

CALL TO ACTION 2.0

**A GLOBAL DRIVE
TO SCALE UP
TB PREVENTION**





WHO Civil Society Task Force On TB

US CDC



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A global drive to scale up TB prevention

With 18 months left to reach at least 30 million people with tuberculosis (TB) preventive treatment, as committed by Heads of State at the UN High Level Meeting on TB (UN-HLM) in 2018, there is great urgency to step up health programmatic action. WHO and partners are calling on governments and other stakeholders to keep the promises they made and accelerate coverage of TB preventive treatment for those in need.

TB remains a major cause of disease and death worldwide. TB prevention can save lives and alleviate suffering but is often neglected. The UN-HLM commitments to end TB include a drive to start on TB preventive treatment at least 4 million contacts under 5 years of age and 20 million older contacts, as well as 6 million people living with HIV by the end of 2022. While the target for people living with HIV is expected to have been achieved in 2020, about 22 million contacts have yet to be reached.

Providing TB preventive treatment to reach targets by 2022 will require a massive scale-up of efforts and larger investment. This becomes more relevant given the disruptions in TB care delivery, supply chains and other programme activities due to COVID-19, which add to the urgency. The UN Secretary General in his 2020 Progress Report on TB called for prioritizing and dramatically scaling up access to TB preventive treatment and stronger multisectoral action. It is now urgent for countries and partners to undertake a systematic and invigorated drive to boost the evaluation of people at risk of TB and increase access to TB preventive treatment and other preventive actions.

WHO, civil society and other partners are therefore joining forces to make a strong Call To Action for access to TB preventive treatment to those in need, urging governments to undertake the following actions over the next 18 months:

- Strengthen and finance TB preventive interventions adequately, as a sound investment and in recognition of TB prevention as a human right and entitlement under the rights to health. Achieving the UN-HLM targets for TB preventive treatment alone requires an annual budgetary increase of the order of one third of the US\$ 6.5 billion currently allocated globally for TB activities each year. This would still be well below the US\$ 13 billion considered necessary to fund all TB programme components adequately each year worldwide
- Expand outreach by giving TB preventive treatment to on average 3 people in contact with each person with bacteriologically confirmed TB
- In order to achieve the UN-HLM targets on TB preventive treatment, fully activate systematic screening to find more people with TB and in need of TPT. In addition to people with TB presenting to healthcare services, 6 million more can be found by active TB case finding among household contacts, residents of informal settlements and other high-risk populations.

For this to happen,

countries, civil society and partners need to work together on key actions:



Strengthen TB case finding in household contacts of all ages and other high-risk groups, such as residents of informal settlements, to accelerate progress, in synergy with efforts for COVID-19 pandemic mitigation



Embrace and increase access to WHO recommended diagnostic technologies such as digital radiography, computer-aided detection software, molecular rapid diagnostic tests and tests of TB infection



Rapidly reinforce programme capacity to ensure affordable access to WHO-recommended shorter TB preventive treatment regimens for people of all ages



Apply successful strategies being used in the large-scale roll-out of TB preventive treatment among people living with HIV to increase coverage for all populations in need



Launch a large-scale communication and advocacy campaign to create demand for TB preventive treatment, and to enhance its acceptability among those who need it as well as healthcare providers



Continue to strengthen all key measures that influence prevention, including improved case finding in primary care, TB infection prevention and control, ending stigma, poverty alleviation, social protection and universal health coverage



Partner with and mobilize communities to generate demand for TB preventive treatment and other prevention services, and to strengthen monitoring and delivery systems



Support research and innovation on TB prevention, especially on vaccine development

Situation and progress towards reaching UN-HLM targets

In 2018, Member States at the UN High Level Meeting on Tuberculosis (UN-HLM) made bold commitments to end tuberculosis (TB), including a drive to start at least 24 million contacts of people with TB and 6 million people living with HIV on TB preventive treatment (TPT) by 2022.¹ Achieving these targets, alongside the UN-HLM target on placing 40 million people with TB on treatment in 2018-2022, will bring about major reductions in TB mortality and morbidity and protect families against catastrophic costs. TPT coverage among people living with HIV remains low but it has advanced markedly and is likely to have achieved UN-HLM targets. In contrast, global action to find the missing people with TB and to expand TPT among contacts has remained very slow in 2018-2019 and well below the UN-HLM targets² (Table 1).

Table 1. Progress towards the UN-HLM targets for TPT among contacts, 2018-2022

Indicators	TPT among contacts (millions)	
	under 5 years	5 years & over
Target, 2018-2022	4	20
Reported, 2018-2019	0.8	0.2
Remaining, 2021-2022 (preliminary)	~3	~19

Offering TPT solely to contacts of people with TB presenting to health services routinely will not bridge the gap of 22 million by next year, particularly in the context of the persistent disruptions caused by COVID-19. Active case finding for people with TB and their contacts in communities thus represents an urgent need and a human right for populations at risk.³ In the next 18 months, this will need to detect at least 6 million people with TB, over and above the TB diagnosed among people presenting to primary care. It is feasible to achieve this by screening key risk groups like contacts (about 3 million) and residents of informal settlements in crowded urban settings (about 3 million). The UN-HLM target for TPT would be reached if for each person with bacteriologically confirmed pulmonary TB three contacts receive TPT.

In 2020 the UN Secretary General called for prioritizing and dramatically scaling up access to TB preventive treatment and stronger multisectoral action⁴. Meeting the commitments made at the UN-HLM will require a reinvigorated drive to improve and boost TB screening and diagnostic testing, to evaluate contacts and other risk-groups and to provide TPT.

[1] United Nations General Assembly. Resolution A/RES/73.3. Political declaration of the high-level meeting of the General Assembly on the fight against tuberculosis. In 2018. http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/3

[2] Global tuberculosis report 2020. Geneva, World Health Organization; 2020. (https://www.who.int/tb/publications/global_report/en/)

[3] Implementing the end TB strategy: the essentials (https://www.who.int/tb/publications/2015/The_Essentials_to_End_TB/en/)

[4] United Nations General Assembly. 75th session. Item 132 of the provisional agenda. Progress towards the achievement of global tuberculosis targets and implementation of the political declaration of the high-level meeting of the General Assembly on the fight against tuberculosis. Report of the Secretary-General (A/75/236). In 2020. (<https://undocs.org/en/A/75/236>)

Strengthening the infrastructure for screening and diagnostic testing

The latest WHO guidelines recommend newer and more accurate diagnostics to test for TB⁵. Adoption of better performing testing algorithms for TB diagnosis will also help target TPT services better, in addition to enhancing TB case finding (e.g. by ruling out TB before starting TPT). Investment in the following technologies in particular will enhance the effectiveness of the TPT interventions:

- digital radiography with and computer-aided detection software (CAD) for TB screening and triage
- Molecular WHO-recommended rapid diagnostic (mWRD) like Xpert MTB/RIF® and Truenat® to replace sputum smear microscopy
- serum C-Reactive Protein and lateral flow urine lipoarabinomannan assay (LF-LAM) among people living with HIV
- tuberculin skin testing (TST) or interferon-gamma release assays (IGRAs) to test for TB infection as needed.

[5] TB Knowledge Sharing Platform (<https://extranet.who.int/tbknowledge>)



Scaling up TB diagnosis and screening among populations at risk

In the context of the continuing COVID-19 pandemic, it is paramount for governments and national programmes to reinstate and sustain access to TB diagnosis and treatment services in public and private health sectors. COVID-19 mitigation activities may also synergize with efforts for TB prevention and care⁶. Community mobilization could enhance the return of people with TB to health facilities and routine care.

In addition, TB screening interventions targeted towards populous communities with a high prevalence of undetected TB is expected to increase TB case finding substantively. This Call to Action proposes a focus on contacts and residents of informal settlements in crowded urban settings. However, TB screening should continue to be improved and expanded among people living with HIV, in prisons and other high-risk groups in need. This includes hard-to-reach populations. Such action requires significant investment into case finding approaches that can be deployed in community settings (e.g. mobile vans equipped with digital radiography equipment and CAD, and tests like mWRDs and C-Reactive Protein). This will involve scaling up strategies found to be successful in studies and implementation research. Integrated TB and COVID19 screening and testing could assist in identifying people with TB and those who may need TPT. In the process, action to minimize the stigmatization of contacts and other high-risk groups targeted for screening and TPT is important.

Evaluating contacts for TB preventive treatment

Among household contacts, 50% may have TB infection and as much as 5% or more have TB disease.⁷ Identifying people to start on TPT requires a careful assessment of exposure and the risk to benefit of preventive treatment. Choosing the best suited models of accessing households of TB-affected families and other congregate settings (e.g. prisons, shelters, workplaces) in different settings is important. While this **Call to Action** focuses on expanding TPT massively to contacts, this does not diminish the importance of expanding TPT further among people living with HIV and other at-risk groups in whom coverage remains low⁸.

[6] WHO Information Note: COVID-19 considerations for tuberculosis (TB) care. Geneva, World Health Organization; 2021.

(<https://apps.who.int/iris/bitstream/handle/10665/341126/WHO-2019-nCoV-TB-care-2021.1-eng.pdf>)

[7] WHO operational handbook on tuberculosis. Module 1: Prevention - tuberculosis preventive treatment. Geneva, World Health Organization. 2020. (<https://www.who.int/publications/i/item/9789240002906>)

[8] These include people initiating anti-TNF treatment, or receiving dialysis, or preparing for an organ or haematological transplant, or who have silicosis, as well as prisoners, healthcare workers, migrants, homeless people and people who use drugs.

Successful strategies applied in the rapid, large-scale implementation of TPT among people living with HIV since the last two years should be used to enhance TPT coverage among all people in need. Integrating TPT into existing differentiated service delivery models and community-led services could assist with reaching target households.

Expanding testing of TB infection

Offering TPT to people testing positive for TB infection improves benefit and efficiency and helps reduce treatment hesitancy and improve medication adherence. The UN-HLM in 2018 also recommended rapid scaling up of access to testing for TB infection. In children under five years exposed to infectious TB and in people living with HIV, testing for TB infection before starting TPT is **not** required given the urgency to stop disease progression in these sub-populations. Currently, national programmes have limited capacity to test: quality-assured TST is in limited supply and IGRAs require blood samples to be taken and transported to well-equipped laboratories. In the short term, the unavailability of TST and IGRA should not be a barrier to giving TPT to individuals at high risk of developing TB disease. Nonetheless, overcoming the infrastructural and supply barriers to access TST or IGRA remains important and will also lay the foundation for the swift roll-out of any new improved point-of-care tests for TB infection. Lessons learnt from the recent large scaleup of COVID-19 testing within a very short timeframe may apply to the expansion of tests for TB infection.

Supporting TB preventive treatment

WHO recommends different TPT options that may be better suited to certain target populations, including children and people living with HIV⁹. Transition to shorter, better tolerated rifamycin-based TPT regimens, with better prospects for adherence should be accelerated by national programmes. Rifapentine-containing regimens lasting 4 or 12 weeks can be used in many people in need of TPT.

[9] These treatments are available from the Global Drug Facility of the Stop TB Partnership (<http://www.stoptb.org/assets/documents/gdf/drugsupply/GDFMedicinesCatalog.pdf>)



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Governments, donors, manufacturers and partners must collectively ensure uninterrupted supply of TPT medicines, particularly rifapentine which is currently in short supply. The limited registration of rifapentine in specific regions (e.g. no registered product in Europe), lack of child-friendly formulations, the implications of nitrosamine contamination, and how to make rifapentine-based regimens more affordable should be addressed. Provider hesitancy to support TPT implementation should be urgently addressed through systematic training and capacity building, as well as engagement with professional associations of physicians and nurses. Community-based interventions can help with TPT follow-up and adherence support. A strong communication drive to promote TPT and allay undue concerns about its safety, effectiveness and risk of generating drug resistance should complement other efforts. This could engage popular celebrities and social media.

Monitoring TB preventive action

Monitoring of strategic information on the cascade of TB screening and TPT should be integrated into the national health management information system to track progress at country level and to alert to timely action. Key indicators include the coverage of TB screening and initiation of TPT, adherence and completion of TPT. Governments and donors should promote the use of electronic data management to generate these indicators and to collect other information useful for individual care (e.g. adverse events)¹⁰.

Investing in TB prevention for now and the future

In the last sprint to reach the UN-HLM targets in the next 18 months, collective efforts will be needed through a whole-of-government approach, with additional investments by technical and funding partners according to their various roles. The COVID-19 response has demonstrated what can be achieved with political will and funding. There should be a significant surge in funding and resources to build national programme capacity to ensure access to testing, TPT and other care. It is estimated that to achieve the UN-HLM TPT targets alone, an annual budgetary increase of the order of one third of the US\$ 6.5 billion currently allocated for TB activities by all countries each year will be required. This would still be well below the USD13 billion considered necessary to fund all TB programme components adequately each year worldwide.

Additional resources should aim to ensure that in the coming 18 months the household of every person with TB can be reached, and every contact effectively evaluated. It will require swift alignment of national policies and strategic plans with global guidance, enrolling additional staff, expanding access to appropriate screening and diagnostic tests, strengthening the logistics and supply chain for procuring equipment and consumables, infrastructural development and robust specimen collection and transportation mechanisms, and modernizing record keeping to maximize screening and diagnosis. Investments are also necessary to mobilize communities, strengthen the contribution of community health workers to primary care, implement education and counselling support for affected persons

[10] The WHO Prevent TB application presents a prototype of the data that countries need to collect to generate the main indicators for TB screening and TPT (<https://www.who.int/activities/preventing-tb#app>)

and provide enablers for transport and other necessities. In many settings the private and corporate sectors will need to be involved to accomplish all this. Partnering with social services, child welfare agencies, peer-groups of affected people, civil society and other community-based organizations could widen healthcare coverage.

TB remains a major cause of disease and death worldwide. Without the imminent prospect of an immunizing vaccine that can be quickly scaled up, TPT remains an indispensable component of any comprehensive TB strategy in both high and low TB burden settings. TB screening and TPT need to be accompanied by continued action in other areas critical to end TB, such as TB infection prevention and control, social protection and universal health coverage. Continued implementation of new technologies at a much more rapid pace will be needed to achieve these changes and to invest in more resilient health services systems and primary care services. New technologies emerging from research will also need to be implemented as supported by evidence.

Partners supporting the World Health Organization in this Call to Action: Aurum Institute, American Thoracic Society, Elizabeth Glaser Pediatric AIDS Foundation, European Respiratory Society, FIND, Global Fund to Fight AIDS, Tuberculosis and Malaria, International AIDS Society, KNCV Tuberculosis Foundation, Médecins Sans Frontières, PEPFAR, Sentinel Project, Stop TB Partnership, Treatment Action Group, UNICEF, The Union, UNITAID, US Agency for International Development (USAID), US CDC, WHO Civil Society Task Force On TB.

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