13th November 2007
Meeting of the TB & Poverty Subgroup at the Union World Conference, Cape Town.

Summary

Chairpersons: Bertha Nhlema Simwaka (Chair of Subgroup/ REACH Trust), Bertie Squire (Secretary of Subgroup, LSTM UK)
Presenters: Vinand Nantulya (FIND), Peter Gondrie (KNCV), Sven Gudmund (IUATLD), Nadia Ait – Khaled (IUATLD), Knut Lonnroth (WHO), Gillian Mann (LSTM), Bertie Squire (LSTM), Kim Barker (Assembly of First Nations)

Overall aim of the meeting:
- To provide joint working amongst sub-group members

Objectives:
- Provide opportunity to meet and share ideas and experiences
- Review progress against outputs of TB and Poverty Action Plan
- Outline future direction and activities

Introduction: Globally, low and middle income countries account for more than 90% of TB cases and deaths. The burden of TB is estimated to be an economic toll of US$12 billion from the income of the world’s poorest communities each year. The average patient loses three to four months of work time as a result of TB. Lost earnings can total up to 30% of annual household income. TB’s economic impact on families can be devastating. Families often have to sell assets to pay for care, stop school or work to care for relatives and people living in conditions of poverty (overcrowding, malnutrition, poor ventilation etc) are more susceptible to falling sick with TB and most likely lack access to detection and treatment services.

The TB and Poverty Subgroup of the STOP TB Partnership's DOTS Expansion Working Group aims to promote global access to quality diagnosis and treatment of TB for the poor and vulnerable in line with the STOP TB strategy and the Second Global Plan to Stop TB.

Successes of the Subgroup 2007

Overall: high level of communication and engagement across the STOP TB partnership. This has been due to the establishment of a strong Core Team and facilitated by the Subgroup Interim Secretariat

Highlights:
- Expansion of subgroup to include all NTP managers to accelerate opportunities for addressing poverty issues in national programmes
- Recruitment of a TB and Poverty Officer within FIND who will conduct societal cost effectiveness analyses and act as the focal point for linking between FIND and the TB & Poverty Subgroup.
- TBCAP funding of a junior consultant within KNCV to develop a tool for use by NTP’s to monitor costs incurred by patients in accessing diagnosis and treatment for TB
- Development of TB and Poverty website which contains articles and information on poverty and a summary of practical steps for increasing access for the poor at country level
- Establishment of a TB Diagnostics and Poverty Subgroup within the New Diagnostics WG
- Further distribution and use of the WHO guide ‘Addressing Poverty in TB control’
- Engagement with Laboratory Strengthening subgroup and New Diagnostics WG has contributed to the policy change, resulting in fewer barriers and lower costs for patients, by permitting categorisation of patients as
  - smear negative on basis of 2 rather than 3 smears
  - smear positive on basis of 1 smear

Future Plans:
- WHO TB and Poverty guide actively used to inform and modify national TB plan in at least 5 countries
- Initial strategies for enhancing access to TB diagnosis available through new diagnostic tools and algorithms
• Enhanced capacity and technical assistance for implementing and evaluating pro-poor strategies in TB control (training courses, use of TB & Poverty Guide at country level)
• Development of strategies for empowering indigenous communities to promote access to TB control

Key Themes:
1. Approaches to address/ measure TB Poverty:

Practical Approaches to Lung Health (PAL) is likely to increase respiratory disease management in PHC setting, since it tends to decrease referral to upper level health services, better identifies other causes of poor lung health and is likely to improve the quality of the process of diagnosis of TB and consequently improve TB case detection among respiratory patients in PHC. Previous studies have shown that PAL decreases inadequate drug prescription, particularly antibiotics and adjuvant drugs, and improves the quality of drug prescriptions for Chronic Respiratory Diseases patients. PAL can reduce the average cost of drug prescriptions per respiratory patient. Where patients have to pay out of pocket for these prescriptions, PAL can mitigate against the impoverishing effects of care-seeking on patients.

Public Private Mix (PPM): evidence has shown that providers of the poor can be engaged in TB care and produce good treatment outcomes. Projects have shown that the providers that people go to first can be engaged in diagnostic processes and consequently, improve access to services for the poor. This means that costs during treatment can be significantly reduced and diagnostic delays can be shortened.

FIDELIS: Launched in 2003 with a grant of $33.85 million to increase case detection in populations with limited access to health service. Funding stream now closed. As of July 1, 2007, 262,062 new smear positive cases have been reported from the initial 49 FIDELIS phase I sites (3 still operational) which represents an additional 81,430 (30%) cases over the previous year. Attribution is more difficult to assess – increasing trends in CDR, multiple interventions, etc. Most of the FIDELIS projects were only feasible in large populations so that the targets could be reached.

Patients’ Costs Tool: The objective is to develop a tool to assess financial and economic costs of TB patients; during the period of delay before diagnosis, during the process of diagnosis and during treatment. The tool aims to be a feasible and realistic tool which can be used world-wide. It will permit national programs to estimate the costs for TB patients before & during diagnosis and during treatment. It will relate to all sectors providing TB care and considers costs due to HIV-Co-infection. After finalization, there will be training of program staff to use the tool.

2. Support for indigenous people initiative

The rates of TB for First Nations and Inuit are 20-30 times higher than for others born in Canada (and ten times greater than for Canadians as a whole). The rates are probably similar for indigenous populations of China, Africa and Latin America where data is more difficult to access. Similarities in circumstances contribute to the increased rates of Tuberculosis including poverty, access to medical care including prevention, treatment and contact tracing.

It is proposed that existing STOP-TB linkages, together with those that already exist with indigenous populations, could be strengthened into full partnerships that cooperate to support a specific programme aimed at addressing TB in Indigenous communities. Key in all of this is indigenous community ownership to engage in the development of a programme and utilization of a fund to improve access to TB care for indigenous peoples.

The Subgroup endorsed the proposal of a secretariat and funded activities to improve access for indigenous people and will continue to engage with these organizations and assist where possible.

3. Subgroup issues:
**Widen subgroup membership**: Calls for the Subgroup to be widened. All members were welcomed and it was highlighted that the Subgroup aims to be as inclusive as possible.

**Increase communication** with subgroup members including interacting more at regional levels: The Subgroup Secretariat will improve communication with its members in 2008 and aim to increase the Subgroup membership through improved communication channels. Stronger links with regions and country level organisations will be built.

**Change name** (include ‘equity’): It was proposed that the TB Poverty Subgroup changed its name to include equity or vulnerability, e.g. ‘the TB Poverty and Equity Subgroup’. It was agreed that the name would not change immediately but instead be considered in light of the STOP TB Partnership possible restructuring.

**Review Action plan**: The Subgroup core team will look at the activities that have taken place in 2007 and review the action plan accordingly. This will be done in light of the potential STOP TB partnership changes.