Tackling poverty in tuberculosis control

Tuberculosis (TB) is the archetypal disease of poverty. Of the 22 countries that have 80% of the world's TB burden, 17 have an annual gross national product per head of less than US$760, the criterion used by the World Bank for classification as a low-income country. Within these countries, the poorest have least access to treatment. Even in those countries with strong TB control programmes that offer free diagnosis and treatment, the poor can face catastrophic health expenditure because of high costs of care before diagnosis (eg, repeated buying of cough linctus, time lost from work) and high indirect costs during treatment (such as travel or childcare costs). For example, in rural Malawi, the cost of accessing TB services is more than twice the monthly income of the poorest.

In 2003, there were an estimated 8·8 million new cases of TB, fewer than half of which were reported to public-health authorities. The global targets, adopted by the World Health Assembly, are to detect 70% of new pulmonary smear-positive cases annually by the end of 2005, and to cure 85% of detected cases. Despite impressive progress towards the cure-rate target (83% of 1·6 million patients were successfully treated under DOTS in the 2003 cohort), the case-detection rate by DOTS programmes was less than 60% by the end of 2004, and there is increasing recognition that most of the undetected TB cases are likely to be found among the poor.

Improving the effectiveness of pro-poor strategies for TB control was the aim of a meeting held last week at Bellagio in Italy, convened by Dr Bertie Squire from the Liverpool School of Tropical Medicine, Liverpool, UK. Three areas of emphasis for TB control aimed especially at the poor emerged from the meeting.
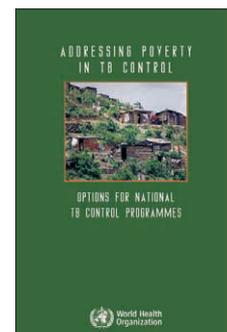
First, experiences in the field must be translated into evidence on what works to achieve equity. In addition to providing free diagnostic tests and treatment for all patients with TB, ways forward may include using grocery stores or traditional practitioners to distribute tests and drugs, and providing food and travel vouchers to help patients to complete treatment. However, there is a lack of evidence on whether such approaches work. More generally, there is a lack of standardised indicators, including quantitative and qualitative measures, to evaluate pro-poor interventions and identify best practices. Moving beyond routine reporting—to include socio-economic indicators in population-based TB prevalence surveys and to promote studies of financial consequences of TB and TB treatment in samples of notified TB patients—is necessary. And cost-effectiveness analyses of efforts to serve the poor must take into account the costs incurred by the affected person and their household, as well as the costs to the health system.

Second, HIV and multidrug-resistant TB magnify the barriers to diagnosis and treatment faced by poor people with TB. Additional investigations are needed for diagnosis and to assess treatment progress (eg, CD4 count or drug-sensitivity testing). Health systems face considerable costs in delivering and sustaining the complex and long-term treatment regimens, and patients can face huge costs with dramatic impact on livelihoods, especially when management is hospital-based. Bringing the required health interventions as geographically close to patients as possible through community-based approaches is necessary to benefit those affected by multidrug-resistant TB and HIV-TB, particularly the poor.

Third, new tools for TB control need to be developed and distributed equitably. The public-private partnerships (PPPs) fostered by the Stop-TB Partnership have increased the number of new TB drugs, vaccines, and diagnostic tests under development. Although all could promote equity in TB control, those with the greatest potential in the short term are new diagnostic tests. More rapid, sensitive, and specific diagnostic tests that can be used in peripheral health centres could reduce the delays that impoverish patients. The challenge is to ensure that intellectual property rights and patents do not restrict the delivery of new tools to where they are needed among the poor.

All three of these areas of activity need to proceed under the umbrella of an equitable health-systems approach that advocates and provides universal coverage and financial protection. Such an approach requires standardised indicators of best practice, regular monitoring, strong governance, a focus on accountability, and involvement of people affected by TB. The Stop-TB Partnership provides a continuing mechanism to take action in all of these areas. With the expected launch of the Second Global Plan to Stop TB (2006–2015) in early 2006, the Partnership has the opportunity to increase its focus on the poorest people who are infected with TB. Failure to seize this opportunity will ensure that TB remains a disease of poverty. ■ *The Lancet*