

Item 10. End TB Strategy

Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)
- [Notes of discussion](#)

In focus

In resolution [WHA73.3](#) (2020) the Health Assembly adopted the global strategy for tuberculosis research and innovation. In response to a request in the resolution, the Director-General will submit a report ([EB154/10](#)) on progress in respect of the End TB Strategy, including implementation of the global strategy for tuberculosis research and innovation, for consideration by the Seventy-seventh World Health Assembly, through the Executive Board. The Board will be invited to note the report and provide further guidance.

Background

[Tracker links](#) to previous global GB discussions of TB

WHO TB [activities page](#) and [topic page](#)

Hoffman (2023) '[Tuberculosis and inequality: how race, caste and class impact access to medicines](#)', HPW 16 Dec 2023

UNGA [HLM on TB 2023](#)

PHM Comment

Overview - slow progress

The present report is submitted as fulfilment of the commitment of the DG WHO to report once in two years until 2030, on progress with regard to the End TB strategy. These strategies and the follow up reports are endorsed in the Political Declarations adopted in two high level UN Meeting on Tuberculosis (2018, and 2023) and in two World Health Assembly resolutions (2014, 2020).

The report in its first seven paragraphs covers the targets set under the strategy, the current level of achievement and the trends. These could be summarized as stating that on every indicator the current levels of achievement are far behind what it takes to achieve the objectives. Incidence and mortality continue to be high, treatment coverage stagnates and preventive treatment rises too slowly. A considerable proportion of symptomatic cases are missed. The

objective of 100% financial protection is still far with over half the patients experiencing catastrophic health expenditure (CHE). In drug resistant TB, over 80% experience CHE. No country reports putting in place a comprehensive health and social benefits package though some financial and nutritional support is included in some of the national programs. The use of rapid diagnostic tests that were projected as becoming the first line of diagnostics for 100% of cases, has a coverage of only about 47%. Only two out of five drug resistant TB patients are enrolled in treatment. In terms of funding, the present budget available for TB in LMICs would have to quadruple to meet the target of \$22 billion funding, and as of now over 80% of this funding is coming from domestic financing.

There has been progress on all three strategic pillars but the extent of progress is about half of what was expected. The first of these three pillars is “integrated prevention and care” under which the issue of updated technical guidelines, the scaling up of testing and treatment for tuberculosis as a co-morbidity with HIV and the introduction of a six month all oral regime for tuberculosis in 40 countries are reported. The report notes that the treatment success rate for TB with HIV was only 63%. Under the second pillar the slow rate of progress to UHC and on the adoption of the multi-sectoral accountability framework is reported.

On research and innovation

With regard to the strategy for research and innovation which is termed the third pillar, the report concludes: “Overall, the development of novel tuberculosis vaccines, diagnostics and medicines and critical research projects is advancing slowly mainly due to inadequate funding. The Treatment Action Group reported tuberculosis research and development investment of US\$1 billion in 2021-2 far below the United Nations global target of US\$ 5 billion per year by 2027.” PHM notes that the projection of how the End TB strategies would be achieved included assumptions that a new range of technologies would be introduced that would improve outcomes. Of this the greatest expectation was the vaccine. Though work is underway, these timelines are clearly unrealistic.

On the area of social consequences, especially the target of 100% coverage with health and social benefits package, there is no mention of what is the coverage achieved or even of how many countries have put in place any package. This is particularly unfortunate because some recent studies published in Lancet have demonstrated that nutrition supplements lead to better patient outcomes and prevent the development of disease in contacts ([Bhargava et al. 2023a](#) and [Bhargava et al 2023b](#)).

Reasons for the slow progress

The positive feature of the report is its clarity in describing the current situation. Its weakness is in the lack of any analysis on why progress is so limited in most countries. One reason for the poor progress that the report does highlight is the set-back due to disruption of services due to the pandemic. However specific measures to prevent such disruptions in the future are not mentioned.

One reason for not being able to go to scale with new technologies are problems related to supply chain and intellectual property rights. The report acknowledges this. To quote: "Wider availability of these (new) regimens requires improving supply and access to the drugs central to them, including through approaches that harmonize the interplay between trade, intellectual property and health." However it lacks a clear commitment by WHO to intervene in the current trade and IPR regime or with the big powers to achieve such a harmonization. These barriers present to the program as reports of stockouts of anti-TB drugs for both preventive treatment and for active disease. The stockouts of drugs for drug resistant tuberculosis is a matter of deep concern. Many of the drugs meant for MDR & XDR TB are under patent and the high prices are unaffordable for governments as well as civil society organisations working in the area of tuberculosis care. Though there are provisions under TRIPS flexibilities it is difficult to use these. A TRIPS waiver on the lines of what was put in place for the Covid pandemic would be very useful.

Similarly the failure to shift from sputum microscopy to rapid molecular testing as the first line of TB diagnostics and further add in genomic testing for multi-drug resistance in all cases put in treatment, while welcome would require considerable health systems strengthening and financial support to be scaled up.

Addressing the two main causes of persistence of the TB epidemic

Whereas the introduction of new technologies and deploying them on scale is most welcome, these do not address the two main causes of persistence of the TB epidemic despite so many periodic strategy changes.

The first challenge is the need to strengthen and universalize access to primary health care so that fewer cases of infectious tuberculosis are missed and so as to ensure follow up and medication compliance. Recent prevalence studies across nations indicate that as many as 50 percent of those with symptomatic lung tuberculosis may not have sought appropriate care. Whereas active case finding will help, this needs to be done as part of routine work where health workers are in close solidarity and support of all families through regular visits, rather than a reliance on sporadic campaigns. Technology improves care for those who have entered the care cascade but does not touch the problem of the many who have not entered it.

The second major requirement is effective action on social determinants taken to scale. This is not a sectoral issue. It is a whole of government approach that chooses a path of development that would reduce inequities and include welfare measures that proactively reach out to the poorest and most marginalized.

Governments must choose programmes and development pathways that eliminate hunger and malnutrition in the entire population. Both pandemics and wars aggravate the food crisis and create nutrition insecurity. Climate changes worsens with respect to food production, procurement and distribution. Mitigation and adaptation strategies that address these crises.

Other social determinants that inter-sectoral action can address are housing (overcrowded shelters), poor working conditions with low wages, and occupational lung disease. While

introduction of new technologies are welcome, the impression created that one could eliminate the disease without addressing social determinants is not likely to work for tuberculosis. It may have worked for small-pox or for Covid, but not for tuberculosis.

In conclusion

The final outcomes are going to be largely dependent on these two areas of intervention. In the absence of addressing these two dimensions, the introduction of a new round of much costlier technologies is only going to occupy a larger part of the available public health budget, giving medical industry higher profits, but with the persistence of slow progress towards objectives that this report presents.

It is possible that the introduction of an effective vaccine could change the above narrative. It is equally possible that it would not. But we are not there yet.

Notes of discussion

MSF statement on EB154/10 - End TB Strategy

<<https://msfaccess.org/msf-statement-eb15410-end-tb-strategy-0>>