Mainstreaming a Poverty Focus within the Stop-TB Partnership

1. Background

1.1. While TB is not exclusively a disease of the poor, the association between poverty and TB is well established and widespread. TB infection is transmitted more readily in the environmental conditions of poverty; overcrowding, inadequate ventilation and malnutrition. In addition TB disease diminishes the livelihoods of affected individuals as well as their relatives and communities by preventing gainful employment and having an adverse impact on social relationships.

1.2. A recognition of the importance of poverty is increasingly reflected in international policy on health and development. Examples of this recognition are framed in the recent Report of the Commission for Macro-economics and Health, the Poverty Reduction Strategy Process, the Millennium Development Goals, and the Global Fund to fight AIDS, Tuberculosis and Malaria.

1.3. The Stop-TB Partnership adopted "Stop TB, Fight Poverty" as the 2002 World TB-Day theme and has commissioned in-depth development of the TB & Poverty theme throughout the year with support from the Stop-TB Secretariat, DFID (UK), Liverpool's EQUI-TB Knowledge Programme, the World Bank, and the Rockefeller Foundation. Activities contributing towards this theme development include the following:-

a) "TB, Poverty & Inequity" – a review of the literature and discussion of the issues by Christy Hanson. This was completed in February 2002.
b) Constitution of an ad-hoc TB & Poverty Advisory Committee of broad technical and scientific expertise and a time-limited mandate (until Feb 2003) to assist the Stop-TB Secretariat in its advisory function for the development of the TB & Poverty theme
c) "A Systematic Analysis of TB & Poverty" – an analysis using review methodology adapted from the Cochrane Collaboration to analyse the existing evidence that tuberculosis causes or worsens poverty and that tuberculosis control (or elements of tuberculosis control) benefits the poor. This was started in April 2002, interim analyses have been presented in June and October 2002 and the final analysis will be complete in February 2003.
d) "Formulating a Research Agenda" – a brainstorming workshop on TB & Poverty held before the 4th World Congress on Tuberculosis, Washington, June 2002.
e) "Satellite Symposium on TB & Poverty" held after the 33rd Annual IUATLD Meeting in Montreal, October 2002.

1.4. A summary document was requested by the participants of the Satellite Symposium on TB & Poverty for presentation to the Stop-TB Co-ordinating Board. This document therefore provides a synopsis of progress to date with the TB & Poverty theme development and indicates possible ways forward with this work for consideration by the Board in order to facilitate action on the recommendations made at that meeting and through the preceding activities.

2. TB & Poverty – what is already known?

2.1. TB is a disease that particularly affects the poor and contributes to poverty in many ways.

2.2. Over the past decade the international community has made remarkable strides in bringing and effective TB control strategy (DOTS) to poorer developing countries.

2.3. At the global level TB control activity has been prioritised for the 22 high burden countries, most of which are low-income countries.

2.4. The most urgent challenge facing international TB control activities aimed at reaching the global Stop-TB targets is improved case detection and overcoming barriers for patients seeking access to TB care.

2.5. Poverty analyses suggest that the poor have greater difficulty overcoming barriers in accessing care and completing treatment than the less poor. They have fewer resources to use for direct costs such as transport to health facilities and consultation fees and indirect costs such as child care.

2.6. At national level and below (i.e. within poor countries) making DOTS accessible and effective for the poorer sectors of society is challenging and will require special attention[1]. This is because

a) Care seeking pathways and the diagnostic process consume patients' and household resources

b) Even when anti-tuberculous drugs are free, patients still incur costs in completing therapy.

Both a) and b) are exacerbated in poorer countries because of underlying health system constraints, particularly shortages of human resources and infrastructure.

2.7. The DOTS strategy is being adapted throughout the world to better address local needs and new approaches are being devised. These include community-based care models, public-private collaboration, social mobilisation strategies and use of enablers and incentives. Whether these adaptations make DOTS more accessible to poor people or communities has yet to be evaluated.

3. TB & Poverty – what are the key needs for knowledge and action?

3.1. It follows from the current synopsis of evidence that DOTS programmes are not reaching all those with TB and missing cases are likely to be the poor and vulnerable.

3.2. Therefore, making DOTS accessible to the poor should make a difference in international TB control, particularly for the urgent challenge of case detection.

3.3. However, the evidence demonstrating that this will be the case is only just becoming available. Several questions were formulated at the TB & Poverty Satellite Symposium in Montreal and they need answering in order to further build the evidence base to support a mainstreamed pro-poor approach in TB control. A selection is presented here:-

a) To what extent are undetected patients poorer than detected cases? Linkage of prevalence surveys to socio-economic profiles of detected and undetected cases is needed.

b) What is the best balance of investment to make DOTS accessible to the poor? At one end of the spectrum improving quality in the delivery of the existing elements of DOTS may enhance access for the poor. At the other end, additional measures, such as active case-finding, or incentives and enablers, may be needed.

c) Does the adoption of pro-poor approaches lead to significant increases in case-detection and cure-rates?

[1] Some examples of approaches being piloted in different settings were discussed at the Satellite Symposium.

d) Is a pro-poor approach more useful in some contexts than others? Some DOTS programmes, or parts of programmes, have been designed exclusively for the poor, outreach programmes for the homeless would be one example. For such programmes a poverty focus may not add value.
e) How can the many existing poverty measures be converted into practical tools that can be used as equity indicators in day-to-day TB control activities? These would be useful tools for monitoring whether or not DOTS is reaching the poor. Many NTP managers may acknowledge the link between TB & Poverty but acceptance of the concept needs to be turned into practical responses and measurable indicators.
f) How can the voices of the poor be heard and used constructively in planning and assessing the impact of pro-poor DOTS?

3.4. In addition to building the evidence base, working groups at the Montreal symposium highlighted other important areas of action that are required including:-
a) The need to build the capacity of TB programmes to contribute to the Poverty Reduction Strategy Process.
b) The need to link to social mobilisation strategies such as the testing of the COMBI approach.

4. What should happen next with TB & Poverty?

4.1. A network of researchers, programme staff, and partners has begun to work collaboratively to pursue DOTS expansion and ensure that the poor are effectively served by efforts to control TB. The participants at the June Workshop as well as the Symposium called for the Stop TB Partnership to facilitate work in this area and to help mainstream these issues within the working groups, advocacy and partnership functions of the Partnership beyond February 2003. This network needs to sustain and further develop an identifiable and useful evidence base for the Stop-TB Partnership based on a clear purpose and an accompanying work plan.

4.2. It was further suggested that the wide network of interested parties needs a core group of partners with different capacities (for example representatives of NTP staff, NGO's, researchers and international agencies) which will continue to enable wide contribution and channel this strategically throughout the activities of the Stop-TB Partnership. In turn this core group needs an anchor or reference point organisation or institution to help further the work of the core group and the larger network.

4.3. A Purpose was drafted for the TB & Poverty network as follows; "To enable south-south and south-north exchange to innovate evidence-based and constructive pro-poor approaches for TB control". This, and the associated objectives for the network, will need further work.

Concluding Remarks

The participants in the Satellite Symposium on TB & Poverty asked that the Stop-TB Co-ordinating Board reviewss this summary and consider the best means of pursuing, as well as mainstreaming, an equity agenda within the working groups and the overall structure and objectives of the Partnership. Several views were expressed on how to pursue this agenda including:-
a) through participation of poverty-TB network members in all of the relevant working groups
b) through the formation of a sub-group within the DOTS Expansion Working Group

c) through the financing of network functions by the partnership (such as a web-site and web manager)
d) through the financing of one entity to serve as an anchor for the work of the network.

These suggestions are not mutually exclusive and no decision was arrived at during the Symposium. The advice and opinions of the Co-ordinating Board would be valued but the incipient TB & Poverty network is keen to explore with the different structures of the Partnership possible ways in which poverty can be mainstreamed.

A list of organisations that participated in the TB & Poverty Symposium is appended.

List of Organisations that participated in the TB and Poverty Symposium, Montreal Oct 2002

Armauer Hansen Research Institute, Ethiopia	IFRC, Russian Red Cross, Russia	National TB Programme, Malawi
Association of Social Development, Pakistan	Indonesian TB Control Association (PPTI), Indonesia	NTB Inititative, USA
Canadian Lung Association, Canada	Institute for Lung Diseases and TB, Serbia	Nuffield Institute for Health, UK
Care, India	Institute National de Salud, Columbia	Pasteur Institute, Algeria
CDC, Kenya	IUATLD Canada	Pimpri Chinchwad Municipality, India
CIDA, Canada	IUATLD, France	Public Health Institution, Serbia
Fudan University, Shanghai, China	World Health Organization, Geneva, Switzerland	World Bank, Washington DC, USA
City of Cape Town Municipality, South Africa	King George's Medical College, India	Regional Hospital Quebec, Canada
City TB Control Centre, India	KNCV, Netherlands	
Damien Foundation, Bangladesh	LHL , Norway	
Department of Health, China	Liverpool School of Tropical Medicine, UK	
DFID, UK	Liverpool University, UK	
Direction Departementale des Affaires, France	Management Sciences for Health, USA	
Doctors of the World, Phillipines	MCN, USA	
EQUI – TB, Malawi	Ministry of Health, Chile	
EQUI – TB, UK	Stop TB Partnership Secretariat	
German Leprosy Relief Association, USA	Montreal General Hospital, Canada	
Harbour – UCLA Medical Centre, USA	MSF – B AIDS Programme, Kenya	
Health and Development Inititative, India	National TB and Leprosy Program, Kenya	