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EDITORIAL

TB nurses are key partners in building a TB-free world

SUMMARY

TB nurses make up a significant portion of the global TB workforce, playing a pivotal role in bridging biomedical, clinical, public health, and community perspectives, yet their expertise remains under-recognised in policy, research, and leadership. Limited professional recognition, exclusion from decision-making, and barriers to research constrain the contribution of TB nurses. Leveraging the expertise of the TB nursing workforce could drive further innovation but requires formal recognition of TB nursing as a speciality, greater representation in governance, expanded research and leadership opportunities, and stronger professional networks. Recognising, resourcing, and empowering TB nurses is essential to delivering equitable, effective TB care.

KEY WORDS: tuberculosis; nursing; workforce; model; relational care

Biomedical advances have transformed the diagnosis, treatment, and prevention of TB. Yet, technical innovations alone have not been sufficient to end the global TB epidemic. Achieving TB elimination requires health systems capable of delivering care that is continuous, trusted, locally adapted, and responsive. The need for a more comprehensive, person- and family-centred approach that acknowledges the social-cultural, economic, and structural determinants of TB is now widely acknowledged.[1,2] TB nurses are integral partners in the multidisciplinary effort to eliminate TB, beyond the operationalisation of biomedical elimination strategies.[3,4] However, the contribution of TB nurses remains under-recognised and as leaders in global efforts towards TB, their expertise is under-utilised. This editorial outlines how the global TB community can better leverage TB nurses to drive innovation that is needed to shape efforts towards a TB-free world.[5] A well-trained and motivated TB nursing workforce is essential to translate biomedical guidance into feasible, person-centred care by bridging the clinical, public health, and socio-cultural contexts. Specialised nursing expertise is required to navigate the complex, longitudinal nature of TB care. TB nurses often support people with TB from first contact with the health system, through diagnosis and treatment, and then post-treatment follow-up. Working closely with people living with TB and their families, in homes and communities, TB nurses are often the first to recognise and respond when technically sound interventions are inaccessible, unacceptable, or misaligned with local realities. TB nurses' deep connections and contextual knowledge places them at the core of person-centred care delivery.

Working alongside a range of Community Health Workers, TB nurses foster trust between patients, families and communities, and the health system.[6] The privileged position TB nurses hold affords the potential to identify, understand, and address systemic factors such as discrimination, stigma, and social, cultural, and geographic barriers to care.[7] Through these relational practices, TB nurses can operationalise the principles of equitable person-, family-, and culture-centred care that are central to contemporary strategies for TB prevention and care.[8] In many settings, nurses make up the largest contingent of the TB workforce and make substantial contributions to clinical care, public health management, and programmatic coordination. However, their contribution remains under-recognised in policy and practice. The 2019 Lancet Commission[2] on TB provides an example of this, by drawing on expertise from medicine, public health, economics, policy, advocacy, and global health leadership to present an ambitious agenda for building a TB-free world. But past or future contributions of nurses are not acknowledged or mentioned, despite there being obvious impacts that nurses would make in the 'disruptive operating model' proposed. The absence of any reference to nursing in this and similar reports reflects a wider pattern in global TB governance in which TB nurses are under-recognised and undervalued. Several inter-related factors likely contribute to nursing's persistent and concerning invisibility.

First, there is limited formal recognition of TB nursing as a distinct and essential speciality. Unlike other nursing specialities, TB nursing often lacks defined educational and professional pathways, accreditation mechanisms, and dedicated professional bodies. These factors limit the visibility of TB nurses within health systems, which then limits opportunities for TB nurses to participate in strategic planning and programme design.

Second, nurses are often treated as implementors rather than a specialised expert workforce able to contribute valuable research, strategic planning, policy development, and programme design. TB nurses implement TB policy, whilst being under-represented in national and international TB policy development. Gender dynamics related to nursing being a predominantly female profession likely play a contributing role in many settings; structural inequalities have long contributed to the marginalisation of female-dominated workforces in decision-making spaces.[9]

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Box. Recommended actions for recognising and strengthening the contributions of TB nurses.

1 Elevate the voices of TB nurses in strategic planning and decision-making processes related to TB programme policy, implementation, and design through nursing representation in national TB programme leadership, global TB governance structures, and TB technical working groups.
2 Foster a research-active TB nursing workforce by creating opportunities for TB nurses to engage in translational research.
3 Develop recognised specialist training pathways, accreditation mechanisms, and career progression structures for the TB nursing workforce.
4 Foster international and national TB nursing communities of practice to strengthen leadership, advocacy, mentorship, and policy influence.

Strict hierarchies are also deeply entrenched in many high-TB-incidence settings, limiting nurses ambition and ability to contribute. Excluding TB nurses from policy development risks failing to translate efficacious interventions in theory into effective ones in practice.

Third, nurses have historically had limited encouragement or opportunity to lead or contribute to research. Participation in research is a key pathway through which health professionals influence policy and practice. Despite nursing being a science-based profession, research is often not recognised as part of a TB nurses' core business. Structural barriers and a lack of research training and mentorship impact TB nurses' ability to design and conduct research.[10,11] Consequently, nursing perspectives are under-represented in the evidence-base that informs TB policy. The factors that limit nurses' ability to design, conduct, and lead research are amplified in resource limited settings, where the opportunity cost is greatest.

Recognising and strengthening the contribution of TB nurses requires deliberate action at multiple levels (see Box). There is a need to elevate the voices of TB nurses in strategic planning and decision-making processes related to programme design, policy, and practice. Practical steps to achieve this include ensuring representation of nurses in national and international governance and advisory structures, and peak bodies. Fostering a research-active TB nursing workforce by creating opportunities for TB nurses to engage in translational research will not only strengthen the evidence base but will upskill and empower nurses. Enabling research-active TB nurses requires greater inclusion of nurses in research by health services, as well as opportunities for better education, training, and mentorship. Academic institutions play a role in increasing participation of TB nurses in this space.

Formal recognition of TB nursing as a speciality professional pathway, supported by standards of practice, training programmes, accreditation standards, and career progression frameworks, could enhance the status of the profession and increase TB nurse recruitment and retention. While such frameworks exist in some low-burden countries,[12,13] standards of practice and formal recognition of TB nursing qualifications remain insufficiently established in high-burden settings. TB nurses must organise within communities of practice. Professional networks can drive improvements in practice, and facilitate knowledge sharing, peer support, and advocacy.[14,15] Communities of practice can also serve as platforms for amplifying the contributions of TB nurses at all levels. For example, The Union, supported by its Nurses and Allied Professionals Sub-Section (NAPS), could facilitate a global community of practice to support workforce networking and leadership development for TB nurses.

TB nurses bring a unique and important skill set that bridges biomedical expertise, clinical care, and public health management with nuanced social understanding and responsiveness. TB nursing practice extends beyond technical proficiency, encompassing sustained engagement with the social, cultural, and structural realities that shape TB risk, access to care, and treatment outcomes. In addition, TB nurses offer an important perspective to research, by bringing relational, operational, and community dimension perspectives of TB care often missed in biomedical accounts.[6,16] This highly skilled and meaningful field of practice offers opportunities to effect tangible and lasting change in the lives of individuals, families, and communities affected by TB. The work of TB nurses is inherently relational, grounded in trust, continuity of care, and deep connections with people and communities affected by TB. Therefore, TB nurses must be recognised, resourced, and included as essential partners at all levels of global and local efforts to build a TB-free world.

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References

1. Coleman M, et al. The tuberculogenic environment. The Lancet Global Health. 2026;14(3):e444-e454.
2. Reid MJA, et al. Building a tuberculosis-free world: the Lancet Commission on tuberculosis. The Lancet. 2019;393(10178):1331-1384.
3. Donnan E, National Tuberculosis Advisory Committee. Tuberculosis workforce policy and development framework in Australia. Commun Dis Intell. 2025;49.
4. Baruch Baluku J, et al. Roles and challenges of nurses in tuberculosis care in Africa: a narrative review. J Clin Tuberc Other Myco Dis. 2023;31:100366.
5. Nivet MA. Commentary: diversity and inclusion in the 21st century bridging the moral and excellence imperatives. Acad Med. 2012;87(11):1458-1460.
6. Devlin SA. Developing understanding with Aboriginal communities about tuberculosis for system change: participatory action research. Townsville, QLD: James Cook University, 2022.
7. Afenigus AD, Kebede AT. Exploring lived experiences of nurses in managing patients with drug-resistant tuberculosis in Western Amhara, Northwest Ethiopia: a descriptive phenomenological study. BMC Health Serv Res. 2025;26(1):121.
8. Oblitas FY, et al. Nursings role in tuberculosis control: a discussion from the perspective of equity. Rev Lat Am Enfermagem. 2010;18(1):130-138.
9. World Health Organization. Delivered by women, led by men: a gender and equity analysis of the global health and social workforce. Geneva: WHO, 2019.
10. Kerr D, et al. Nurses' opinions about clinical nursing research: a cross-sectional study. J Adv Nurs. 2025;82(6):6005-6017.
11. Ballintine A, Potter R. What are the experiences of nurses delivering research studies in primary care?. Prim Health Care Res Dev. 2023;24:e46.
12. Health Service Executive (HSE) Public Health. Tuberculosis nurse competency framework version 1.1. Dublin, Ireland: HSE Public Health, 2024.
13. National Tuberculosis Nurse Coalition. Tuberculosis nurse case management: core competencies. In: National Tuberculosis Coalition of America. Smyrna, GA: National Tuberculosis Coalition of America, 2024.
14. Noar AP, et al. The aims and effectiveness of communities of practice in healthcare: a systematic review. PLoS One. 2023;18(10):e0292343.
15. Abraham SA, et al. From bedside to system change: the TRIL nurse advocacy model for sustainable healthcare. BMC Nurs. 2025;24(1):1224.
16. Foster J. Epidemiological profile of tuberculosis patients from the Torres Strait islands, including visitors from Papua New Guinea to the Torres Strait protected zone. Townsville, QLD: James Cook University, 2023.