Positioning TB in the post-2015 development agenda

Aim

To develop a strategy to shape the ongoing discussion on the post-2015 development agenda and to successfully place tuberculosis (TB) as an explicit indicator with ambitious targets into this agenda.

Background

"TB is the child of poverty - and also its parent and provider."

(Archbishop Desmond Tutu)

The inclusion of TB in the Millennium Development Goals (MDGs) as an indicator under Goal 6 has proven to be a powerful promotion to gather political and financial support in the global fight against this disease. The presence of a target (although more implicit than explicit) and of specific indicators has allowed focused attention on TB by Member States and the international community alike.

In view of the deadline of the MDG agenda in 2015, and considering the ongoing discussion about what will come next in terms of global development and health goals, it is crucial that the TB community makes key decisions on how to ensure that global political support for TB is sustained and increased after 2015.

Despite global progress, TB remains one of the major causes of death in the world with over 1.4 million people dying of this disease in 2011. Combined with the fact that TB is an airborne disease and that multi- and extremely-drug resistant TB (MDR-/XDR-TB) are a growing concern, TB represents a major global public health threat, hampering economic progress and the fight against poverty in developing countries. This is unfortunate, because up until today, TB care and control have been shown to be highly cost-effective interventions in public health.

The un-ambitious TB-related MDG of halting and reversing TB incidence trends was technically reached in 2004 but is coming down at an unacceptably low speed (i.e. 1.6% annual reduction which ' with population growth ' has caused the total number of deaths to remain virtually unchanged). The other international targets of halving TB prevalence and mortality compared to 1990 are globally on track, with the significant caveat that two regions – Africa and Europe – are not.

At the same time, elimination of TB as a public health problem will take probably several decades of intensified efforts. Millions of lives are at risk of being lost if an acceleration of TB care and control interventions is not pursued by Member States and all stakeholders in health.

Therefore, it is crucial that current efforts are consolidated, sustained and enhanced as quickly as possible to save lives, further reduce the spread of the epidemic, accelerate incidence decline and promote societal well-being. TB interventions

(i) *contribute to development of communities and nations;*

(ii) *benefit from overall sustainable development efforts in any field; and*

(iii) *offer a powerful and measurable indicator for health and development.* (Lancet 2012; 379: 1077-78)

Context

The development of the post-2015 development agenda follows three major processes.

- **The first process (track one)** is driven by the UNSG who has recently established a high-level panel of 27 eminent persons[1]. This panel will be producing a report to the UNSG in May 2013. This report will focus on the global development framework beyond 2015, and will follow a series of consultations with Member States, civil society, the private sector, academia, and research institutions from all regions. The panel is chaired by the Heads of States of Indonesia, Liberia and the UK.
- **The second process (track two)** is based on 9 global thematic consultations driven by UN agencies on various aspects of development. **The thematic consultation on health** for the post-2015 development agenda is convened by WHO and UNICEF, in collaboration with the governments of Sweden and Botswana. After numerous consultations with governments, civil societies, academia and the private sector, the health consultation will result in a report that will be finalized in February/March 2013. This paper will likely inform the report of the high-level panel of eminent persons. A website www.worldwewant2015.org/health has been created to provide regular updates, stimulate discussions and post papers, thus contributing to the consultation. As a co-convener of the thematic consultation, WHO has prepared and posted a discussion paper. This paper describes the current global health scenario, and promotes universal health coverage (UHC) and healthy life expectancy as the potential main topic and targets for the post-2015 health agenda. It describes how UHC could be the overarching umbrella for any health goal. It offers a way of accommodating and maintaining the visibility of internationally agreed health goals related to specific diseases as sub-goals. In the WHO discussion paper, specific diseases include AIDS, TB, Malaria, NCDs and other conditions such as maternal and child health.
- **The third process** is based on an inter-governmental working group tasked to design "sustainable development goals" as agreed at the Rio+20 Conference held in June 2012. This report, which may be mainly focused on environmental issues, will ultimately be submitted to Member States for further deliberations.

[1] The Members are: H.E. Mr. Susilo Bambang Yudhoyono, President of Indonesia (Co-Chair), H.E. Ms. Ellen Johnson Sirleaf, President of Liberia (Co-Chair), H.E. Mr. David Cameron, Prime Minister of the United Kingdom (Co-Chair), Fulbert Gero Amoussouga (Benin), Vanessa Petrelli Corrêa (Brazil), Yingfan Wang (China), Maria Angela Holguin (Colombia), Gisela Alonso (Cuba), Jean-Michel Severino (France), Horst Kohler (Germany), Naoto Kan (Japan), H.M. Queen Rania of Jordan (Jordan), Betty Maina (Kenya), Abhijit Banerjee (India), Andris Piebalgs (Latvia), Patricia Espinosa (Mexico), Paul Polman (Netherlands), Ngozi Okonjo-Iweala (Nigeria), Elvira Nabiullina (Russian Federation), Graça Machel (South Africa), Sung-Hwan Kim (Republic of Korea), Gunilla Carlsson (Sweden), Emilia Pires (Timor-Leste), Kadir Topbaş (Turkey), John Podesta (United States of America), Tawakel Karman (Yemen), Amina J. Mohammed (ex officio).

- There are additional initiatives that would involve social media and other means.

The importance of WHO in this process

(see Note for the Record – Meeting with the Director General - Annex 1).

As co-convenor of the thematic consultation, WHOhas expressed an intent to drive one unifying goal for health: Universal Health Coverage (UHC). The process of determining which indicators would be included in that definition is underway at WHO and it is essential that TB is there if UHC is to become the one 'supra-goal' for health. A unilateral effort to achieve a distinct and separate goal for TB is unlikely to succeed.

Strategy

In this entire process, among the main global health issues, the least supported and visible at the high political level is likely to be TB. Without an intensive and joint effort by the international TB community, the risk exists that TB will be left out of the post-2015 agenda. Multiple approaches will be needed that are carefully assessed based on their potential for impact. This will require a broad range of tactics and approaches that the TB community needs to put in place as quickly as possible during the next quarter.

Influencing the official process of developing the post-2015 targets

1. **Preparation of documents for wide dissemination:**
    a. Preparation of a document defining why TB needs to be in the post-2015 agenda. What happens if the achievements are not sustained beyond 2012, what are the human losses in terms of lives and the financial burden, what are the gains – this document should serve as "roof" for all other messages to be drawn from it. As such it should include the various different aspects of TB.
    b. Develop new, or adjust existing, one pagers on 2-3 topics to be disseminated globally, including on MDR TB, TB/HIV, TB and social determinants, TB and universal health coverage, etc.
    c. Post the documents on the website and disseminate widely.

2. **Sensitizing the 27 high-level panel of eminent persons (track one)** to the problem of TB and the opportunities to achieve clear results:
    a. Preparation of a letter by UN Special-Envoy to the panel explaining the issue and requesting support and attention;
    b. Preparing a statement signed by the members of the Coordinating Board to the panel
    c. Personal contacts of UN Special-Envoy and other TB champions with the panel (for instance towards panel members from UK, Brazil, Cuba, South Africa, Timor-Leste, Turkey etc.) – high level meetings or phone calls

d. Efforts to engage the office of Special Envoy on Malaria (Ray Chambers) to support in this approach

3. **Participating in the thematic consultation on health (track two)**:
   a. Advocating with the DG and WHO focal point responsible for the co-convening of the thematic consultation and ensuring that TB is included as indicator/tracer under the UHC umbrella
   b. Preparing a statement signed by the members of the Coordinating Board to the panel
   c. Personal contacts with Sweden and Botswana to promote the paper and its rationale as well as the TB related indicators;
   d. Requesting and supporting Stop TB partners to actively participate in the discussion including the posting of statements and papers on the website.

Shaping a favorable policy environment

4. **Reaching out to UN Member States** and identifying TB champions:
   a. Letters by the UN Special-Envoy to targeted UN missions in New York requesting support for the inclusion of TB in the post-2015 health agenda;
   b. A series of small meetings/events (or a single large one) with UN missions in New York – possible Geneva- to promote TB inclusion in the post-2015 health agenda;
   c. Strategic contacts with key Member States through possible existing channels like UK-APPG, US-TB Caucus, Brazilian TB Caucus, Ambassadors of key countries based in Geneva (France, Italy, etc.) etc.

5. **Informing and mobilizing partners:**
   a. Discussing at the Stop TB Coordinating Board and identifying action points by partners;
   b. Proactively discussing and engaging in a meaningful manner with civil society representatives and activists
   c. Support partners with documents and talking points and opportunities for interaction with members of the different panels

6. **Influencing the UN SG's office:**
   a. Placement a TB-champion in the office of UN Secretary-General Ban-Ki Moon for a restricted period to be fully informed about the latest developments and process;
   b. Preparation of a short letter by UN Special-Envoy to the SG/DSG explaining the issue and requesting support and attention.

Estimated budget required:

Activity	Estimated budget
2 short-term staff at P3 level for 8 months - One position in the UN SG's office in NYC - One position with the TBP in Geneva	 US $ 229.000 US $ 229.000
High-level missions - Minimum of three missions by the Board and other high-level influencers to key decision makers (@ US $ per mission)	US $ 30.000
High-level advocacy events - Minimum one advocacy event	US $ 30.000
TOTAL	US $ 520.000

Annex 1

Meeting with the Director-General - Note for the Record

1. Mr Jan Eliasson, UN Deputy Secretary General
2. Dr Anarfi Asamoa-Baah, Deputy Director-General
3. Dr Andrew Cassels, Director Strategy, DGO

23 October 2012

The Director-General welcomed Mr Eliasson to WHO. In follow up to an earlier written request from the DSG Dr Chan confirmed that she was ready to second a WHO official to New York to provide health advice and support to Ms Amina Mohammed, Adviser to the Secretary General on the post-2015 development agenda. Arrangements would be discussed with Ms Mohammed during her forthcoming visit to WHO.

The DG outlined her growing conviction that in respect of the post-2015 there was a need for a unifying health goal. Universal Health Coverage, understood as both access to services as well as financial protection, provides such a unifying concept. However, it is early in the process and the need now is to listen to as many views as possible. The DG noted that UHC would also be included as part of the annual Foreign Policy and Global Health resolution to the UNGA later this year.

In response to a question about the coordination of health matters in the UN Secretariat, the DSG spoke of his role as making the S-G's agenda for his second term a reality. Health is an important component of that agenda with several different aspects requiring coordination across the Secretariat, as well as coordination with the SG himself and his new Chief of Staff. These relationships are currently very solid and working well.

In relation to the processes established to work on the post-2015 development agenda support for both the High Level Panel and the Member State driven Working Group (established after Rio to develop Sustainable Development Goals) will rely on support from the UN task Team. There is currently close coordination operating at the Principals level between himself, the UNDP Administrator and USG Wu in the Department of Economic and Social Affairs. At the same time the DSG expressed concern about the potential for these two processes to take divergent directions – with the HLP focusing more on poverty reduction and the SDG working group focusing more on environmental concerns. He also noted that there was a risk that the two main processes were very selective; with the risk that many countries may feel excluded. Bottom up consultations in over 100 countries is therefore an important way of making the process more inclusive.

To date the UNGA working group on SDGs has yet to agree on membership or methods of working. The DSG hoped that some compromises would be reached to enable work to begin and to ensure that the result was clear and concrete, avoiding purely rhetorical statements that are not amenable to measurement. Both DG and DSG agreed that this would not preclude developing a set of guiding principles that underpin all goals (e.g. on rights and good governance), providing the new set of goals

themselves were clear and reliably measureable. The DSG recalled Agenda 21 which not only received global attention but was useful to local authorities. To produce a framework that allowed adaptation of goals at global, regional, country and local level is what we should aspire to.

In response to a question by the DDG, Mr Eliasson spoke about his personal commitment to work in the field of water and, particularly, sanitation. It was clear that this area might constitute a fruitful area for collaboration tween his office and WHO.

A sustainable agenda for tuberculosis control and research

In 2010, *The Lancet* published a call to action on tuberculosis to all stakeholders.[1] Since then, notable progress has been made towards international targets for achieving tuberculosis control.[2] Annual incidence rates of tuberculosis and total numbers of patients with tuberculosis are slowly declining, deaths have been reduced by 40% compared with 1990, and a remarkable 46 million patients with tuberculosis have been cured since 1995.[2]

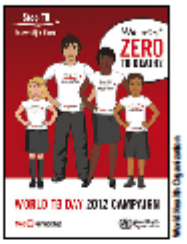
Despite exceptional achievements in countries such as China, progress in most low-income countries has lagged behind.[2] Control programmes for tuberculosis in these countries, especially in Africa, are fragile and remain dependent on donors with more than 50% of all funding provided from external sources.[2] At the same time, although Brazil, Russia, India, China, and South Africa are now essentially self-funded, these countries remain challenged by huge disease burdens, in some cases complicated by a high prevalence of multidrug-resistant tuberculosis (in the Russian Federation and China) or HIV-associated tuberculosis (in South Africa).

Encouragingly, some countries are introducing bold initiatives to respond to the challenges. South Africa, for example, launched a national campaign that aimed to test 15 million people for HIV while also screening them for tuberculosis between April, 2010, and June, 2011. In addition, the South African Government launched an ambitious project to visit 200 000 households, between World TB Day on March 24 in 2011 and 2012, as part of an intensified tuberculosis case finding effort, and has also introduced on a large scale a new molecular diagnostic (Xpert MTB/RIF)[3] recommended by WHO.

The global economic recession and current financial constraints at the Global Fund to Fight AIDS, Tuberculosis and Malaria, which provides the majority of external funding, and other aid mechanisms make it imperative that every effort is made by stakeholders to sustain tuberculosis control activities.[4] In 2012, tuberculosis control and research efforts must be consolidated with a strong emphasis on sustainability. A particular focus is required on the orphaned areas of: multidrug-resistant tuberculosis, tuberculosis in disadvantaged groups, paediatric tuberculosis, latent tuberculosis infection, and tuberculosis associated with non-communicable conditions. This effort will unfold in a challenging environment, in which global health is grappling with key transformative concepts. The expected shift from global solidarity and a macroeconomic perspective of development towards a focus on sustainability will change the dynamics of development initiatives with unpredictable consequences for existing global health efforts.[5] Without innovative thinking in investments for tuberculosis control by endemic countries and international aid agencies during this turbulent period, there is a major risk that recent progress will be neutralised or even reversed.

The low profile of health in the agenda of the United Nations Conference on Sustainable Development (Rio+20),[6] which will take place in Rio de Janeiro, Brazil, in June, 2012, is already of major concern. Health must be kept high on the global agenda. The global health community needs to promote an inclusive "health in all policies" approach and simultaneously ensure more categorical identification of health as a specific priority area, particularly at international summits that will address the post-Millennium Development Goal global targets and UN-based discussions such as Rio+20. If health is emphasised as crucial in sustainable development, then tuberculosis control has a chance to be maintained as a prominent and sustainable public health good.

Interventions to prevent and control tuberculosis are cost effective[7] and can have a direct effect on poverty and sustainable development. Tuberculosis prevention and control contributes to the sustainable development of people, making poor and affected communities healthier and thus supporting the economic growth of society. Moreover, tuberculosis prevention and control benefit from most interventions designed to alleviate the social, economic, and environmental determinants of ill health. Food security and adequate nutrition, healthy cities, and housing with better ventilation and reduced indoor air pollution, as well as the promotion of healthy behaviours that discourage smoking and alcohol use, are key interventions to contain tuberculosis.[8,9] The time is ripe to identify strategies that recognise and build on the strengths of current approaches, but expand the horizons to a more holistic approach beyond 2015 that also considers social and environmental perspectives alongside the more traditional health and economic ones.



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A recognised strength of the Stop TB Strategy, today implemented in most settings, is the monitoring and evaluation system that is standardised worldwide[2] and provides measurable outcomes that can be monitored as indicators of success or failure of any sustainable development strategy. As a key indicator of deprivation and social dysfunction, tuberculosis control can reflect global developmental progress. Thus, tuberculosis control is an excellent example of an intervention to be consolidated and enhanced, since it contributes to, and benefits from, sustainable development; it also provides a robust infrastructure to monitor progress, with relevance beyond tuberculosis control and health towards a broader development theme.

To achieve this, a new strategy for tuberculosis control and research is needed that will redesign a post-2015 paradigm and has bold and realistic targets that fit fully into future sustainable development initiatives. Core to this vision, a unifying aim is necessary. Universal health coverage and social protection mechanisms are the non-negotiable interventions that must be present everywhere so that free access to care for all poor patients with tuberculosis is assured, catastrophic expenditures are prevented, and poverty is ultimately alleviated.

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What (if anything) to do about low-risk prostate cancer

Published Online January 24, 2012 DOI:10.1016/S0140-6736(12)60066-X
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Low-risk prostate cancer is a major public health issue in those countries that have embraced prostate-specific antigen screening. Up to one in five American men will be diagnosed with prostate cancer.[1] Most of these men will have low-risk disease, meaning an impalpable, low-grade tumour with a prostate-specific antigen concentration of less than 10 ng/mL. Active surveillance provides a period of observation to help men with low-risk disease decide whether or not to be treated.[2] Repeated biopsy sampling is used to monitor the cancer, with detection of higher-grade disease used as an indication for radical intervention. Whether such intervention involves surgery or radiotherapy it carries risks of erectile dysfunction and incontinence, and so is best avoided if not necessary.

In *The Lancet*, Neil Fleshner and colleagues report on a new strategy for dealing with low-risk prostate cancer.[3] The investigators suggest that active surveillance provides a chance not just to monitor, but also to employ pharmacological intervention to change, the behaviour of the cancer. A safe oral drug that could prevent prostate cancer progression (avoiding the need for radical surgery) is certainly an attractive proposition. In Fleshner and colleagues' randomised placebo-controlled trial of 302 men undergoing active surveillance, the investigators noted that use of the oral 5α-reductase inhibitor, dutasteride, reduced the number of patients undergoing radical treatment. Risk of pathological or therapeutic progression, the trial's primary endpoint, was reduced in patients given dutasteride as compared with placebo (hazard ratio 0·62, 95% CI 0·43–0·89). So should men on active surveillance now receive dutasteride?