

based at WHO, Geneva, and especially Marcos Espinal; the tuberculosis teams of WHO's regional and country offices; and members of all Working Groups and Subgroups of the Stop TB Partnership for their input.

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The Global Plan to Stop TB: a unique opportunity to address poverty and the Millennium Development Goals

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The Millennium Development Goals (MDGs) provide the guiding framework within which the Stop TB Partnership's Second Global Plan to Stop TB has been conceived, and poverty is rightly recognised as a key cross-cutting issue for tuberculosis control. This explicit pro-poor focus, although important in itself, will only make a difference to the individual lives of the poor if practical steps are taken to address the obstacles that these people face in accessing good tuberculosis services, and if programme implementation takes account of the distribution of poverty within target communities as a whole. That the Plan goes beyond the rhetoric and lays out the practical steps that tuberculosis programmes can take to address poverty is encouraging (panel).¹

Each of the Partnership's three Implementation Working Groups (DOTS Expansion, MDR-TB, and TB-HIV) now have the opportunity, through the Plan, to allocate resources, both human and financial, to the activities outlined within the six steps. This allocation of resources will be especially important for the MDR-TB and TB-HIV working groups, because HIV infection and multidrug resistance magnify the barriers to diagnosis and treatment faced by poor people with tuberculosis. Additional investigations are needed to guide the initiation of therapy and assess treatment progress (eg, CD4 counting and drug sensitivity testing), and health systems and patients face considerable costs in sustaining the complex and long term treatment regimens.²

The New Tools Working Groups are geared towards developing new diagnostics, drugs, and vaccines for tuberculosis control. The vision in the Plan is that as

new tools come online they will be taken up by the Implementation Working Groups and used, according to the six steps, to address poverty to maximum benefit for the poor. The potential gains for the poor are enormous. For example, a more rapid, sensitive, and specific diagnostic test that can be used in peripheral health centres has huge potential to simplify the long and costly health-seeking pathways³ that so impoverish those with tuberculosis. As such, poverty seems not to be something that the New Tools Working Groups need to address; it seems to be an issue for the Implementation Working Groups. However, as the world has learned through the experience of efforts to expand access to antiretroviral therapy for HIV/AIDS,

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Panel: Addressing poverty in tuberculosis control: six practical steps¹

Step 1: Establish profile of poor and vulnerable groups

- Government or other data
- Locally done surveys

Step 2: Assess poverty-related barriers to accessing of tuberculosis services

- Economic barriers
- Geographic barriers
- Social and cultural barriers
- Health-system barriers

Step 3: Take action to overcome barriers to access

- Economic barriers: integrate services within primary-care provision, encourage pro-poor Public-Private Mix DOTS, promote tuberculosis control in workplaces, improve coverage of smear microscopy networks, avoid user fees, provide free smear microscopy and other diagnostic services
- Geographical barriers: extend diagnostic and treatment services to remote regions, provide free transport to patients from such regions, promote community-based care
- Social and cultural barriers: engage former patients and support groups to advocate for services and encourage community mobilisation
- Health-system barriers: engage in health-service decentralisation to ensure capacity strengthening in less well served areas and by establishing tuberculosis control as a district-level priority

Step 4: Work with groups that need special consideration

- Refugee communities, asylum seekers, economic migrants, displaced populations
- Pockets of deprivation in wealthier countries; ethnic minorities, homeless people
- Injecting drug users
- Prison populations

Step 5: Harness resources for pro-poor services

- Global Fund to Fight AIDS, TB and Malaria, poverty reduction strategies
- Technologies to enhance efficiency and effectiveness of services

Step 6: Assess pro-poor performance of tuberculosis control

- Harness human and other resources through alliances with partners (such as universities)
- Include socioeconomic variables in routine data collection
- Include tuberculosis-related questions in district health surveys
- Undertake periodic studies of care-seeking, diagnostic delay, and use of DOTS
- Do qualitative assessments among community members and patients about who benefits from tuberculosis services (including linked services for HIV) and who does not

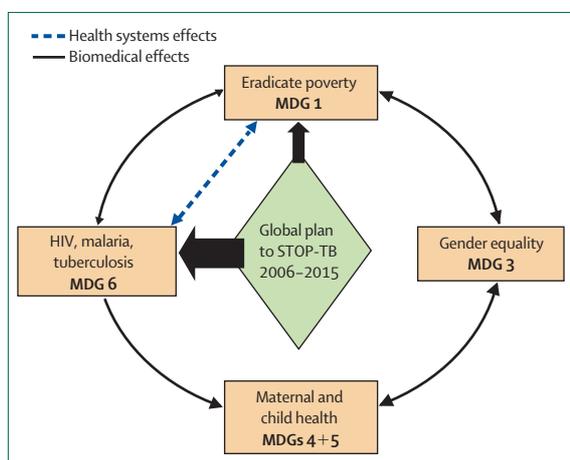


Figure: Global Plan to Stop TB within the framework of key health-related MDGs

issues of the cost and affordability of new commodities need to be tackled up front.

Although the New Tools Working Groups all aim to develop products that are affordable and inexpensive, the challenges should not be underestimated. What is the definition of affordable in this context? The New Diagnostics Working Group works towards an affordability goal in which the new diagnostics it develops will consume no more than what is currently spent on diagnosing tuberculosis in the public-health systems of developing countries. This goal is laudable, but, as the overall Plan clearly recognises, the health systems within which control activities will take place over the next decade and a half are set to incorporate multiple, often private-for-profit, providers. How can equity and quality in deployment of these tools be assured across such complexity? Without careful advance planning, the new tools could end up, as

dictated by the inverse care law,⁴ beyond the reach of the poor. Specific action is needed to use intellectual property rights and patents in a way that does not restrict the delivery of new tools to patients and populations with buying power.

All the MDGs seek to contribute to poverty reduction. The greater the effect on any of them, the greater the effect on poverty will be. The Global Plan to Stop TB will have its greatest direct effect on MDG 6 by combating tuberculosis as one of the “other diseases” mentioned alongside HIV and malaria (figure). By reducing the toll of ill health associated with tuberculosis on the poor, however, and by reducing the health-care costs associated with securing a diagnosis, treatment, and cure, MDG 1 (eradication of poverty) will also be affected. How the Plan might indirectly contribute to achievement of MDGs 3, 4, and 5 is not explicit but would require a clearer focus on the gender related aspects of tuberculosis control.

The Second Global Plan to Stop TB clearly has poverty and the MDGs in its sights. However, to meet its targets over the coming decade, the Stop TB Partnership will need to continuously review and prioritise its activities. For example, activities in the 22 high-burden countries that together account for 80% of the global tuberculosis burden are a priority at the moment; China and India alone account for 35% of all estimated new cases per year. Taking a strictly epidemiological approach, this focus makes sense; however, it does not take account of the fact that prospects for economic growth in several of the 22 countries (notably China and India) are good and their needs for international technical assistance and funding support for tuberculosis control are likely to

diminish between now and 2015. As we gain greater control over the disease globally, a focus, for example, of activities on countries with a combination of high burden of tuberculosis and low development indices might be more appropriate.

Overall, the Plan does well to move beyond economic want in its conceptualisation of poverty and acknowledges the importance of lack of opportunities (including capabilities), lack of voice and representation, and vulnerability to shocks as key additional components of poverty. There are opportunities within the Plan to address all of these factors: economic want means that strategies must be cheap for patients; lack of infrastructure means that strategies must find innovative ways to work beyond existing infrastructure; lack of power means that strategies must be equitable. With clear budgetary allocations to the activities that the Plan proposes for addressing poverty, the Stop TB partnership can, and should, seize these opportunities.

Conflict of interest

S B Squire and B Nhlema Simwaka are members of the TB and Poverty Sub-Group of the Global STOP-TB Partnership's DOTS Expansion Working Group and have been involved in development of the Second Global Plan to Stop TB and in the writing of reference 1. A Obasi declares that she has no conflict of interest.

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