Explanation for UN High-Level on TB Political Declaration

Key Topics for UN Member States

TB infection – TB disease

- **TB infection** is a state where the TB bacteria has entered the body of an individual, but the bacteria is not growing and does not cause any sickness.
  - Globally about 2 billion people already have TB infection¹,².
  - Most people with TB infection will not become sick in their lifetime but about 10% may develop sickness, a state which is called TB disease. People suffering from other health issues and vulnerabilities that reduce their immunity status are more likely to progress to sickness, e.g. people living with HIV, people with undernourishment, diabetes, etc.
  - An individual with TB infection does not spread it to others.

- There is treatment available for reducing the risk of progression from TB infection to TB disease, known as TB Preventive Treatment (TPT), which is currently recommended for household contacts of people undergoing TB treatment, people living with HIV, and other groups at higher risk or whose immune systems are suppressed.

- **TB Disease** is when TB bacteria in the body grow and cause damage to tissue, which manifests in sickness. Unless diagnosed and treated the mortality can be very high.
  - A person with TB disease can spread the infection to others. On average one untreated individual with TB can spread the infection (airborne/droplet route) to 10-15 others per year.
  - To prevent transmission it is important to diagnose TB early (before it spreads) via screening and providing access to diagnostics, and start effective treatment as soon as possible.
  - Globally about 10 million people develop TB disease each year³. Of them, currently about 7 million are able to access diagnosis and treatment.
  - The remaining 3 million people with TB disease each year go missing and are often referred to as the ‘missing people with TB’. This group is a major reason for continued transmission and high mortality due to tuberculosis.

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TB Preventive Treatment (TPT) for contacts

- TB is an airborne infectious disease. People who are in close proximity (e.g. an immediate family member) and share the same airspace for a long time are at risk.
- In the context of TB, just as with COVID-19, ‘contact’ means a person who has been in close proximity with someone who has TB.
  - Household members of a person with TB are called ‘household contacts’ and there may be other contacts at the workplace, or other social contacts.
  - Every person undergoing TB treatment was at some point a ‘contact’ of someone else with TB.
- Contacts are at particular risk of developing TB and need to be protected with TB Preventive Treatment (TPT). TPT for contacts has been an international guideline for many years but has not been a priority in many high-burden countries due to lack of resources and the preoccupation with diagnosis and treatment of people with TB disease.
- In future if we are to end TB it is not enough to just diagnose and treat people with TB disease, but it is very important to prevent TB amongst contacts with TPT.
  - The duration of TPT in the past was 6 months but newer regimens are much shorter: a 12-dose (once-weekly for 12 weeks) course or a 1-month daily course.
- For scaling up TPT it is important to commit to bold numerical targets and at the same time scale up TB infection testing among contacts.
- The Political Declaration from the 2018 UN HLM included a target of providing TPT to at least 4 million contacts under 5 years of age and 20 million older contacts, and a commitment to scale up TB infection testing.

What we mean by ‘vulnerable groups’

- TB disproportionately affects the poor and vulnerable people.
- ‘People who are vulnerable’ or ‘in vulnerable situations’ is established language from the 2018 TB Political Declaration on TB.
- Key and vulnerable populations in the context of TB have been defined in the *Global Plan to End TB 2023-2030*:
  - People who have increased exposure to TB due to where they live or work,
  - People who have limited access to quality TB services and
  - People at increased risk of TB because of biological or behavioural factors that compromise immune function.
- Reaching key and vulnerable populations – people who are vulnerable, marginalized, underserved or at risk of TB infection and illness – will be essential for ending TB. It is imperative, from both an epidemiological and an equity and human rights perspective, that programs:
  - Prioritize ending TB among key and vulnerable populations;

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○ Ensure that key and vulnerable populations have convenient access to TB prevention and care, including through primary care and integrated health services (e.g., TB and nutritional support, TB-HIV, TB-diabetes, TB and tobacco cessation);
○ Understand the social, political, legal and economic barriers key and vulnerable populations face in accessing TB services;
○ Involve key and vulnerable populations as priority stakeholders and equal partners in the fight against TB; and
○ Coordinate and collaborate with other programs and ministries focused on gender, rights and development.

Gender in relation to TB
● In recent years, we have all become much more aware of how expectations and patterns of behaviour for men and women shape life chances and life choices.
  ○ For example: often in the company of their peers, young men tend to take more and dangerous risks; and women will often eat least and last because expectations of them as care-givers dictate that they must see to the nourishment of male breadwinners and growing children first8.
● Gendered patterns of behaviour also affect health and access to quality health care, including for TB.
  ○ For instance: in some countries, men are more likely to be exposed to TB because of the nature of their work (such as mining, where workers are together in enclosed spaces for long periods and less likely to have access to fresh air) and more vulnerable to their experience of TB being worse because they are less likely to seek out health care9.
  ○ We also know that stigma impacts all people with TB – but it can manifest differently for men, women and gender diverse populations10.

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These gender-related barriers to TB care were noted in the Secretary General’s report on progress toward implementing the Declaration from 2018 UN HLM on TB\textsuperscript{11}. This derives from ‘gender responsive’ programming and ‘gender equality’ terminology featuring in the 2018 TB Political Declaration.\textsuperscript{12}

This is why global civil society has pushed so hard for the Political Declaration to contain strong and consistent references to gender: if we are to end TB by 2030, we need to pay attention to the different behaviours and needs of men and women.

**Community, rights gender (CRG) and stigma-related barriers and developing CRG Costed Action Plans to find and treat all people with TB**

Every year, health systems miss millions of people affected by TB because of human rights barriers to health services, including stigma and discrimination, lack of access to support services, breaches of confidentiality.

\begin{itemize}
    \item We know that these barriers manifest differently for men and women, the young and the elderly, for migrants, urban poor and indigenous peoples.
    \item We also know that different groups are impacted in different ways and have different challenges in accessing services.
\end{itemize}

To end TB as outlined in the *WHO End TB Strategy*\textsuperscript{13} and the *Global Plan to End TB 2023-2030*\textsuperscript{14}, we must identify, mitigate, monitor and overcome these barriers – an area that has been historically neglected by the TB response.

Putting people at the heart of the TB response is critical for ending TB. A rights-based and gender-sensitive TB response is both an ethical imperative and a pillar of public health.

Drawing on the *End TB Strategy* pillars\textsuperscript{15}, the *Global Plan to End TB 2023-2030*, *Global Fund Strategy (2023-2028)*\textsuperscript{16} and the Secretary General’s 2020 progress report on implementation of the Political Declaration from the 2018 UN HLM\textsuperscript{17}, community, rights and gender (CRG) can be summarized as ‘the meaningful engagement of TB-affected communities in the TB response; the overcoming of social, economic, policy and legal barriers to TB services; and the application of human rights and gender approaches in planning, implementation, monitoring, evaluation and governance of TB programs’\textsuperscript{18}.

In the Political Declaration of the 2018 UN HLM on TB\textsuperscript{19}, the world committed to:

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\textsuperscript{11} https://digitallibrary.un.org/record/3887628?ln=en, paragraphs 62 (c) and 68.
\textsuperscript{12} https://digitallibrary.un.org/record/1645268?ln=en, paragraphs 18 and 33.
\textsuperscript{13} https://apps.who.int/iris/bitstream/handle/10665/331326/WHO-HTM-TB-2015.19-eng.pdf?sequence=1&isAllowed=y
\textsuperscript{16} https://www.theglobalfund.org/en/strategy/
\textsuperscript{17} https://digitallibrary.un.org/record/3887628?ln=en, paragraph 63.
\textsuperscript{19} https://digitallibrary.un.org/record/1645268?ln=en
○ Promote equity, ethics, gender equality and human rights in addressing tuberculosis (paragraph 33);
○ Reduce (paragraph 14) and end TB stigma (paragraph 37);
○ ‘Recognize the various socio-cultural barriers to tuberculosis prevention, diagnosis and treatment services, especially for those who are vulnerable or in vulnerable situations’ (paragraph 18);
○ Remove ‘discriminatory laws, policies and programmes against people with tuberculosis’ (paragraph 37);
○ Ensure strong and meaningful engagement of civil society and affected communities in the planning, implementation, monitoring and evaluation of the tuberculosis response, in accordance with the principle of social inclusion (paragraph 38).

● As a means of realizing the commitments made at 2018 UN HLM on TB:
  ○ Numerous countries have made progress with tools such as TB Communities, Rights & Gender Assessment\(^2\) and TB Stigma Measurement Assessment\(^2\) that have been implemented, endorsed by National TB Programs and discussed in the UN Secretary-General’s report on progress toward the targets of the 2018 UN HLM\(^2\).
  ○ Numerous countries have conducted, or will conduct, TB CRG Assessments, undertake stigma measurements, develop specific TB CRG Costed Action Plans based on the findings and recommendations of those assessments and integrate those plans into their National Strategic Plans. This process will help to overcome barriers to access by which we will find the ‘missing people’ needed to end TB.
  ○ The following 6 countries are working toward or have finished TB Stigma Assessments:
    ■ Bangladesh (scheduled), DR Congo (in progress), Ghana, Indonesia, Mozambique (in progress), Nigeria.
  ○ The following 35 countries are working on or have completed TB CRG Assessments:
    ■ Bangladesh, Bolivia, Cambodia (in progress), Cameroon, Colombia, Dominican Republic, DR Congo, El Salvador, Ethiopia (in progress), Ghana (in progress), Guatemala, Honduras, India, Indonesia, Kazakhstan, Kenya, Malawi (in progress), Mexico, Mozambique, Myanmar, Nepal, Nigeria, Pakistan, Panama, Paraguay, Peru, Philippines, South Africa, Tanzania, Tajikistan, Uganda (in progress), Ukraine, Vietnam, Zambia (in progress), Zimbabwe (in progress).
  ○ The following 20 countries have developed or are developing TB CRG Costed Action Plans:
    ■ Bangladesh, Cambodia (in progress), Cameroon (in progress), DR Congo, Ethiopia (in progress), Ghana (in progress), Indonesia (in progress), Kazakhstan (in progress), Malawi (in progress), Mozambique

(in progress), Nepal (in progress), Nigeria, Pakistan, Philippines, Tanzania, Tajikistan (in progress), Ukraine, Zambia (in progress), Zimbabwe (in progress).

- The results of this progress have been published in the peer-reviewed scientific literature.\(^{23}\)

- **TB CRG Assessments and development and implementation of TB CRG Costed Action Plans** are the best approach we have to overcoming these barriers.
  - Drawing on established wording presented above, alternative phrasing for ‘TB Community, Rights and Gender (CRG) Costed Action Plans’ could be ‘undertaking an assessment of social, financial, legal and policies barriers to TB services and developing costed plans to monitor, mitigate and overcome identified barriers’.

- The leading mechanism for supporting this work is the Challenge Facility for Civil Society\(^{24}\) grant mechanism.
  - The following 28 countries are Challenge Facility grant recipients:

- It is important to support the proposal for referencing this community financing mechanism, which is included in the Secretary General’s 2020 report on progress toward achieving the targets of the TB HLM, alongside other funding sources.\(^{25}\)

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**Community led monitoring (CLM)**

- Community-led monitoring (CLM), as part of the Multi-stakeholder Accountability Framework (MAF) agreed in the Political Declaration of the 2018 UN HLM on TB\(^{26}\), is a key strategic response to combatting the challenges faced by TB survivors and communities affected by TB and overcoming the bottlenecks to ending TB.

- The Secretary General’s 2020 report on progress toward achieving the targets set in the first Political Declaration on TB specifically reflects on the progress of CLM in 10 countries – which has subsequently grown to 25 countries\(^{27}\).

- CLM provides for comprehensive community empowerment, community engagement and solutions that put people at the heart of the TB response. It empowers people affected by TB with information, ways to engage and report challenges in accessing TB-related services and stigma. CLM also ensures that people using TB services can contribute to strengthening the quality of, and access to, these services.

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The following 28 countries are currently implementing TB CLM:
- Azerbaijan, Bangladesh (scheduled), Belarus, Brazil (scheduled), Cambodia, Cameroon, DR Congo, Ethiopia, Georgia, Ghana, India, Indonesia, Kyrgyzstan, Kenya, Malawi, Mozambique, Nepal, Nigeria, Pakistan, Peru, Philippines, Romania, South Africa, Tanzania, Tajikistan, Ukraine, Zambia, Zimbabwe.

Language related to community-led monitoring was agreed to and included in the 2018 Political Declaration on TB:
- Paragraph 17: ‘…in order to make the elimination of tuberculosis possible, prioritizing, as appropriate, notably through the involvement of communities and civil society and in a non-discriminatory manner, high-risk groups and other people who are vulnerable or in vulnerable situations, such as women and children, indigenous peoples, health-care workers, migrants, refugees, internally displaced people, people living in situations of complex emergencies, prisoners, people living with HIV, people who use drugs, in particular those who inject drugs, miners and others exposed to silica, the urban and rural poor, underserved populations, undernourished people, individuals who face food insecurity, ethnic minorities, people and communities at risk of exposure to bovine tuberculosis, people living with diabetes, people with mental and physical disabilities, people with alcohol use disorders, and people who use tobacco…’ and
- Paragraph 18: ‘Recognize the various sociocultural barriers to tuberculosis prevention, diagnosis and treatment services, especially for those who are vulnerable or in vulnerable situations and the need to develop integrated, people-centred, community-based and gender-responsive health services based on human rights’.

The importance of community engagement and CLM were also recognized in the 2021 Political Declaration on HIV and AIDS:
- Paragraph 64(a): ‘Ensuring that relevant global, regional, national and subnational networks and other affected communities are included in HIV response decision-making, planning, implementing and monitoring and are provided with sufficient technical and financial support’ and
- Paragraph 64(d): ‘Supporting monitoring and research by communities, including the scientific community, and ensuring that community-generated data are used to tailor HIV responses to protect the rights and meet the needs of people living with, at risk of and affected by HIV’.