EDITORIAL

Addressing the challenges of TB diagnosis in the COVID era

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Ten million people fell ill with TB worldwide in 2019, of whom 1.4 million died, and 2.9 million were not notified, or not diagnosed¹ and therefore continued transmitting the disease in the community. Sustained action against TB, including optimised uptake of best practices, is critical,² particularly as the Covid-19 pandemic threatens the progress made over recent years.¹ Within the Covid-19 pandemic, health access has been affected by, among others, the redirection of staff, resources, and facilities, the curtailment of movement, the stigma and fear of Covid-19, and the loss of income from business closures and salary reductions.^{1,3}

Mwamba et al.'s study among recently diagnosed TB patients, in this issue of *Public Health Action*, illuminates the dynamics arising within the intersection of personal, social, and structural factors in a high TB- and Covid-19 burden, low-income setting.⁴ Their participants recount anxieties related to worsening economic precarity, the virulence, high transmissibility and taxing isolation requirements of Covid-19,⁵ and reduced access to and quality of healthcare. The participants had been ill prior to the Covid-19 pandemic, and most were therefore not concerned when seeking care for their illness; rather, they wanted to improve but also know what else could be wrong. However, they were concerned about contracting Covid-19 during clinic visits.

Unlike Covid-19, TB is curable and has preventive therapy.² It is, however, similarly serious and virulent,¹ and additionally heightens the risk of worse Covid-19 outcomes.⁶ The scenario of being confronted with two severe, similar yet different, and interacting diseases, and being confirmed with one (TB) and ill prior to the other (Covid-19) amid drastic disruption of social relations, growing omnipresent precarity and reduced access to social and economic support structures entailed ambivalence. Concern was thus expressed about contracting Covid-19; nevertheless, there was also trust in preventive measures at healthcare facilities, as well as fatalism regarding Covid-19 at the same time.

Limitations of Mwamba et al.'s study include the non-incorporation of a gendered analysis, and the possibility people not diagnosed with TB might approach healthcare engagement differently, perhaps avoiding it until too late.⁶ Having said this, efforts to address TB diagnosis in the Covid-19 era must be cognizant of the dynamic interaction of several factors at different levels and in different domains of social organisation and relations. How the factors and processes influence the TB-Covid-19 syndemic within and across contexts needs to be understood and factored into policy responses and public health messaging. Some general recommendations, echoed too by Mwamba et al., include facilitating early TB diagnosis through easing access and avoiding long waiting times at facilities, carrying out integrated contact tracing, making use of digital technologies, and implementing messaging that reassures regarding infection control measures at health facilities. The Covid-19 pandemic may also be a pivotal moment to re-emphasise the message that TB is curable, particularly when diagnosed early. All these actions will need to be backed by a broader policy strategy that intensifies infection control, minimises Covid-19-related disruptions to health systems, and comprehensively addresses the needs of groups experiencing special vulnerability to Covid-19, TB, and social and health inequity more generally.

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