

Impact of Member State Representation at UN High Level Meeting on Country Progress

Background

In 2018, the UN General Assembly hosted the first UN High Level Meeting (HLM) on the Fight Against Tuberculosis. In the run up to the event, the TB community placed significant emphasis on securing high-level representation during the meeting itself. This was motivated by the understanding that a meeting attended by Heads of State and Government would build vital political momentum, ensure an ambitious political declaration, and lay the foundation of robust implementation thereof.

A follow-up UN HLM is set to take place in 2023, in a political landscape marred by the COVID-19 pandemic. Simultaneously, two further, much broader health-related HLM's are set to take place in the same year (Universal Health Coverage and Pandemic Preparedness & Response). In this context, securing high-level political commitments, let alone attendance at the meeting itself, will be especially challenging.

Noting the significant effort required to secure high-level representation at meetings of this nature, this paper seeks to establish what impact, if any, this has on country progress towards ending TB.

Methodology

Country representation was based on speakers in the plenary of the 2018 UN High Level Meeting on TB. While some countries sent additional representatives to participate in individual panels, these were usually represented by more senior speakers in the plenary.

High-burden country progress was measured via data reported to WHO's Global TB Report:

- TB case finding: average percentage change in the proportion of estimated positive cases that were diagnosed and notified, between 2018 and 2021.
- TB budgets: average percentage change in reported domestic TB budget, between 2018 and 2022.

High-income country progress was measured via:

- Global Fund Pledges: average percentage change in pledge amount (USD) across 2016, 2019 and 2022 replenishments.¹
- R&D Investment: average annual percentage change in reported TB R&D investment (USD) between 2017 and 2022.²

¹ This data is taken from the Global Fund to Fight AIDS, TB and Malaria's post-replenishment reporting. To be included in the analysis, countries must have pledged (or announced a formal USD 0 pledge) in all 3 replenishments. The UK and Italy were not included in the analysis for this reason, as their 2022 pledges have not been announced.

² This data was taken from Treatment Action Group's annual reports on TB research funding trends. Data is self-reported. Countries needed to have reported data in at least 3 out of 4 years to be included in the analysis. It should be noted that reporting quality is variable here, which may result in pre-existing funding mechanisms that are reported to TAG for the first time being counted as 'new' money or non-reporting being counted as a funding drop.

To minimise the effect of short-term increases or decreases in funding or case notifications, we have focused the analysis below on trends (i.e. average percentage change over multiple years). Where countries did not report data or did not report enough data to establish a clear trend, they were excluded from the analysis. The analysis was completed using Microsoft Excel.

Results

High Burden Countries

The below table demonstrates that the seniority of representation at the 2018 UN HLM is not a significant predictor of high-burden country progress on TB.

HBC UNHLM Representation	Case Finding Progress ³	Domestic Budget Change
Head of State or Government	-2%	+191%
Minister	-20%	+43%
None	-3%	+743%
Other ⁴	-26%	+16%

We can also look at the 10 best and worst performing countries against each indicator.

Of the 10 countries who made the greatest progress on increasing case notification in percentage terms over the 2018 baseline, eight (80%) did not have any senior representation at the UN HLM.⁵ The remaining two were represented by their Head of State or Government.⁶

Meanwhile, of the 10 countries who performed the worst on the same measure, the majority (70%) had senior representation at the UN HLM, with three Heads of State or Government⁷ and four Ministers⁸. Only 3 (30%) did not have any senior representation at the UN HLM.⁹

On the other hand, of the 10 countries who increased their domestic investment in TB most significantly, six (60%) were represented by senior government officials, with three Heads of

³ While the COVID-19 pandemic has had a significant impact on case notifications, we can reasonably assume that countries more committed to ending TB were able to limit its impact and recover case finding efforts more rapidly.

⁴ Indonesia's Vice President & China's First Lady

⁵ Zambia, United Republic of Tanzania, Uganda, Guinea, Guinea-Bissau, Democratic Republic of Congo, Bangladesh and Ethiopia.

⁶ Nigeria and Central African Republic.

⁷ Lesotho, Indonesia and Zimbabwe.

⁸ Myanmar, Botswana, Tajikistan, and Mongolia.

⁹ Kyrgyzstan, Belarus and Kazakhstan.

State or Government and three Ministers.¹⁰ However, the three countries not represented by senior actors were in the top 5 for budget increases.¹¹

High-Income Countries

For high-income countries, high-level representation at the UN HLM was a much better predictor of progress on R&D investments but did not appear to relate to the country's contribution to the Global Fund to Fight AIDS, TB and Malaria.

HIC UNHLM Representation	GFATM Pledge Change	R&D Investment Change
Minister	30%	29%
None	30%	2%

It should be noted that only 19 high-income countries sent a minister to attend the HLM. Of these, only 11 consistently pledged at Global Fund replenishment conferences and only 10 regularly reported R&D investments to Treatment Action Group. This indicates that high-level representation at a UN HLM does not necessarily translate into a commitment to playing one's part in the international fight against TB.

Only 21 high-income countries have consistently pledged to the Global Fund to Fight AIDS, TB and Malaria. Of the five countries who have increased their commitments most substantially, only two (40%) were represented by a minister.¹² This is equivalent to the two ministers¹³ among the five countries who reduced their commitment to the Global Fund most substantially.

Only 15 high-income countries have consistently reported TB R&D spending. Of the five countries who increased their investment in TB R&D most significantly, 4 (80%) were represented by a minister.¹⁴ While high-level representation may therefore be a better overall predictor of TB R&D investment rises, two of the five countries who decreased their investment since the UN HLM were also represented by ministers.¹⁵

Discussion

The above analysis reveals no clear correlation between the attendance of a senior political figure at the UN HLM on TB in 2018 and the rate of subsequent progress against the disease or financial commitment to the global effort. Nor is there clear evidence suggesting that the seniority of the individual representing a country (Head of State/Government vs Minister) represents greater political commitment, as represented by more domestic spending or progress on case notification.

¹⁰ Lesotho, Sierra Leone and Mozambique were represented by Heads of State or Government, and Ukraine, Myanmar and Mongolia by Ministers.

¹¹ Uganda, Bangladesh and Angola.

¹² Republic of Korea and Spain.

¹³ Norway and Australia.

¹⁴ Denmark, France, United Kingdom and Australia..

¹⁵ Norway and Ireland.

This is not to say that having high-level representation isn't important. The indicators that we have assessed are somewhat confounded by COVID-19, and by focusing on percentage rate of change between 2018 and 2021 levels, countries that were performing particularly poorly in 2018 rank highly in our data. It is possible that examination of other indicators or reviewing the data in different groupings might reveal evidence not captured in our analysis. However, we consider it unlikely that such analyses would result in dramatically different conclusions.

That there appears to be limited correlation between senior level attendance and subsequent progress against TB does not, by itself, imply that senior political leadership through the HLM process is not important. Engagement of Heads of State and Government can be powerful in many ways, without their physical presence being necessary. For example, through encouraging a more ambitious Declaration, through peer accountability, and by positioning champions to negotiate for their regional blocs and carry the HLM agenda forward into subsequent regional forums.

Through our analysis, we have identified a number of countries that have made significant progress and could be engaged, on that basis, to act as champions for the HLM process. There are 18 countries in which the annual TB budget doubled in the period we considered: Uganda, Cote D'Ivoire, Lesotho, Bangladesh, Rwanda, El Salvador, Ukraine, Guatemala, Angola, Belize, Tajikistan, Central African Republic, Congo, Sierra Leone, Mozambique, Tanzania, Myanmar, and Yemen.

Likewise, ten countries have seen case notifications rise by more than 20% (in both metrics, part of the scale of the percentage change could be due to low starting numbers): Nigeria, Saint Lucia, Zambia, Tanzania, UK, Syria, Uganda, Guinea, Niger, South Sudan.

In relation to R&D spending Denmark, France, Colombia, Brazil, and Philippines have seen large spending increases and Republic of Korea and Qatar stand out for larger Global Fund pledges.

Whilst some of these countries may not be ideal political champions for geopolitical reasons, some clearly could be flagbearers for their regions and there is a strong narrative for asking them to be so, particularly Tanzania and Uganda who appear on both lists. Early, tailored, outreach from a range of stakeholders to the Heads of State/Government of these countries, inviting them to act as champions on the basis of their progress since the last HLM, would be a worthwhile use of resources.

This could be accompanied by targeted outreach to larger countries with greater ODA budgets and large burdens of TB, aiming for attendance and/or focusing on securing support for (or non-opposition to) relevant key asks, as determined in collaboration with local civil society partners.

Overall, the purpose of a HLM is to elevate the conversation about TB care and prevention from a technical level to a political level and in doing so, unlock new resources and renewed efforts. The HLM plenary itself is an important part of that process, but only part of the process. Our analysis should offer some reassurance that the competition of other, high-

profile, health HLMs, in Leaders' Week and the impact that may have on Head of State/Government attendance at the TB High-Level Review will not fatally undermine the impact of the process.¹⁶

¹⁶ Similarly, it does not mean that if the modalities resolution on the High-Level Review places the meeting in June or at another time of the year then the process has less value.