RESEARCH ARTICLE

A transformative research on the gender dimensions in strengthening and sustaining TB Patient Support Groups in the Philippines

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ABSTRACT

Background: Tuberculosis (TB) Patient Support Groups (PSGs) are important in strengthening gender dimensions of TB response because gender-blind strategies aggravate the impact of gender inequalities in TB disease elimination. The study aimed to describe the patterns in issues and challenges faced by TB patients as women, men, or Lesbian/Gay/Bisexual/Transgender/Queer/Intersex (LGBTQI); as well as the potentials and program support needs of TB PSGs using the sociological and demographical gender lenses.

Objectives: The objective of the study is twofold: to describe the issues, situations and challenges that are faced by the TB patients as women, men, or LGBTQI and; determine the challenges, potentials and program support needs of the TB PSGs using the gender lens.

Methodology: Through purposive and maximum variation sampling, a total of 35 respondents — 46% women, 31% men, 23% LGBTQI from Luzon, Visayas, Mindanao and National Capital Region – participated in the study. They completed questionnaires with closed and open-ended questions, and were interviewed for validation. Quantitative data described proportions of variables stratified according to gender. Qualitative data were analyzed through Grounded Theory approach of open coding, axial coding, and selective coding towards themes, theories and logic diagrams. Central to the research design was Transformative Mixed Methods to incorporate social justice and community participation.

Results and Conclusion: Unique gender themes in mental health and human capital, as well as gender-targeted case finding framework, were revealed. Moreover, social constructs on gender roles and catastrophic costs associated with Tuberculosis were perceived as major impediments to TB treatment completion. Results of this study may be used for development of policies and models for TB services with focus on gender, human rights and patient-centeredness.

Keywords: *TB, Tuberculosis, patient support group, patient-centered care, gender, LGBT*

Introduction

Harnessing Tuberculosis (TB) Patient Support Groups' (PSGs) potential in strengthening gender dimensions of TB response is important because gender-blind strategies aggravate the impact of gender inequalities in TB disease elimination [1,2]. However, gender analysis and gender-responsive programming are still relatively new fields in TB response [3].

The objective of the study is twofold: to describe the issues, situations and challenges that are faced by the TB patients as women, men, or Lesbians, Gay, Bisexuals, Transgender, Queer, Intersex (LGBTQI); and determine the challenges, potentials and program support needs of the TB PSGs using the gender lens.

Globally, TB is a major cause of ill health and one of the top 10 causes of death. In the Philippines, TB continues to be the single biggest infectious disease killer among Filipinos, with 27,000 TB deaths in 2017. About 70 Filipinos die every day because of the disease; and many of them died after developing Multi-Drug Resistant Tuberculosis (MDR-TB) [4].

Moreover, the Philippines, which ranks among the highest in TB incidence among the 30 High TB Burden countries in the World, is among the few countries where the number of people having TB is continuously increasing annually [2].

However, improving the situation will be impossible if gender remains a blind spot in TB control, which results to weak program capability to address gender implications that result to disparities in terms of access to care, health-seeking behavior, timely diagnosis, stigma, gender-insensitive services, and other service-related barriers [5]. *Gender-blind*, as defined by the United Nations, refers to the failure to acknowledge the different needs and realities of men, women, and LGBTQI; and thus, aggravates the impact of gender inequalities and social norms [1].

Globally, epidemiological data, including prevalence, case detection rate, and notification, are showing that TB is a "disease of men than women" [29]. Geographic, social and economic factors affecting men – smoking, alcohol consumption, social contacts, lifestyle, occupation, exposure, norms and expectations on masculinity including familial duties as breadwinners – led men to sideline their health and not receive proper care [1,4,5,6,7,8]. There is also a need to address global health initiatives that treat "gender" issues in health as "women's health"; while there were significantly more men than women who are being diagnosed with and dying from TB [6,9].

At the same time, studies showed that women are also suffering from higher stigma, less knowledge on TB, higher direct costs for treatment, less priority by family, lack of financial independence, dependence on husband's decision, preference for traditional healers, among others. These lead to poorer outcomes such as longer delays in diagnosis and treatment, poorer access to treatment services, and under-reporting of cases among women [1,7,10,11].

TB control strategies are affected by the various context of gender roles and relations, which has consequences that exacerbates each other. However, current documents do not always differentiate sex (biology) and gender (social constructs) [12]. There are calls for health research and programs towards a clearer definition of gender as a complex relationship between social context, sex, gender, and the psychosocial construction of the illness that has physical, social, and economic impacts on TB outcomes [9].

Studies showed the value of interventions addressing patients' psychosocial and economic barriers to TB treatment completion, including the gender-related barriers. This includes development of social and psychological support package for patients, counselling toolkit; peer support; patient-centered approaches by bringing TB treatment in the communities; and patient-involvement and empowerment [13,14,15,16,17,18].

A form of patient empowerment is mobilizing cured and ongoing patients into Patient Support Groups (PSGs), especially for MDR-TB, to help address the social and economic barriers to TB treatment completion, such as those caused by gender social construct. PSGs can provide the needed psychosocial support through education, psychological/counselling support, development of coping mechanisms, referral to community social and development networks and services, among others. The social support interventions for TB help reduce stigma and discrimination experienced by TB patients and improve information sharing between and among patients and caregivers [19,20,21].

In some countries, patients (cured or ongoing) were trained and organized to provide support to patients through TB communication, sharing of experiences, motivation for adherence, dealing with stigma, and other forms of mutual support [22,23,24,25]. Studied also showed that TB patients who received counseling support or were involved in TB PSGs had the treatment success rates or highest cure rates [24,26,27].

However, there are still relatively few programmatic best practices on social support services for TB Patients. Effects of social support interventions to help patients overcome barriers to treatment completion are also rarely shared among the TB program managers and the care givers themselves [19,21].

In the Philippines, which has a TB prevalence that is three times higher among males [6], the gender dimension remains a blind spot and PSG mobilization to address this is still to be strengthened. As pointed out in the strategic plan for TB elimination, patient care approach, gender sensitivity and promotion of human rights have not yet been explicit in the policies; models and guidelines are still to be developed; and health workers still need training on these aspects [6].

The results of the study, highlighting the importance of gender dimension in the interventions that will be implemented by the PSGs, may serve as input to roadmaps, policies, and programs towards TB patient empowerment. Thus, TB patients of all gender identity and expression may

be moved to take action and contribute to the development of a gender assessment framework for TB response.

Methodology

Study population

The respondents of the research study are Key Affected Populations (KAPs) of MDR-TB. Most of them are living in poverty and had to stop work or schooling because of their disease. The use of Transformative Research Design ensured that their voices and perceptions are taken into account throughout the research process; and that they have a sense of ownership on the data, therefore encouraging them to use the research results for social action [28,29].

Purposive sampling was done by selecting participants who can answer the research questions. Recruitment of respondents was done through the support of the Samahan ng Lusog Baga, Inc. (SLB), which holds office at the Lung Center of the Philippines (LCP). SLB is the national coalition of Patient Support Groups (PSGs) whose members are former and current TB patients and are active in national and global activities for TB Key Populations.

To promote trust on the study and community ownership among the target population, peer approach through SLB members referring the researcher to the other patients/PSG members in the identified treatment facilities was done. The SLB coordinators also first studied the Data Collection Forms and gave their feedback if this could be understood by the respondents. The risks were explained to the respondents and indicated in the informed consent form.

All of the respondents went through the interview and survey, using a guided questionnaire. Focused Group Discussions (FGDs) were conducted by discussing the questions to the respondents and allowing them to share their perspectives.

There was a total of 35 respondents from among current and former MDR-TB patients, comprised of 46 percent women, 31 percent men, and 23 percent LGBTQIs. Around 40 percent of the respondents belong to the 15 to 34 age group, 54 percent in the 35 to 54 age group, while only 6 percent were 55 and over. The mean age is 38, with the youngest being 17 years old and the oldest being 60 years old. The youngest and oldest respondents both belong to the LGBTQI gender group (Table 1).

Table 1. *Age and gender profile of the respondents investigated.*

Gender Distribution (%)	
Women	45.7
Men	31.4
LGBTQI	22.9
Age Distribution (%)	
15 to 34	40.0
35 to 54	54.3
55 and over	5.7
Average Age	38
Minimum Age	17
Maximum Age	60

The sampling population of ongoing patients came from the Programmatic Management of Drug-Resistant Tuberculosis (PMDT) Treatment Center (TC) at the Southern Philippines Medical Center (SPMC) in Davao City and Satellite Treatment Center (STC) at Rogaciano Mercado Memorial Hospital (RMMH) in Bulacan. The sampling population of graduate TB Patients are the SLB members from the SPMC; German Doctors – Xavier University PMDT Treatment Center in Cagayan de Oro; Lung Center of the Philippines and Kabalikat sa Kalusugan in Quezon Institute (KASAKA QI) in Quezon City; Jose B. Lingad Memorial General Hospital in Pampanga; and TB HEALS Patient Support Group members in RMMH. There was also one respondent who is as PSG Member at the Northern Samar Provincial Hospital STC.

Promoting social justice through research design

In alignment with the principles discussed in "Transformative Paradigm: Mixed Methods and Social Justice" by Donna M. Mertens [28,29], this study aimed to further gender and human rights. In the transformative paradigm, it is important to use mixed methods to enhance the community's trust to the researcher. It makes the researcher more responsive to the needs of the communities; at the same time, the communities are able to benefit from the power of quantitative and qualitative data [29], which were concurrently collected through the survey/questionnaires.

The major focus of data analysis is the rich qualitative data. During the process, there is recognition that reality is socially constructed, and hence, diversity (even gender

diversity) will result to different perceptions of realities and understanding of the research focus and questions [28,29].

Grounded Theory [9,18,23,30,31,32,33] was mainly used because there are limited, if not none at all, theories on PSG and the processes that lead to its effectiveness, and of how gender social constructs affect the performance and motivation of MDR-TB patients as PSG members. As the study design suggests, this theory will be founded in the data collected from the study, and not from other textbooks or other researches [9,18,23,30,31,32,33].

Qualitative analysis was conducted using the Grounded Theory approach of Coding: (1) Open Coding Stage: picking up the key words and/or their meanings from the respondent's responses; (2) Axial Coding stage: identifying clusters of related categories and checking on how these categories may form a theory; and (3) Selective Coding Stage: binging out the story line for the theory to explain the core phenomenon or process [9,18,30,32,33].

From the categories that resulted from the coding process, logic diagrams were formulated by identifying which categories may represent the causes (causal conditions), strategies and core phenomenon and connecting all these in order to build a logic diagram [31].

The study protocol was reviewed by the University of the Philippines Manila Research Ethics Board (UPMREB 2019-512-01) and approved on 06 February 2020.

Results

Challenges and areas of support

From all the respondents who are or became TB patients, mental health problem is the most common form of challenge perceived, with 63% of the respondents claiming to have experienced mental health challenges. This is followed by problems in employment (26%) as well as the need to stop working (23%) while on treatment. More women are affected by mental health problems and employment issues compared to men. While men are more affected by problems in education/school, and discrimination at work.

There are variations in the challenges faced by gender. More than 60 percent of women and LGBTQI respondents experienced mental health problems, but only less than 55 percent of men experienced this challenge. Around 31 percent of women and 25 percent of LGBTQI had to stop working while only 9 percent of men faced this challenge. Meanwhile, no men and women respondents experienced discrimination in accessing sexual health services while around 13 percent of LGBTQI respondents had this challenge during treatment (Figure 1).

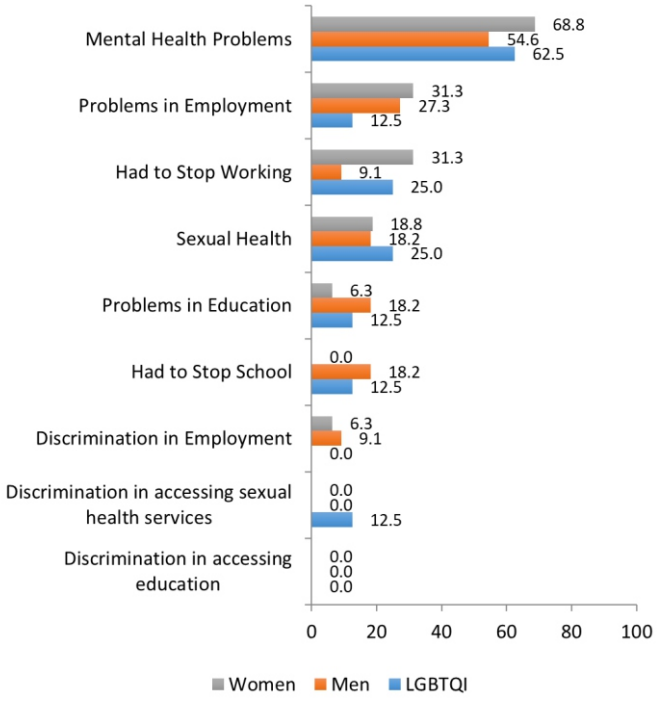

Figure 1. *Challenges of the TB patient respondents by gender*

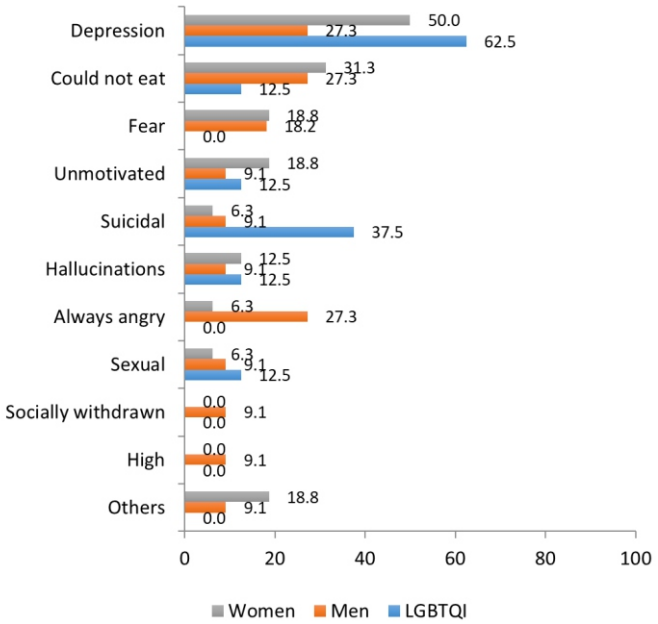

Figure 2. *Mental health problems of the respondents during TB treatment by gender*

Mental health: TB patients' challenges and PSG program support needs

Among mental health issues identified by the respondents were hallucinations, depression, suicidal thoughts, loss of appetite (prolonged), feeling high/stoned, extreme anger, changes in libido, memory loss, loss of motivation, fear, and social withdrawal.

About 63 percent of the respondents experienced mental health problems when they were undergoing MDR-TB treatment. Half of the women and most of the LGBTQI (62.5%) suffered from depression during treatment, while equal number of men (27%) reported depression, anger, and loss of appetite. It is notable that no LGBTQI recorded feelings of anger and fear during treatment. However, the higher number of LGBTQI that reported depression understandably results also to higher number of those having ideas of committing suicide or wanting to die (37.5%) among this gender group (Figure 2).

The logic diagram created from the coding process revealed that respondents of the study connected their mental health issues to the other aspects of their lives as individuals and as members of societies (Figure 3). Part of this is how their families and societies see and treat them, and their gender is a major determinant of how they are perceived and treated.

For women, there were expectations by the family to take care of children, take care of household, and contribute to family finances even while they are sick. At the same time, they are perceived by society as weak, and they also perceive their gender group as weak in terms of body and emotions. Abandonment by partners or spouses in the midst of sickness is also one of the challenges. Pregnancy is unique to women, and instead of this being pursued as a blessing, it is perceived as a major problem when the woman is sick with TB. It is also quite ironic that women are perceived as weak, but they are the ones, among gender groups, who are carrying so much responsibilities on their shoulder – the children, the household, their husbands, financial problems.

For the male, it is their responsibilities – in family and workplace – that they could not get off their mind when they

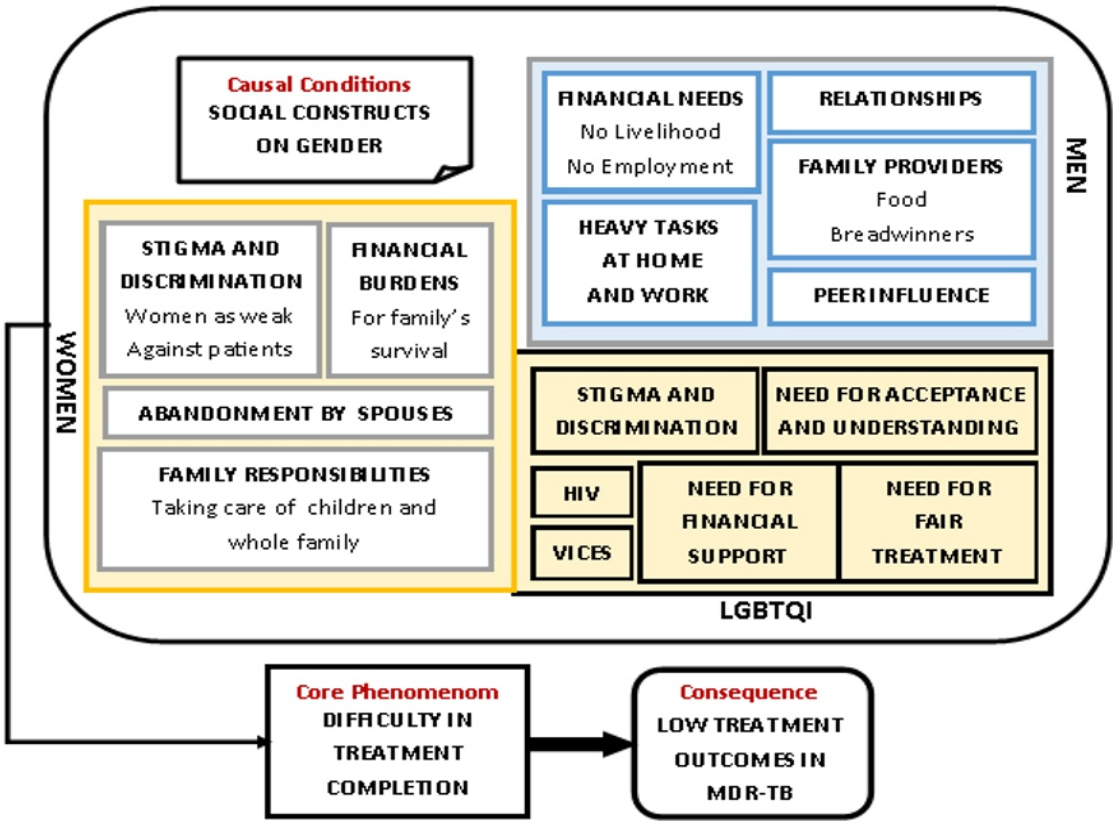

Figure 3. *Social constructs on gender affecting TB patients*

are sick. Meanwhile, the LGBTQI reveals a population segment who are facing a double-edged sword – disease related (TB/HIV) and gender-related social constructs – while hoping other people will understand them and treat them fairly.

The framework serves as an alert that, it is not so much the Adverse Drug Reactions (ADRs) in their minds, but how the society regard them and the expectations on their gender roles and qualities that are actually making treatment completion difficult for them and are affecting them mentally and emotionally.

Meanwhile, the stories about mental health problems showed that what LGBTQIs experienced mentally (and emotionally), is an inner battle against TB in terms of choosing between wanting to live or wanting to die. For women, there were many sources of depression, including losing loved ones as there are cases of husbands abandoning wife and family. Likewise, the men are connecting mental health to family life/relationships, social life and their body and mind (Figure 4).

It is also a matter of life and death, as the depression coming from all fronts, seems to be leading to suicidal thoughts. This is especially true among the LGBTQIs, who also have issues on acceptance by others and have feelings of being misunderstood by both society and their families because of their gender preference. It can also be seen from

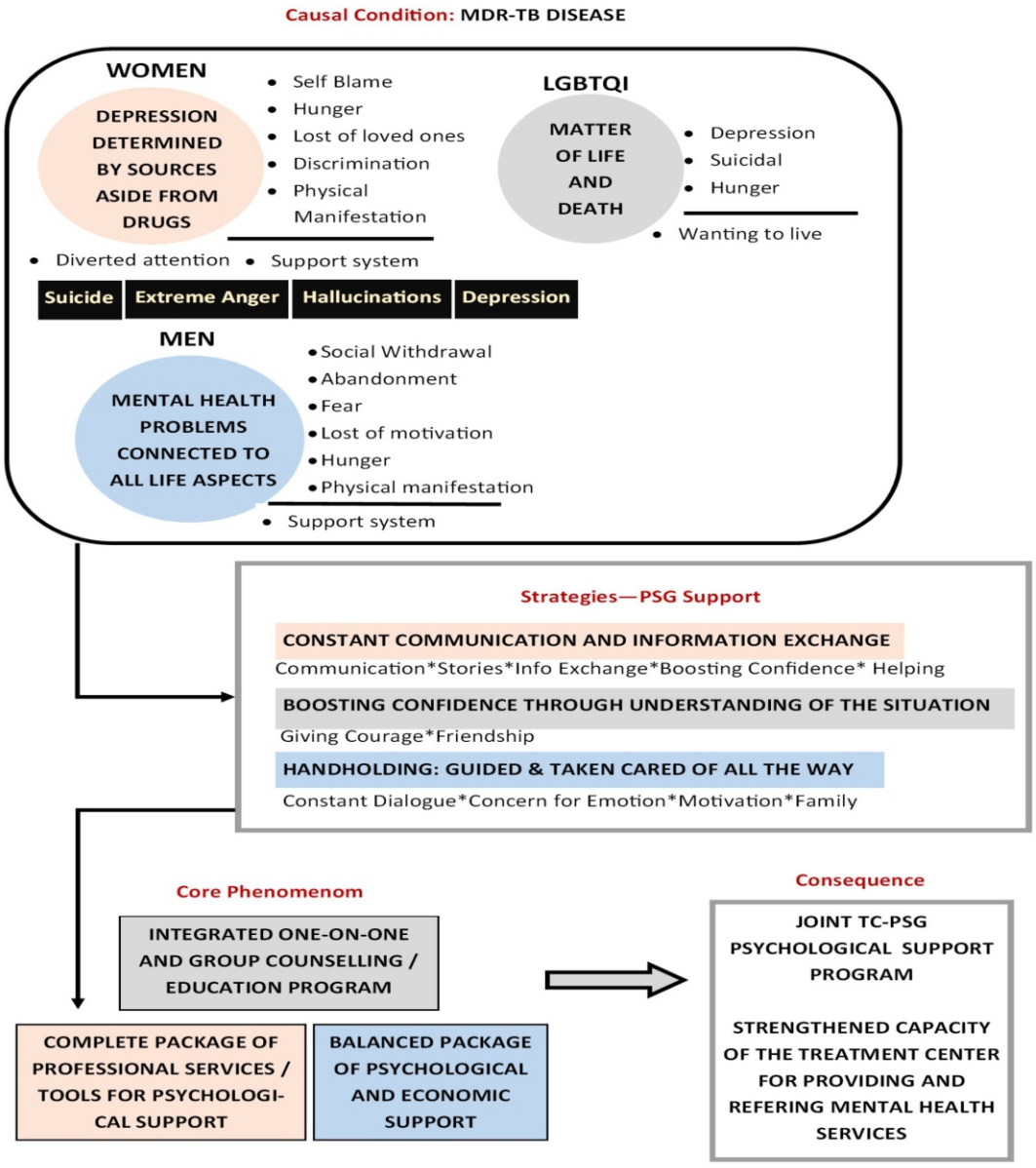

Figure 4. *Mental health challenges and program support needs*

the strategies suggested by the LGBTQI group that being able to understand the situation will boost a TB patient's courage.

Hunger, caused by prolonged loss of appetite, came out as a major challenge considered by all genders. PSGs included giving food and their own money, as well as treating patients to restaurants and eating sprees, as their way of helping patients experiencing Adverse Drug Reactions (ADRs).

The coding process on patients' responses to the question of how the PSGs was able to help them with their mental health problems was categorized in the framework as the strategies that will make the suggested PSG/TC program on Mental Health possible. Disaggregating the responses per gender helped to identify the necessary dimensions of a TB and mental health strategy to ensure that the needs (*i.e.* needing someone to talk to, as highlighted by the women's responses; seeking to understand and be understood, as highlighted by the LGBTQIs' responses; and being guided and taken care of throughout the treatment journey, as highlighted in the men's responses) of TB patients for better mental health are taken into account.

The theory created from this framework is that existing and proposed PSG strategies of helping patients address mental health problems may be integrated into national programs and policies on tuberculosis, mental health and social protection for an integrated, complete, and balanced package of psychosocial and economic support. This kind of package will make it possible to boost government mental health services through the PSGs both in the treatment facilities and communities.

Economic challenges of TB patients and PSG program support needs

Meanwhile, the country, in alignment with the Universal Health Care Act, targets zero catastrophic costs for the patients [34,35,36]. However, the results of the study will show that there is a need to look beyond the healthcare costs because unaddressed catastrophic costs associated with TB lead to economic catastrophe in the patients' lives.

Financial burden came out as a major challenge for all genders. For the respondents, the major catastrophe are the loss of income and the opportunity to work and study because of TB. From the interviews, there were stories of students unable to go back to school as well as stories of those about to start in their jobs or getting a promotion but lost all opportunities for employment because of TB. For some patients, the catastrophe extends to their relationships and families when they are abandoned by partners because of their TB disease.

The respondents, as PSG members, were asked on what they believe should be the strategies to ensure economic resilience of TB patients. Consolidation, coding, and integration of the answers into the logic diagram helped identify a holistic package with whole-of-government and –society approach to address the issue (see Figure 5. Economic Challenges of TB Patients https://drive.google.com/file/d/1BSBo02CmOqmpzgJxSzzIKZ86f96v3qvI/view?usp=sharing). This consisted of four main strategies: (1) coordination with key national government agencies; (2) economic assistance packages; (3) TB in the workplace; and (3) legislation on employment for TB patients.

Potentials of PSGs

Strengths of women as PSG members

When the women respondents were asked on why they continue being PSG members, their answers (see Figure 6a. Women as PSG Members https://drive.google.com/file/d/1a8kVdVGUJhVGWn0Kbm-HGY4oEr6MiJ_P/view?usp=sharing) revealed that leadership can lead patients to treatment completion and proper intake of TB drugs. They have confidence with their capacity to help the patients and, at the same time, contribute to national efforts on TB elimination. The core phenomena of the *Bayanihan* Spirit through active citizenship, advocacy, good governance, empowerment and collaboration from empathy and altruism that the women PSG members expressed. They express these emotions by bringing out their expertise in the field of TB control through their knowledge and wisdom from months of experience of dealing with and surviving the disease. They also use their own time and money to help through different channels – TB patients, the PSG, in Treatment Center Tasks, and reaching out to the community. In effect, they serve as inspiration to the patients to strive for treatment completion, as well as to the communities as models of good health seeking behavior. These creates potential for PSGs to be highly sustainable with the right support.

The women's stories on their participation in PSG activities showed the potential of women to contribute and take action. They believe that the strategy should be to organize women TB patients for women-specific programs so that they can address all aspects – livelihood, reproductive health, discrimination – and thus they can become effective

counselors for fellow women. They perceive themselves as mothers in the PSGs, they support each other as women, and they become leaders and experts. In their context are the physical and emotional challenges that a woman has to face, including the effects of stigma and discrimination, and their responsibilities in the families. The conditions that might affect their performance are their divided time for family or work livelihood, the level of dedication of the woman, and the support of their families as well as of the treatment facility to the PSG (see Figure 6b. Women's Potentials in Organizing Women Affected by TB https://drive.google.com/file/d/17je_0NTJeXD0_y7qbNJpw2PHuwLNfl9bB/view?usp=sharing).

Strengths of LGBTQIs as PSG members

The responses from the LGBTQI such as doing PSG work for love and gratitude because they were healed opened up the core reason for the strength of PSGs – from the moral conviction and sense of moral responsibility of the former patients to serve and to give back the strength that was given to them when they were sick. Principles of ethical capitalism and moral capitalism emerged. The love for humanity expressed by the respondents is at the center of the strategy, not only to help patients seek and complete treatment, but also to ensure that the citizens have the inner power to regain their lives after being seriously ill (Figure 7a).

The quest for understanding and acceptance, their advocacies for gender equality and their willingness to help without asking for anything in return makes them interested in PSG activities on TB-HIV and outreach to their own gender group. They believe that their role is to promote gender sensitivity while promoting TB treatment and to give credibility that the program can help LGBTQIs. They do these while having to deal with effects of medicines, need for financial support and the fact that LGBTQIs are not yet widely mobilized to address TB among them. The support of the community, their own personal issues, and gender-based violence and discrimination are conditions that might affect their performance (Figure 7b).

Strengths of men as PSG members

The men's responses on why they are PSG members points out to the understanding on TB Treatment of TB Patient Support Group members, and the confidence to be able to help patients who needs to be guided towards treatment completion. This results to a clear sense of what actions are needed in order to achieve goals – of both the patient, the PSG and the Treatment Center (see Figure 8a. Men PSG Members https://drive.google.com/file/d/1KvAxFhTI_eGSMdtpeSupn7WcIQLfiP78/view?usp=sharing).

The men are motivated by their leadership skills and teamwork. They want to champion men's causes in the treatment facilities, calling for equal representation, dialogues, and programs that address their needs and realities as men. They also believe that they are ready to take on physical tasks. With these concepts, they could be very effective in linking the men to the health system and

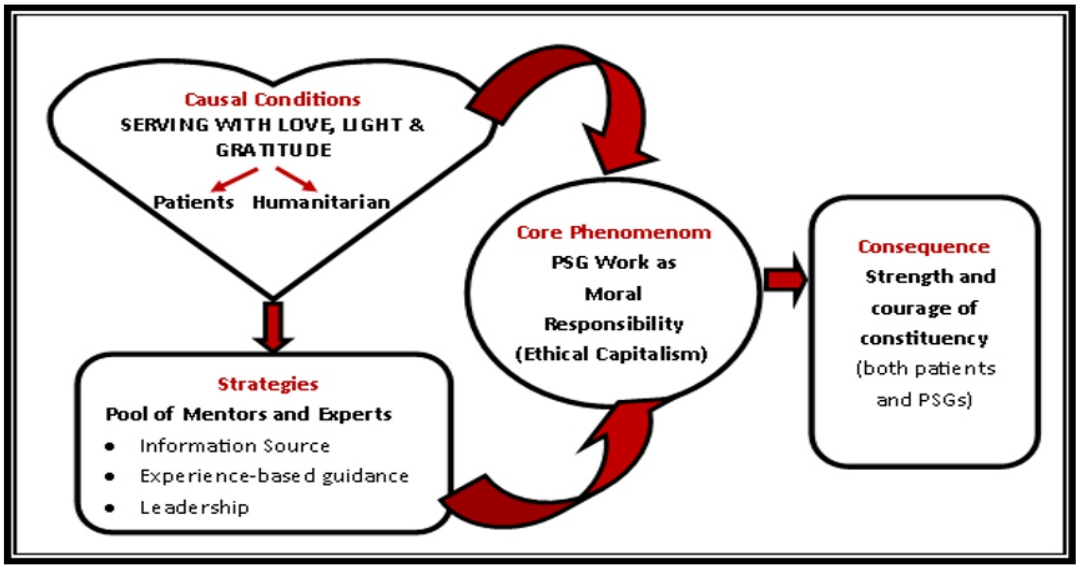

Figure 7a. *LGBTQI as PSG members*

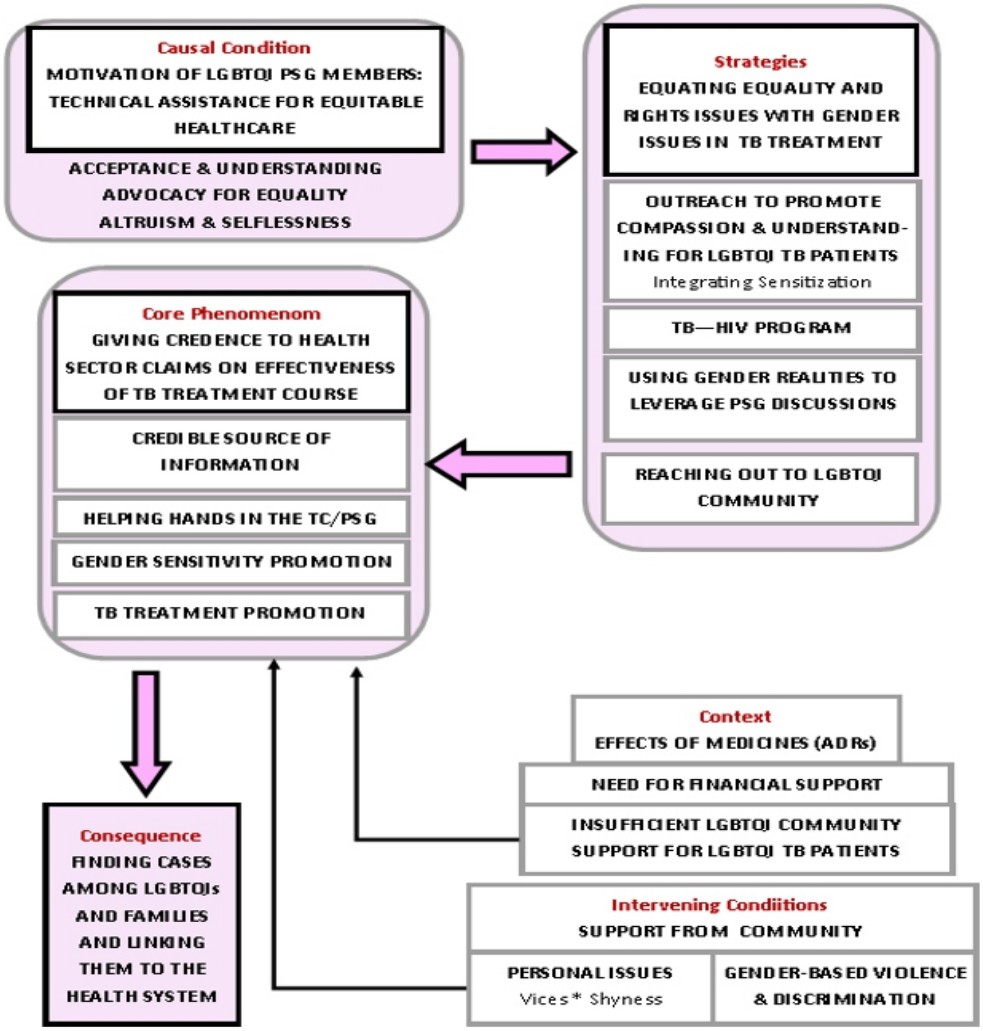

Figure 7b. *LGBTQI potentials in organizing LGBTQI affected by TB*

complete treatment amidst social constructs of masculinity, viewing weakness as unacceptable, heavy responsibilities for their families, and financial problems especially as bread winners (link to Figure 8b. Men's Potentials in Organizing Men Affected by TB https://drive.google.com/file/d/1jgdXapU9vEsZ0nr0NSbc_3YnVkfu64wG/view?usp=sharing).

Potentials of PSGs for activities inside and outside the treatment facilities

Inside the treatment center, the coding process (see Figure 9. PSG Potential and Program Support Needs Inside the Treatment Facilities https://drive.google.com/file/d/12TCNSNveUFDOLFU9gvQ8e7pSbQVcgvrW/view?usp=sharing) showed that the PSGs serve as champions and spokespersons of the national government's goals on Tuberculosis inside the TB treatment facility. Their first-hand experience of dealing with taking the medicines for many months, dealing with ADRs and finding coping mechanisms to be able to address the demands of living, also provide the treatment facility with the expertise needed by the patients to be able to complete the treatment journey. In this sense, the counselling, dialogues and mentoring fosters active listenership and meaningful dialogues necessary for the mental health and emotional well-being of the patients.

An intervening condition is the financial support to the PSG for its activities. Insufficient support for PSGs has caused some very active members to lose motivation.

The respondents also shared stories on their participation in PSG activities outside the treatment facilities into the communities (see Figure 10. PSG Potential and Program Support Needs Outside the Treatment Facilities https://drive.google.com/file/d/1KA8WjWK6BifKAltWULkgGrXxuPzogs4p/view?usp=sharing) for contact tracing, home visits, community

orientation, attending national and international consultations and training, providing TB 101 in the workplace, among others.

In PSG activities in the community, it is interesting to note that it is with the women respondents' groups that the role of PSGs as myth busters and their roles in correcting wrong information were highlighted. The coding process revealed that women, as PSG members, are primarily concerned with spreading correct information on diseases.

Based on the inputs from the PSG members, there is a need to ensure equal opportunities for members of the PSGs, and for all gender groups, to participate in activities outside the treatment center. There are also challenges in terms of time and energy devoted to PSG activities, but the members still manage to participate despite these limitations.

The coding process revealed that the PSGs are actually the link of the health system to the communities affected by Tuberculosis. The PSGs are voices for the government health system when they convince the citizens on the correct information that the public health sector would like to communicate and on the health services that treatment facilities need to provide.

Discussion

Summary and interpretation of findings

Social constructs on gender roles and catastrophic costs associated with Tuberculosis were perceived as major impediments to TB treatment completion. Gender constructs on gender is a causal condition of the pressure and burdens carried by TB Patients during treatment. Although weakness of body is among the challenges, ADRs are not really perceived by the patients when asked about their challenges in treatment. The root cause is how the society perceives their roles based on their gender and how they have to live up to or deal with these gender social constructs, *e.g.* women as mothers, men as breadwinners, or LGBTQI need for understanding at their most trying times. Meanwhile, financial burdens is also a major challenge perceived across all genders.

The Philippines is targeting a 90% patient satisfaction rate for the TB services as highlighted in the country's Strategic TB Elimination Plan [34]. This study revealed that part of TB patient satisfaction is not only being treated but also having the opportunities to actively participate in the national disease response; and where the PSG programs provide equal opportunities to all gender and are customized based on unique gender needs of the patients.

The coding process for each gender revealed a storyline that provides keys to sustainability of PSGs and to the potentials of PSGs to serve as a sustainable and competent workforce capable of providing patient-centered care that will help ensure treatment completion. The government criteria of Patient-Centered Care is transferring TB Treatment Services to the homes and communities of the patients [10]; and the PSGs are among those who will be at the frontlines at this level [29]. PSG members have expertise from experience and are driven by passion and altruism. This makes the former TB patients professionals and experts in specific fields of TB response and elimination.

The national government also targets to enhance case finding by mobilizing community-based workers for home and community-based screenings [34]. The potential of PSGs to bring out more strategic and gender-targeted interventions for case finding, contact investigation and link-to-care was revealed in the study. This will be beneficial to the country's plans to enhance case detection by targeting gender-specific or gender-targeted enhanced case detection strategies.

The gender dimensions provide a deeper analysis of results of previous studies on risk factors associated with TB patients' treatment adherence, including their motivation, social and cultural support systems; social norms prescribing certain behaviors based on the patient's sex, age, and other categories; and their financial and economic security [21]. This allows for more targeted approaches to psychological, economic, and social problems which are exacerbated by having TB and reinforces risks of treatment relapse or death [19,21].

It provides the key for appropriate interventions responsive to the needs of a patient. Based on a randomized control trial in selected DR TB treatment centers and sub-centers on support that patients need, some sectors, such as women, are more vulnerable, and some aspects of support packages need to be individualized and tailored based on the need of the patient [14].

It also reinforces use of evidences from empirical studies on the formation of support groups as necessary components of psychosocial support, which are seen as crucial in the completion of TB treatment [12,26,21,22].

Reinforcing PSGs by considering gender lens in its counselling and information activities may actually be more

important than financial support. Globally, on average, TB patients lose 50 percent of their annual income during TB treatment. The costs are higher among those with MDR-TB and those belonging to the poorest quintiles [4]. However, as shown in a mixed methods study on the right combination of counselling and financial support, there was higher cure rate among those who received counseling support than those who received combined counseling-financial support. Moreover, there was lower default rate among those who received counseling support than those receiving combined support [27].

Implications

The results of the study contributes the following implications to research, policy and practice, as well as possible actions, in the overall TB response:

Challenges

1. Gender Social Constructs. Social constructs on gender as serious causal condition for the impediments to treatment. Hence, gender transformative strategies should be explicit in national policies and strategic plans on TB [34,37,38]. There should be focus on addressing gender relations and roles during the TB treatment journey. For example, PSGs' women's groups may target a paradigm shift in the community and families' psyche towards women's strengths and roles.

2. Catastrophic Costs. For all genders in the study, the real catastrophe is the long-term socioeconomic impact of acquiring TB. The UHC and national TB Plan, which targets lessening catastrophic costs to the lives of patients [34], may be reinforced by introducing provisions in the TB Law for a whole-of-government approach for social protection and economic programs preventing life-time economic catastrophes due to the disease, with programs customized for each gender group.

3. Mental Health. Mental health problem is the most common form of challenge perceived, with 63% of the respondents claiming to have experienced mental health challenges. Mental health issues are also tightly connected to the other aspects of the patients' lives as individuals and as members of the society. Part of this is how their families and society see and treat them. Their gender is a major determinant of how they are perceived and treated. The quantitative and qualitative results on the mental health aspect both showed tendencies for suicide. It actually came out across all genders, and most of all for the LGBTQIs. Meanwhile, in a 2019 study on the global receptivity of National TB Program (NTP) directors on the idea of integrating tuberculosis and mental health services, it was found out that NTPs currently do not routinely address mental disorders. However, receptivity among NTP directors is high, thus opening opportunities for the integration of TB management and mental health into TB policies [38]. Strategies to address mental health challenges of TB patients:

a. Integration of National Mental Health Act implementation with the Comprehensive TB Elimination Plan Act of 2016 [38,39,40]. This implies implementation of the Mental Health Act, especially in making mental health services available to the community [39] integrated with the National TB Program's patient-centered care package through community-/home-based TB care and treatment, while considering the unique tendencies and context of each gender group.

b. Roll out of community engagement tools for suicide to the MDR-TB Patients' communities, especially LGBTQIs.

Potentials

The TB PSGs have the potential to contribute in the following areas:

1. Patient Satisfaction. An important dimension of TB patient satisfaction is the equal opportunity to actively participate in the national disease response; and where the PSG programs are customized based on unique gender needs of the patients.

2. Patient-Centered Care. PSGs are the link of the health system to the communities affected by Tuberculosis. Its members can provide gender-responsive messages on TB, and convince the citizens on the correct information that the health sector would like to communicate and on the health services that the treatment facilities need to provide. PSG members have the potential to serve as professional, competent, and expert workforce on TB in terms of strategic and gender-targeted interventions for case finding, contact investigation, and link-to-care.

3. Case Detection. To address the low MDR-TB case detection rate, gender-targeted case finding strategies are the key to addressing the countries' low case notification rate in MDR-TB.

Program support needs

The following program support needs are important to harness and sustain PSG role and contribution in Philippine government targets of 90% patient satisfaction rate for the TB services; patient-centered care through home-based or community-based care for TB patients; and enhanced case

finding by mobilizing community-based workers for home- and community-based screenings [34].

1. Government investments on gender and PSGs in TB response. Funding support for PSG and its gender-related programs is a call of TB patients and PSG members of all genders. A budget line item in the General Appropriations Act (GAA), for TB PSG establishment, strengthening and support is a sustainable move and will motivate PSG members.

2. Policy implementation plans to recognize the human and ethical capital within the PSGs are necessary solutions to the low case detection and low treatment outcomes in MDR-TB. Elevating how the government regard the role of the PSGs and recognition of the motivation and capacity of PSG members – as men, women, LGBTQIs – to provide expertise that the medical sector could not provide should be expressed in policy provisions around health human resources for TB.

3. Mobilizing gender-groups of PSGs to link their specific gender-groups in the communities to the health system.

4. Inclusion of gender and PSGs in the National TB Control Program Adaptive Plan for COVID-19 [41], specifically:

a. Gender sensitive and gender transformative interventions and standard messages to ensure access to treatment

b. Key messages and guidelines on the roles of TB PSGs in the TB Program's COVID-19 response

Conclusion

Being unable to deliver on its commitment in terms of MDR-TB detection and treatment completion has been the country's major challenge in terms of national TB response for many years [34,37,42]. To aid in finding solutions, the study looked into the challenges that the patient/PSG members as women, men, and LGBTQIs had to deal with, their coping mechanisms, and their recommendations.

The challenges, potentials and support needed by women, men and LGBTQI as TB patients and TB PSG members should be recognized and addressed for the country to be able to be aggressive in finding and treating TB cases. This is imperative so that the country can deliver its commitment to find and treat 2.5 million with active TB and 1.2 million people with latent TB by 2022 [43,44].

Supporting PSGs with consideration of the gender dimensions will help ensure the sustainability of interventions involving communities and patients, especially when PSGs will be the front liners helping in TB treatment at the communities and homes. Only then can gender transformative interventions be formulated or reinforced. Thus, PSG programming needs a gender lens.

Whole-of-government and whole-of society approaches are needed so that there is shared goal among government agencies that results to policy coherence for effective and efficient TB response [11,44]; and the contributions of all community stakeholders are acknowledged and provided support for strengthened coordination [45,46].

A bigger representation of TB Patients and PSG members, with drug susceptible TB would reinforce the findings of the study.

The results are significant in the formulation of gender-sensitive and transformative framework of interventions for PSGs. In particular, this will be useful for the development of policies and models for TB services with focus on gender, human rights and patient-centeredness; and for the formulation of interventions targeting the specific needs of men, women and LGBTQIs with TB.

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