TB treatment to the National TB Program across three cities.

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2   https://www.innovatorsinhealth.org/

3   http://www.tbhilfe.org/

Interventions and impact

Prior to TB REACH Wave 7, both FIT and IIH understood the importance of addressing gender equity in the workplace, but without the requirement to approach this systematically, steps towards this had been happening slowly in their organizations. The TB REACH Wave 7 requirements set a different level of focus and urgency in place.

"Accountability to a donor may not have changed what we do, but it has changed how we prioritize what we do."

Andrew Codlin, FIT

For Wave 7, both organizations developed gender performance indicators focused on their employment ratios ensuring that women were employed in key roles, including at a management level. As they had previously done, FIT continued to require all staff to take the UN women's "I know gender" course. In IIH, key project implementation team members underwent a two-day residential workshop on gender equity, women's empowerment in programming, and the identification of women's barriers to care access. Gender sensitivity training was undertaken with a broader group of the management team, and leadership positions were earmarked for women.

Both organizations set about ensuring an appropriate gender policy was in place. For this, IIH partnered with an established gender organization, which conducted a gender assessment of the organization. This formed the basis of a new gender equity policy. FIT included a new section in their employee handbook. Both organizations realized there was a greater need for the protection of all staff from sexual harassment. FIT incorporated a clause against sexual harassment for all partner agreements and established a gender equality task force, while IIH changed the composition of their sexual harassment committee to ensure that the right voices could be heard. IIH also set up a digital reporting system which allows women to report on the treatment they are receiving from their supervisors. This has resulted in additional instances being reported, in a context where it has historically been difficult to have oversight of the more distal team members. FIT incorporated a gender section in their employee satisfaction survey, allowing for the voicing of areas where staff members felt there was space for organizational improvement.

" I don't think it is just about organizational [change]...hopefully [the required additional attention to gender] can lead to differentiated care at some point."

Andrew Codlin, FIT

"Previously the females in the team never used to raise any voice...a worker, at the lowest level, might not have said anything because of a fear of losing their job. But this project has changed that. [Now] if the language is not good, they write a written complaint."

Surya Rai, IIH

Both organizations reported on the ways that the required attentiveness to gender had shaped their understandings of the intra-team dynamics. FIT reported that the recognition that social-cultural reluctance exhibited by women to accept roles of prominence, contributed to an attentiveness to the gendered dynamics of who is offered leadership positions, and who takes them up. An analysis of pay structures also alerted the management team to some unintentional gendered discrepancies in responsibilities and pay structures, which were then rectified.

The IIH team also reported on their increased attentiveness to their own gendered dynamics and biases and allowed for active countering of harmful norms, such as who gets to speak and who is listened to. Beyond this, both teams reported on the long-lasting effects of the Wave 7 women's empowerment focus and organizational change. These changes are not limited to a project or a time but are structural. Organizational change not only shapes organizational function, but also shapes the attention to gender in other realms of the organizations' work. It also sets up a long-term focus on gender in monitoring processes.

Collectively, the required attention to gender equity and women's empowerment has set a precedent for the organizations of what to pay attention to, and how to respond to issues at hand. The changes made in both organizations have reportedly led to greater awareness, better gender related monitoring, evaluation and reporting systems, a safer work environment for women, an increased number of women in leadership positions, and greater opportunities for women to raise their voices, and be heard.

Lessons learned

- Key potential organizational women's empowerment interventions include:
    » setting up organizational gender equity assessments
    » developing or improving gender equity policies
    » setting and attaining targets for women's employment and leadership
    » gender sensitivity training of all staff (starting with management)
    » ensuring safe systems of reporting – especially of sexual harassment – and having clear response systems in place

- The structural requirement of women's empowerment activities and indicators at an organizational level can accelerate change towards gender equity

- Leadership teams who understand and embody a women's empowerment approach spread that approach through the rest of the organization

- Organizational sensitization is key to programmatic change

- Partnerships with gender equity organizations can support comprehensive change