TB PEOPLE

INPUD
International Network of People *who* Use Drugs

Stop TB Partnership

Joint position paper

TB AND PEOPLE WHO USE DRUGS – A CALL TO ACTION

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Acknowledgments

In line with the Memorandum of Understanding, signed between INPUD, International Network of People who Use Drugs, and TBPEOPLE, the global network of people affected by tuberculosis (TB), the two networks committed to "collaborate on raising the profile of the problem of TB among people who use drugs including the impact of prohibition and systematic discrimination of people who use drug to regard to the promotion of integrated people-centered services for people who use drugs and are affected by TB". As a first step, the two networks agreed to develop a joint position paper on TB among people who use drugs, which will lay the foundation for future advocacy and programs.

This position paper was developed by a joint TBpeople-INPUD working group, consisting of Timur Abdullaev, Mauro Guarinieri, Dilshat Haitov, Jude Byrne, Prashant Sharma, Ruth Birgin, and Samson Karume. Judy Chang (INPUD), Paul Thorn (TBpeople), and James Malar, Brian Kaiser and Viorel Soltan (Stop TB Partnership) provided invaluable inputs. The development of the position paper became possible with the financial support of the Stop TB Partnership`s Challenge Facility for Civil Society (Round 9).[1]

Photo on the cover: Pavlo Khodymchuk, Instagram: @maysternya_svitlopysu.

1 This position paper was finalized in late 2021, before the beginning of the war in Ukraine. However, it recognizes that wars and other armed conflicts, as well as any other emergencies, further increase vulnerability of people who use drugs. It is therefore essential that in such situations extra efforts are taken to mitigate the impact on access to essential services for all vulnerable groups, including people who use drugs.

When we listen to the voices of people and communities affected by TB, we are reminded that ending TB is not just about ensuring access to health services. It's also about defending human rights. As you know, TB is deeply rooted in populations where human rights and dignity are threatened.

Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

INTRODUCTION

Tuberculosis (TB) is individually devastating as well as being a threat to global public health. Although TB is preventable and curable, it is among the world's deadliest infectious diseases. In 2020, approximately 1.5 million people died from TB and 10 million more fell ill with it.[1] The World Health Organization (WHO) has emphasised that as a result of COVID-19 the numbers of deaths are likely to significantly increase.[2]

TB thrives in places where inequality and poverty are widespread, living quarters are cramped and poorly ventilated, healthcare systems are weak, people are malnourished and subject to stigma, discrimination and incarceration – all of which are common experiences among the global community of people who use drugs.

TB is a threat to the health and well-being of people who used drugs. According to the WHO, TB rates among people who use drugs are up to ten-fold higher than those among the general population.[3] People who use drugs are also particularly vulnerable to HIV (which increases the risk for and worsens TB) and viral hepatitis (which is associated with poor TB treatment outcomes).[4]

Thirteen of the twenty completed TB Communities, Rights and Gender Assessments completed in mostly TB high burden countries have also identified people who use drugs as a priority TB key and vulnerable population requiring resources and nuance in policy and programming.[5] A range of structural, legal, social, economic and other barriers create and enhance health disparities, including TB, among people who use drugs. These include – and are driven by – criminalization of personal drug use and the resulting high rates of imprisonment, which fosters transmission of TB, HIV, and hepatitis C virus (HCV).[6] Restrictive policies at health services, inadequate access to, and coverage of harm reduction services, and the lack of integrated, low-threshold health services contribute to endangering the human rights, health and well-being of people who use drugs.

In some countries people who use drugs are in practice excluded from treatment on the grounds that they are active drug users, or because they are unable to continue opioid agonist therapy or drug use during TB treatment. This position paper calls for capacity building for drug user networks to advocate on TB issues and for much greater and urgent attention to TB testing and treatment access for PUD.

In the context of COVID-19 these human rights related barriers have continued to increase. People who use drugs have also found barriers to work during that pandemic, as many industries, both formal and informal, slow or close, and with that comes enhanced insecurity of food and shelter.[7] Accompanied by reduced access to health and social protection services, and the competing demands on health infrastructure and human resources, has placed unprecedented stress on the community of people who use drugs. The TB civil society report, *The impact of COVID-19 on the TB response: A community perspective,*[8] further supports these reflections, including: 70% of surveyed health workers reporting a reduction in the number of people seeking TB services, 75% advocates from Global Fund eligible countries report an increase in barriers to accessing services, 69% of respondents from Global Fund eligible countries reporting insufficient personal protective equipment, 57% of TB researchers reporting they did not have the required resources to continue their research during the pandemic, and over half the respondents reporting funding and human resources being diverted from TB to COVID-19.

The high TB prevalence, morbidity and mortality rates among people who use drugs call for an urgent response, and the necessary data to fully resource it. Two communities have joined forces to address these issues: the community of people affected by TB, and the community of people who use drugs.[9] They are fighting for rights - and evidence-based TB policies, programs and services which are adapted to the needs of people who use drugs.

INTERNATIONAL TB STANDARDS, POLICY DOCUMENTS, AND GUIDANCE

Existing policies, standards and guidelines include measures for TB services that will reach people who use drugs. These resources can be used for advocacy campaigns and to mobilize resources for programming that integrates TB services into harm reduction programmes. For example, the 2018 *Political Declaration from the United Nations (UN) High-Level Meeting (HLM) on Tuberculosis* recognizes that "…poverty, gender inequality vulnerability, discrimination and marginalization exacerbate the risks of contracting tuberculosis and its devastating impacts… such that the disease requires a comprehensive response, including towards achieving universal health

coverage and one that addresses the social and economic determinants of the epidemic and that protects and fulfils the human rights and dignity of all people."[10] It explicitly mentions people who use drugs, calling for "effective people-centred and community-based models of care supported by integrated care services."[11]

The Global Plan to End TB 2018-2022 is a costed blueprint for achieving global targets to end TB. It calls attention to key populations (people with increased exposure to, and risk of TB, who have limited access to quality TB services), including people who use drugs, specifying that a "… harm reduction approach is critical for providing rights-based TB care for people who use drugs."[12] In addition, *The Global Plan* underscores the need to ensure meaningful involvement of key populations in the design, delivery and evaluation of TB services, and provides model investment packages which will enable countries to achieve the 90-(90)-90 targets (see Figure 1).

Figure 1. The three people-centred 90-(90)-90 targets

The WHO produces and updates TB guidelines, including programmatic and operational guidelines,[13] which are used by countries, donors and other partners to guide their TB responses. TB prevention, diagnosis, care, treatment and support are core components of internationally endorsed, cost-effective and evidence-based harm reduction services, as described in the 2016 consolidated guidelines, *Integrating Collaborative TB and HIV Services Within a Comprehensive Package of Care for People who Inject Drugs.*[14]

The 2021 TB community report, *A Deadly Divide: TB Commitments vs TB Realities*,[15] reiterates the need to adopt an inclusive, equitable, rights-based and gender transformative TB response, at the heart of which are calls for increased investments to ensure the meaningful participation and empowerment of

vulnerable populations, such as people who use drugs. Achievement of the UN HLM on TB targets and commitments will require operationalising the six calls to action, including leveraging COVID-19 as a strategic opportunity to end the TB pandemic.

WHAT DOES THIS MEAN FOR PEOPLE WHO USE DRUGS?

Stigma

Eliminating TB will be impossible if people who use drugs are left behind. Therefore, it is essential to address the pervasive stigma they face in communities, workplaces and healthcare settings, which prevents them from obtaining timely and quality TB prevention, diagnosis, treatment, care and support. Negative attitudes about people who use drugs are common among healthcare providers: people who use drugs report denial of care or substandard care, mistreatment and feeling dehumanized, distrustful and frustrated in healthcare settings; this leads them to delay or avoid healthcare.[16] Women who use drugs are often subject to additional stigma when seeking healthcare, and have even less access to TB and other services than their male counterparts.[17]

Criminalization

Stigma and discrimination are deeply rooted in criminalization of personal drug use, which society uses to justify unacceptable treatment of people who use drugs.

The most critical intervention for reducing vulnerability, stigma and marginalization among people who use drugs is to decriminalize personal drug use and possession. Punitive legal frameworks have disastrous consequences for people who use drugs. They create a substantial barrier to housing and employment – and even basic liberty – as well as essential harm reduction, medical and social services. Criminalization of personal drug use leads to frequent imprisonment in overcrowded correctional facilities, compulsory drug treatment centres and other closed settings where TB is rampant, and prevention, testing, treatment, care and support services are suboptimal.

People who use drugs in prisons and other closed settings are 26 times more likely to become infected with TB than people outside of these settings; once this happens, they are 23 times more likely to develop active TB disease than people who use drugs who are not in these settings.[18] While in prisons or closed settings, people who use drugs should be provided with quality, rights-based and WHO-recommended integrated harm reduction and healthcare services, including systematic TB screening.

In some contexts, COVID-19 has exacerbated criminalisation of people who use drugs. While no exact data is available, it was reported by INPUD members that, because of lockdowns and arrests of people in the streets, people who use drugs were stockpiling drug supplies to stay safe, putting them at greater risk of criminal sanctions and higher penalties.[19] For people who use drugs living on the streets, it has not been uncommon to be rounded up, beaten and harassed by law-enforcement officials or sent involuntarily to 'quarantine camps.'[20]

TB Services for People Who Use Drugs

Although people who use drugs are considered to be a key population for TB, they are often members of other key population groups, which increases their vulnerability and the stigma, discrimination and criminalization directed towards them. Stigma-free, low-threshold TB programmes need to adapt to various cultural and linguistic needs of people who use drugs, who may be detainees/prisoners, refugees, migrants, ethnic minorities, inmates at rehabilitation programmes or homeless. TB services must adopt and embrace gender-sensitive and gender-affirming policies, programmes and interventions that meet the needs, priorities and preferences of women and lesbian, gay, bisexual, transgender and intersex people who use drugs.

COVID-19 has further reduced access to TB care, opioid agonist therapy (AOT) and social support services and contributed further barriers through lock downs and limitations on operating hours and shifts in human resources from a range of health areas into COVID-19.[21] Initiatives such as teleclinics[22] are being implemented provide some respite to some of these areas they do not address all of the problems. In addition, harm reduction services must be considered essential services and efforts for their safe continuation must be prioritised.[23] Also, it should be taken into account that TB is not a counterindication for COVID-19 vaccination;[24] however, as of the end of 2021, WHO did not issue clear recommendations on the vaccination among people who use drugs.

Resources and Data

It is crucial to allocate sufficient human, technical and financial resources to capacitate people who use drugs as a key population in the fight against TB. Networks of people who use drugs have successfully influenced communities and governments; their meaningful involvement in national dialogues has overcome barriers, increased resources, and improved service access, uptake, reach and quality.[25]

Advocacy for evidence-based, quality TB services for people who use drugs requires more robust data. To inform service delivery and allocation of resources, information, TB data needs to be disaggregated by: drug use status,

gender and TB prevalence among people who use drugs (including those who are imprisoned), to inform resource allocation and service delivery. People who use drugs can and should play an important role in collecting data, monitoring commitments and building this evidence base. Nonetheless, until such data are available, it is clear that additional funding is needed to ramp up access to, and coverage of harm reduction – and for building TB advocacy capacity and integrating TB services. Growth of harm reduction programmes has been largely stagnant since 2014; a 90% funding gap for these services exists in low-and middle-income countries where drug use is prevalent and 95% of all TB deaths occur.[26]

GOOD PRACTICE APPROACHES

Successful integration of TB and harm reduction programmes requires 'meeting people where they are,' – meaningfully including people who use drugs in decision-making, program and project design, implementation, and delivery and monitoring of services, and by abolishing restrictive policies that have a profound and negative impact on health-seeking behaviours.

As they seek to integrate TB services, harm reduction programmes should continue to collaborate closely with networks of people who use drugs, who bring valuable knowledge and experiences, and can inform development of programmes, services, policies, optimal use of resources, and advocacy priorities and strategies.

While advocating for full decriminalization of personal drug use and drug possession, activists can fight for full resourcing and deployment of WHO-recommended, simple, rapid tools to diagnose TB – including drug-resistant (DR) forms – and shorter, user-friendly regimens for latent TB infection (LTBI) and DR-TB for people who use drugs, including:

- Testing for LTBI with reliable assays that provide results quickly and minimize the risk of people falling out of care;
- Shortest, most effective treatment regimens for LTBI with close monitoring of drug interactions;
- Appropriate TB screening when people who use drugs interact with the health system (e.g., four symptom screen, digital X-ray ideally with computer-aided detection, molecular WHO-recommended rapid diagnostics, C-reactive protein tests for people living with HIV);
- Initial diagnostic testing with molecular WHO-recommended rapid diagnostics, such as GeneXpert MTB/RIF Ultra, or TB-LAM (for people with AIDS and/or who have a serious illness and/or a CD4 cell count of <100 cells/mm3), rather than smear microscopy, which is less reliable for people living with HIV;

- Additional drug resistance testing in people with rifampicin-resistant TB;
- Shortest, most effective treatment for drug-susceptible TB that is delivered, whenever possible, in outpatient settings with preference given to using fixed dose combinations;
- Shortest, most effective all-oral treatments for people with drug-resistant forms of TB that minimize the risk of drug interactions;
- Proper counselling, psychosocial, nutritional, and financial support;
- Monitoring for hepatotoxicity and other adverse events associated with TB treatment (including heart rhythm irregularities from bedaquiline, fluoroquinolones, clofazimine, pretomanid, delamanid, especially when used with methadone);[27]
- Prevention, testing, care and treatment for HIV and hepatitis B (direct-acting antiviral treatment for HCV should be offered after TB treatment, since drug interactions prevent both from being administered at the same time);
- Sexual and reproductive rights and health services, including prevention, testing, care and treatment for sexually transmitted infections;
- Ongoing provision of opioid treatment programmes (including averting withdrawal symptoms by titrating buprenorphine and methadone dosing to adjust for drug-drug interactions with rifampicin/rifapentine/rifabutin during TB treatment, and after its completion),[28] needles and syringes, and naloxone;
- Avoid linezolid in persons receiving methadone or buprenorphine to avoid adverse drug interactions.

PRIORITIES FOR ADVOCACY

TB will never be eliminated if people who use drugs are left behind - forcing them into health services where they are stigmatized and receive substandard care is not acceptable. Decriminalization of personal drug use is essential to ensuring the meaningful and unhampered participation of people who use drugs, improving their health outcomes and achieving goals and targets to end TB. Additional advocacy priorities include working to:

- Develop, fully fund, implement and monitor integrated, people-centred, gender sensitive, evidence-informed and rights-based TB and harm reduction responses, as recommended by the WHO;
- Donors should consider quality issues and task shifting for greater peer involvement among harm reduction service providers in order to facilitate TB service integration;

- Promote and resource meaningful involvement from PUD in the design, delivery, monitoring and evaluation of TB services;
- Advocate for rapid molecular diagnostic tests to be used in TB testing among people who use drugs (and everyone for that matter);
- Build political will by engaging policy makers, Ministry of Health and governmental support for integrated harm reduction and TB services for people who use drugs to ensure their inclusion in national budgets, plans, guideline development, collaborative networks and coordination mechanisms.
- Close data gaps and delays on TB incidence and prevalence, TB disease and TB mortality and barriers experienced in access TB services among people who use drugs;
- Advocate that donors and technical partners prioritise technical assistance and investment for TB services for people who use drugs - including through Global Fund country grants, Global Fund Strategic Initiatives (including Strategic Initiatives on Communities, Rights and Gender, Finding the Missing People with TB, and Community-Led Monitoring) and the Stop TB Partnership Challenge Facility for Civil Society, TB REACH, and USAID Local Organization Networks (LON) to identify opportunities for integrating TB services with harm reduction;
- Foster co-development of National Drugs Strategy Programmes and National HIV and TB Strategic Plans to facilitate integrated TB and harm reduction programmes for people who use drugs;
- Encourage donors to recognize the importance and value of community and peer workers, and allocate resources to build their capacity to deliver integrated TB and harm reduction services - and fully and fairly compensate them and protect them with PPE;
- Ensure that opioid treatment programmes are offered and available in a people-centred manner to all opioid-dependent people with TB;
- Ensure flexibility in OAT dosing and/or TB regimen for OAT clients receiving TB treatment;
- Guarantee that all people who use drugs and who have TB have access to needle and syringe programmes;
- Ensure that people who use drugs are enabled to receive TB care, regardless of drug use;
- Conduct research on drug interactions between bedaquiline, delamanid and pretomanid, as well as medicines used in TB preventive treatment with opioid substitution treatment and apply relevant results to ensure flexible dosing of opioid substitution treatment;

- Implement TB/COVID-19 bidirectional screening and testing among people who use drugs;
- Develop integrated stigma reduction interventions that incorporate issues of TB, COVID-19 and are nuanced to the needs and experiences of people who use drugs;
- Advance comprehensive social protection policies inclusive of people who use drugs, including mental health support, nutritional support, housing support, legal aid and income support, both in the context of the COVID-19 pandemic, but also after the impacts of the pandemic have been mitigated;
- Promote peer awareness raising, TB literacy, and screening skills in non-literacy dependent formats as needed (use of visual prompts, IEC, videos and phone apps).

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