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GENDER TROUBLE FOR TUBERCULOSIS

The TB field prides itself on being painstakingly evidence-based and yet in one arena, acknowledged inequality has persisted for years without triggering much reflection or retooling. In fact the prevailing discourses continue to obscure gender inequality that is inconvenient and distract from efforts to fight TB where it lives.

To understand the dilemma we are in, it is necessary to look back at where we have come from. For years, the normative sex ratio for TB was measured as 1.7 men for every female patient diagnosed. It has been common knowledge that most TB patients are men and most deaths are male.[1-2] This gender orthodoxy is so fixed that the quality of TB surveillance systems is often judged by how consistently skewed the rates are over time.

The TB gender disparity has skulked in the background for years without serious attention beyond the occasional systematic review or qualitative study. While some attributed the gender disparity to barriers to care for women, others thought it was simply men's greater engagement in smoking, drinking, criminalized activities and deep pit mining that was tipping the scales. Some even explored the biological angle.

The absence of consensus on why the disparity exists has stymied efforts to address it. Every now and then an intrepid pragmatist would dare to propose doing something to address men's disproportionate burden of disease and disability, only to be quickly countered with stats from the Afghan surveillance system (M:F:0.62): the only place on earth where women's TB rates consistently exceed those of men.

The tuberculosis field only added a 'gender lens' recently, about the same time that donors stepped up demands for improved health access for women and girls. Once stirred to action, great efforts were made to dutifully highlight women's heightened risk. But even the development of a simple women's TB fact sheet was fraught with challenges because in many places women's use of TB services exceeds men's

and the data to support women's extra TB burden were nowhere to be found.

On the contrary, ever stronger evidence for men's disproportionate vulnerability continues to pour in from the massive household surveys underway in high-burden countries. Reports from the multimillion-dollar, Global Fund-sponsored TB national prevalence surveys in Indonesia, Vietnam, Nigeria, Ethiopia, Rwanda and Tanzania are revealing a gender gap that is much wider chasm that previously acknowledged [2-6].

Across sub-Saharan Africa, from Kenya to Zimbabwe and Zambia and elsewhere, where the feminization of HIV would be expected to drive the feminization of TB, well-designed surveys find no extra burden among women[7-9].

Even where women face formidable challenges, in countries such as Pakistan, there was no oft-cited undue toll on women [3].

These studies chip away at the notion that women's lower TB burden reflects a lack of access to health services. But this inconvenient gender inequality is not just about the disparate burden of TB in men; it is also what happens to men once they are diagnosed. Systematic literature reviews of gender and TB have found that:

1. Men tend to delay seeking care longer than women when they experience TB symptoms[10].
2. Male TB patients are more likely to abandon TB treatment and be lost to follow up.
3. Men are more likely die while on TB treatment

Even if the epidemiological justification for focusing on men was widely embraced, the awkward politics would not be.

Recasting men as a vulnerable group is risky business and extremely inconvenient because in addition to being counterintuitive, it simply does not appear to jive with the explicit preferences expressed by both the Global Fund and the US government for strategies that empower women and girls.

The gender focus advocated by TB's biggest donors has been almost exclusively geared toward framing women as a TB risk group. This emphasis is not lost on TB program managers. Indeed a recent technical meeting at WHO erupted in giggles and smirks at the very suggestion that adult men be considered as a vulnerable key population. Few TB stakeholders see significant resources flowing toward underserved men any time soon, regardless of what the data say.

Is it possible for donors to perceive the high incarceration rates of poor men as a form of institutional gender-based violence? Can a strong and persuasive voice in civil society help them view the commodification of men's bodies in the mines of Southern Africa as a gender issue and not only a human rights concern?

Is a focus on inequality a zero-sum game? Those who step up to champion the unmet needs of men will have to tread carefully, and resist implying that women are not felled by TB in unacceptable numbers. No one questions that women and girls deserve tailored TB strategies of their own.

Fortunately there are signs of a subtle shift that may portend something bigger. Initial discussions on gender-responsive TB programming are rumored to be starting in Rwanda, Malawi and Nigeria.

The Global Fund called on 30 September for civil society groups to provide technical assistance to help ensure gender assessments occur as part of TB program reviews. The following week, USAID signalled an interest in bundling TB screening with voluntary medical male circumcision.

There is an inordinate amount of groundwork still needing to be done to better understand the cultural,

biological and structural forces that make TB so dangerous for all of us. Having the blessing of the Global Fund and USAID to do that work may spur some sleeping giants and bring new insights and solutions to this old problem.

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