“TB and Poverty: Are We Doing Enough?”

Bellagio 5th-8th December, 2005

<u>**Contents**</u>

1 Introduction 1
2 Main report 2
2.1 Group Work 2
2.2 Panel Discussion 7
2.3 Other issues 11
3 Way forward-conclusions from Bellagio 11

Annex A: Timetable 14
Annex B: Participant List 17
Annex C: Resources 21

The "TB and Poverty: are we doing enough?" Conference Participants

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Abbreviations

CB	Coordinating Board
CD	Case Detection
CR	Cure Rate
DFID	Department for International Development
DHS	Demographic and Health Surveys
DOTS	Directly Observed Treatment Short course
FIND	Foundation for Innovative New Diagnostics
GDF	Global Drug Facility
GP2	Second Global Plan to Stop Tuberculosis
IP	Intellectual Property
KNCV	The Royal Netherlands Chemical Society
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDR	Multi Drug Resistant
MICS	Mid Decade Assessment
MoH	Ministry of Health
NGO	Non Governmental Organisation
NTP	National Tuberculosis Program
PPM	Public Private Mix
PPPs	Public Private Partnerships
REACH	Research for Equity and Community Health
SES	Socio Economic Status
STAG	Strategic and Technical Advisory Group
SWAPs	Sector Wide Approaches
WHO	World Health Organization

1 Introduction

The Bellagio meeting on *"TB and Poverty are we doing enough?"* was held at the Rockefeller conference centre 5th-8th December. Its aim was to bring together key individuals working within the framework of TB and/ or poverty to create a platform for debate on the issue of TB and Poverty. By presentation of a synthesis of available evidence and current strategies, the conference asked if more can be done and whether there should be increased efforts in this area. Specific issues around policy support for TB and poverty, examining the Global Stop TB strategy and advising on how TB control can be improved to better cater for the needs of the poor. A special emphasis was given to how National TB managers can implement pro-poor DOTS strategies and how they can participate further in national poverty alleviation dialogue. The conference looked to other poverty and equity initiatives for insight and potential linkages. The meeting was organised by Dr Bertie Squire from LSTM's Equi-TB Knowledge Programme and chaired by Ian Smith from WHO. It was designed to synergise with the on-going work of the TB & Poverty Sub-Group of the Global STOP-TB Partnership.

The Goal of the TB Poverty Conference was to address the following questions:

1. What is poverty and how is it measured?
2. Are there effective implementable strategies?
3. Could National and International Policy Makers do more?
4. Addressing TB and Poverty in a wider context – what can be learnt from other initiatives?
5. The future: where should our efforts lie?

The remaining narrative will describe the outcomes of the conference discussions including a panel discussion and group work activities (see Annex A for full timetable). Along with presentations by the participants these were used as a framework to address the conference goals. Reference is made to the Powerpoint presentations accompanying this report which were used to stimulate debate and describe some of the progresses made to date in, amongst other things, measuring poverty and implementing pro-poor interventions both within TB and the wider health context. The Powerpoint presentations can be viewed on the TB & Poverty web-site http://www.stoptb.org/tbandpoverty/. The report concludes with an action plan which was formulated at the conclusion of the conference.

2 Main report

General areas of discussion

Defining poverty
As the conference progressed a definition of poverty began to emerge. Poverty is associated with vulnerability and a lack of enabling environment, containing both economic and non-economic dimensions and can be defined according to an individual, household, community or nation. Indicators of poverty can therefore relate to economic factors, basic needs and social impact. The MDGs can also be used. Whatever indicators of poverty are chosen, the importance of listening directly to the poor was stressed. The value of incorporating both quantitative and qualitative dimensions to any poverty assessments was also emphasised. Whilst some policy makers traditionally favour an epidemiological approach there was also recognition of the increasing importance of qualitative approaches and the inclusion of social scientists in the debate.

Poverty in the context of TB
Whilst there are signs that globally the TB control targets of 70% case detection (CD) and 85% cure rate (CR) may almost be reached by the end of 2005[1], there is increasing concern that the poor are still being missed from these figures. When focusing on the next stage of DOTS expansion, should the emphasis be on increasing coverage, or increasing access for the poor? It was pointed out in this debate that there is now a need to step back and reflect on the 30% who are missed by the 70% CD target. There is concern that they are most likely the poor, but the evidence for this needs to be strengthened. There was strong advocacy, therefore, for the use of equity dimensions in existing indicators i.e. case detection and morbidity/ mortality and debate about the next steps which must be taken in terms of resource needs required to develop this evidence base and who should coordinate the effort? It was recognised that the effectiveness of TB programmes can be limited by the context of the environment they are in e.g. where HIV/AIDS is prevalent or skilled human resources are scarce programmes will struggle to reach desired targets. Even strong programmes which find it relatively straightforward to meet targets of 70% CD and 85% CR can struggle to reach the very poor.

The question was asked, how much more do we need to know about the correlation between TB and poverty and why? And can we use TB as a proxy for poverty?

2.1 Group Work

Two groups were formed from the participants in order to promote constructive discussion. They used a mixture of their own personal experience and expertise along with information from presentations to inform their discussions. The two areas of discussion were equity in the development and implementation of new tools for TB control and ensuring equity in DOTS expansion and scale up of TB/HIV and DOTS plus in the implementation of the Global Plan.

1. Ensuring equity in developing and implementing New Tools for TB Control *(Facilitator: Giorgio Roscigno)*

Participants were asked to use their knowledge of the new Global Plan to Stop TB to reflect on the existence of pro-poor approaches in the strategic plans of the new tools

working groups and areas where further development was needed. They were also asked to refer to evidence that new tools do reach the poor. Issues surrounding affordability and its definition were discussed along with practical measures to ensure equity in access to new tools. The groups were asked to discuss appropriate indicators for ensuring equity in access to new tools and finally what next steps should be taken.

Discussion

Pro-poor approaches in the New Tools Strategic plans of the Global Plan

Discussion focussed mainly around the New Diagnostics Working Group Strategic plan as the participants were more familiar with this Working Group than the New Vaccines and New Tools Working groups. Within the New Tools strategic plan there is reference to the Intellectual Property Policies required in order to protect the public sector and avoid the development of prohibitively costly products. Similar policies are in place for the New Vaccines and New Drugs Strategic Plans. Affordability is also addressed in the plan. An area which does still need more emphasis is the prioritisation of technical approaches that will maximise benefits to underserved populations for example: point of care diagnostic, intermittent and/or short regimens, oral vaccine (as opposed to a parenteral vaccine). Out of all the current developments, the group felt that new rapid diagnostic tests have the greatest potential for empowering patients and improving access for the poor.

Evidence that new tools reach the poor

Two examples were presented of new tools which were felt to have improved access for the poor. These are Fixed-Dosed Combination TB drugs through the GDF pooled procurement mechanism: This has promoted increasing coverage in low income settings. The second example was the delivery of short course chemotherapy in Tanzania which doubled case detection. This was primarily as a result of the word of mouth which surrounded its introduction. In both cases, however, it was recognised that there is currently no data on the extent to which these new tools have extended the reach of TB control to the poorest quintiles

Affordability

There is no accepted definition of affordability in the context of new technologies for TB control. The economic costing that FIND diagnostics make in producing new tools was discussed. FIND links its calculation of an affordable price for the public sector on the fully loaded cost that the government already pays for the implementation of existing diagnostic modalities, in order to work towards sustainability and willingness to pay. FIND uses cost effectiveness findings in policy dialogue with WHO and IUATLD, they also consider the cost of manufacturing and a reasonable profit margin in calculating an agreed private sector price with manufacturers.

Practical measures to ensure equity in access to new tools

With the introduction of new tools, there is the challenge to ensure that intellectual property (IP) rights and patents do not restrict their delivery. Public Private Partnerships (PPPs) provide a means of addressing IP (patents) and profitability issues incurred by the willingness and ability of health systems and governments to pay and so assist in developing new tools whilst ensuring access to those technologies by the poor. FIND's IP policy for TB is intended to ensure that the underprivileged have access to new technologies, while concurrently respecting FIND's commercial partners' legitimate right to profits. FIND defines the public market as any products purchased through a public tender by MOH or purchased by civil society or NGOs collaborating with the NTP / MOH. After discussion it was clearly

recognised that in some settings in Asia there is a need to carefully define private sector versus public (formal and informal, private not for profit, private for profit, etc).

A point was made that it is important to remember that the success of any program can rest not only on the appropriate delivery of new tools but also on the quality of the service and attitude of health personnel. As services move away from the centre, monitoring of quality assurance becomes a priority, even for the use of the kind of hand-held, point-of-care diagnostics (like dipsticks) that are envisaged by FIND as being needed to promote easier access to TB diagnosis by the poor. This, in turn, requires linkage to laboratory systems that can deliver quality assurance.

Indicators

The development of new tools for TB treatment brings with it many challenges not least in ensuring that their distribution and delivery is achieved in an equitable fashion. It was proposed that mechanisms should be in place to ensure this takes place, however in reality this rarely happens. Within TB programs there is a lack of systematic reporting and data collection using indicators of equity such as socio-economic status.

Other examples of tools that could be used in developing equitable distribution were to follow up and learn from existing pro-poor strategies assessing how they are achieving equity in their access i.e. Fixed-Dosed Combination through the GDF pooled procurement mechanisms.

Service delivery

Other points were highlighted as a result of the group's feedback in plenary. Service quality in terms of personnel and technical delivery are obstacles in the successful provision of new tools. The stigma and discrimination found in health services towards TB patients can hinder any attempt at service scale-up and how communities view a health service is an important dimension to the success of any tool. Quality assurance monitoring of technical delivery becomes more important as services move away from the centre and without appropriate supervision can result in new tools being used ineffectively and inequitably.

Next steps in moving forward

- TB-Poverty Sub-Group to give input to a concept paper for STB Coordinating Board on how to move from policy to access to new tools for the poorest people.
- Involve NTPs in early Intellectual Property discussions
- Learn from systematic reviews on introduction of new tools but keep in mind TB context. Example: IMCI
- Examine when the appropriate stage is for policy implementation. Example: GDF and 4FDC
- Determine whether existing delivery systems are adequate
- Determine whether existing reporting lines are adequate
- Consider access issues for tools developed outside of the Public-Private Partnerships

2. Ensuring equity in DOTS Expansion and scale up of TB/HIV and DOTS+ as part of the implementation of the Global Plan to Stop TB 2006-15 *(Facilitator Knut Lonnroth)*

This group was assigned the task of reviewing the pro-poor strategies incorporated into the global plan with a focus on the three implementation working groups. They focused most of their discussion on indicators and methods to measure equity in access and financial protection as part of TB programme M&E as this is a crucial step towards improving the evidence base for pro-poor strategies. They also attempted to prioritize activities / next steps, and identify possible collaborators and expected outcomes

Discussion

Review of pro-poor strategies

GP2 highlights the following:

- An explicit understanding of the need to have pro-poor strategies, however no recommendations on how to identify the poor, nor how to monitor & evaluate pro-poor strategies
- That equity (in access/treatment) is both an outcome, and a means to achieve reduction in TB morbidity and mortality

The group came up with the following indicators for monitoring and evaluation of the reach of TB control activities to the poor

Equity dimension	Indicator	Data source
Equity in access (geographical level)	Correlation between notification rate and poverty index on district level (cross sectional and difference in change over time)	Routine data on case notification plus poverty mapping data
Equity in access (individual level)	• % poor people among people with TB registered in a TB programme • Ratio of % of poor in programme to % poor in population • Ratio of % of poor in programme to % poor identified in TB prevalence survey	• Survey of patients at the time they are registered in the programme • Living standard survey • TB prevalence survey with data on SES
Treatment delay	• Absolute health seeking delay and provider delay • Difference in delay between different socioeconomic groups	Patient survey as above, retrospective data to describe health seeking
Equity in treatment outcomes	Ratio of treatment success rate among poor to treatment success rate among less poor	Patient survey as above, plus follow up survey to allow cohort analysis with individual level data
Economic consequences / catastrophic expenditure[a]	• Absolute expenditure on accessing TB diagnosis and treatment (direct and indirect costs), by income quintile • Ratio of expenditure to income, by socioeconomic group	Patient survey with follow up as above, with costing data retrospectively (before treatment) and prospectively (during treatment)
Equitable reduction in TB prevalence (incidence and death rate)	Difference in change in prevalence between two prevalence surveys (absolute and relative) and between different socioeconomic groups	Prevalence survey with socioeconomic data, repeated

[a] Health expenditure has been defined as catastrophic if a households financial contribution to the health system exceeds 40% of income remaining after subsistence needs have been met[2]

There are thus three principle data sources for indicators suggested in the table above:

1. Existing data: Routine case notification data from district level, combined with available poverty mapping data on district level
2. Patient survey: Baseline and follow up survey of sample of patients registered in a TB programme
3. TB prevalence survey; including SES data

The necessity to incorporate qualitative data indicators into the above was emphasised in reference to qualitative studies performed in China and Malawi which provided additional evidence on the barriers to accessing TB treatment and care.

In addition to the indicators shown above there is a need to have an additional column in order to indicate how these indicators will be used to influence policy.

From the group's feedback in plenary, challenges were identified. These were related to a) developing a standardised methodology for monitoring and evaluating pro-poor implementation, b) accepting TB as an indicator of poverty and c) ensuring that data collected will influence policy change and promote equity in DOTS expansion and scale up. With these challenges it was highlighted that WHO has a crucially important role in continuing to open the discussion on TB and poverty (especially at country level) and continuing to advocate for it.

Standardised evaluation methodology
Different reasons for standardising a strategy were discussed. There is a need to define whether the strategy is intended to evaluate within or between countries. It was also discussed whether defined indicators would be used in all countries, but the ways of measuring the indicators could be adapted to be country-specific.

Data and evidence for policy change
After meeting the challenge of large data collection efforts, it must be clear how this data is to be used to change policy. National TB programmes by themselves will have little voice if not supported by WHO. The data collected will be able to highlight where there are problems and, with the support of WHO, this should set the scene for to push forward the debate. From Malawi it was mentioned that discussion of the implementation of socio-economic targets has been possible through the process of SWAPs.

Defining indicators
Clear steps need to be addressed in order to arrive at defined indicators for measuring equity in TB control. Technical assistance from the Health Metrics Network could be utilised along with a systematic review of current pro-poor strategies. These would include pro-poor strategies highlighted in the conference presentations of REACH trust Malawi and EPI-LAB Sudan, and the indicators for defining poverty presented by BRAC, Bangladesh.

Next Steps in moving forward

- Develop standardized methodology and instruments to analyse available information from an equity perspective
  - NTP routine data
  - Census, DHS, MICS, & longitudinal data say from INDEPTH network
- Develop standardized methodology and instruments for baseline & follow-up patient surveys
- Develop standardized methodology and instruments for including socioeconomic data in prevalence surveys

2.2 Panel Discussion

Four questions were presented to the panel. These were:

1. Improving TB control automatically reaches the poor - or does it?
2. Are there any issues within TB/HIV and MDR-TB relating to equity that require special and specific approaches?
3. What more can be done for the poor
    a. At community and household level
    b. At service delivery
    c. Across public sector policies
4. Will public-private mix address poverty within TB control?

1) Improving TB control automatically reaches the poor – or does it?

Points made by the panel relating to this question were that the answer to this question is largely "No" due to a combination of a) weak health systems, b) a lack of political will and c) barriers of access for poor patients requiring health services.

Weak health systems
Health systems need the capacity to support a TB control programme. Many health services are already constrained by lack of personnel and equipment. If they are, therefore, struggling to maintain a basic service to the poor, they may be unable to support a TB programme with a pro-poor focus. Such an addition may even create a negative effect of weakening a health service further, having a detrimental effect to the health care needs of the poor. However, if the health service is improved then this may have the effect that the poor are more likely to travel to access what is known as a "good" service and therefore their access to TB control will be improved.

Access
Regarding access to health care it has been demonstrated in some instances that the pathway to cure can be twice as long for the poor. The concentration of health facilities among urban populations can create insurmountable costs of transport and loss of working time which have meant that the poor are automatically discriminated from accessing services. In such circumstances, even if TB control is improved within existing health facilities, the poor can face too many barriers of access, and so they will not be reached.

Lack of political will
One of the reasons for the lack of political will to address the area of inequity in TB service provision is the absence of pressure on governments to do so largely because of the absence of equity indicators. The lack of concrete measures contributes to the situation in which in already hard pressed ministries find it difficult to seek to address the issue of TB and poverty.

Other factors which can have an effect on improving TB services for the poor were decentralisation of health facilities and community empowerment. Decentralisation of health services has the potential to decrease delays in access to treatment, improve cure rates and increase the gender equity. In so doing improving TB control will automatically mean that the poor are better served. Community empowerment is key for improving TB control amongst the poor. Giving communities a voice to advocate for improved health services, access to treatments has the potential to lead to an

improvement in TB services and consequently improved TB control amongst the poor.

2) Are there any issues within TB/HIV and MDR-TB relating to equity that require special and specific approaches?

The panel responded to this question by affirming that there are equity issues within TB/HIV and MDR-TB that require special and specific approaches. These were highlighted as a) an increase in barriers to accessing appropriate treatment and care, b) catastrophic expenses that the poor incur as a result of the disease itself and obtaining treatment and c) the lack of knowledge of their condition and appropriate care.

Barriers to accessing care

Greater barriers to accessing care for these patient groups occur because of the complexity of the health interventions required. For MDR-TB, the treatment is long (at least 18 months) and complex. It entails hospitalizations or travelling to specialized centres to receive treatment. Treatment is very complex and the drugs are toxic, so you need more follow-up examinations which cost money and time. All these have catastrophic effects to the poor, because they live away from the treatment centres, they have to leave work for many months, and second line drugs and tests are not usually provided for free. And even with second line drugs being available, treatment success is still very much lower than non-MDR TB.

For patients with TB-HIV, the issues are similar, but even more extended and the increasing complexity of health interventions required, coupled with a lack of cohesion in care between TB and HIV departments results in patients facing confusion as to where and how to access services. Illness episodes in both groups are likely to be more severe with an increased fatality if appropriate treatment is not received.

Mortality is more than 10 times higher in this group of TB patients, and it is the poor are the most affected: MDR-TB is a result of poor programmes and poor treatment compliance during initial treatment course, which is more likely to be found among the poor. For TB-HIV, there is already evidence that HIV is much more a problem among the poor, and the access to early detection of TB among HIV sufferers is low.

Lack of knowledge

It was highlighted that the poor often lack in-depth knowledge about their condition and the treatment that they need to receive. This ignorance has the potential to result in confusion in where to access services (stated above) and the potential for abuse to occur e.g. being sold inappropriate and costly medications. These issues are not restricted to developing countries alone but are worldwide concerns.

3) What more can be done for the poor

a. At community and household level

Empowerment of the community was emphasised by the panel as an area that should be effective in reaching the poor. It was agreed that more could and should be done. Information needs of communities and households were identified along with specific suggestions of how communities could be empowered to assist with

information flow, advocating for improved health services and reducing the stigma attached to a patient with TB.

Information needs of communities
The panel indicated specific information needs of communities and households. At the household level, it is important that there is an awareness of the symptoms of TB. Patients themselves need to be knowledgeable of their treatment in order to combat any abuse from stigma etc. Problems were identified in China where Chinese health workers did not want to be involved in providing any health information to poor patients due to the inherent stigma that they placed on them.

Communities need an awareness of the resources available to them through their health facility. This would include an accurate picture of what services are offered for free, what needs to be paid for. Examples were given where inaccurate knowledge of service availability results in the poor seeking treatment only to find that costs are charged to them which they are unable to afford. This results in a detrimental effect not just to that person but to the whole community as word spreads.

Community structures
Suggestions made for how communities could be empowered in order to be effective for the poor included the promotion of DOTS committees and the active use of resource people. DOTS committees were pointed out as being a useful means of disseminating information to households, lobbying for improved services and reducing the stigma attached to having TB. Resource people could include well known, respected individuals who have had or are suffering from TB. They are well placed to promote TB treatment and control and like the DOTS committees go some way to reduce the stigmatising effects suffered by patients with TB. DOTS committees and resources persons are also well placed to improve and strengthen the link between the health service and the community. This link would be useful not only for the monitoring of service provision and lobbying for improvements but also for the dissemination of health information between the provider and the community and to reduce the stigma that health providers themselves impose on sufferers of TB.

In reference to the discussion above it was also mentioned that community based approaches have the potential to benefit those affected by MDR-TB and TB/HIV, particularly the poor.

b. At service delivery

The panel opened this discussion by pointing out the barriers known to exist for the poor to access health services. These included the aforementioned catastrophic expenditures, the poor attitude of health workers and the financial disincentive posed to health workers to treat the poor for free due to loss of income for the health services. Potential solutions to these problems were suggested: a) the provision of incentive/ enabler schemes for patients and b) education and incentives for health personnel.

Incentives /enablers for patients
The financial cost incurred by patients is one of the many barriers to accessing health services for the poor. This conference discussed ways of combating this huge barrier of access. One method proposed was the use of incentive enabler schemes shown by examples given by DFID using cash transfers and by Malawi to be effective. These incentive/enabler schemes in the form of food, transport, skills training or peer work could be organised by NGOs working alongside the NTP.

Human resources
Problems identified within the human resource context include the staffing crisis and the attitude of health personnel to TB patients. The latter maybe a result of the former and can result in a stigmatising attitude towards patients with TB. The need was recognised for input to be provided at health provider level for education on TB, and an attempt to find innovative solutions to combating the problem. The issue of using financial incentives for health staff, primarily as a means of offsetting income losses incurred by providers providing free treatment to poor TB patients was proposed as one such action.

c. Across public sector policies

Suggestions were made on how more could be done for TB patients across public sector policies. These included advocating for poverty reduction measures to be incorporated in sector wide policies, scaling up a technical resource base which can be utilised by NTP managers, active promotion of existing TB legislation and involvement of media to promote TB awareness.

SWAPs
At both global and national level there is a need to advocate for sector wide policies which look to decrease the socio-economic impact for the poor. The national TB program manager should lobby for this alongside a more global effort to produce an advocacy package for parliamentarians.

Technical Resources
At the global and national level there is a need for scaling up technical resources available for NTP managers and policy makers in order to guide scale up of activities for making TB services more pro-poor. This would include demonstration sites costed at national level which can then be incorporated into national healthcare spending budgets.

Legislation
Promotion of existing legislation i.e. “TB in the workplace” at ministerial level is necessary in order for relevant parties i.e. businesses to take more responsibility for improving working conditions for the poor and reducing discrimination.

Media involvement
The potential powerful influence of the media could also be utilised more in advocating for TB services to the poor. Involvement of journalists and media at a national level has a role to play alongside that of policy makers and the NTP manager.

4) Will public/ private mix address poverty within TB control?

The panel’s response to this question was mixed. It was noted that public/ private mix has been seen as being a successful means to improve access of health services to the poor, however expression was made that it is still debateable whether PPM can in itself address the issue of poverty within TB control. The importance of defining clearly what is meant by the private sector was also raised. The spectrum of private provision is very broad, ranging from grocery storekeepers (e.g. Malawi) to large private teaching hospital facilities (e.g. India).

Positive

From the conference presentations it was demonstrated that mobilisation of storekeepers in Malawi to provide DOTS services is a successful innovation in bringing TB treatment closer to the poor, this innovation was implemented as a direct result of qualitative research to assess where the poor go for treatment.

Negative
The danger of targeting the poor through the network of private facilities is that if insufficient preparatory work is done to understand the treatment seeking behaviour of the poor, the providers of the poor may not be targeted. It was pointed out that private facilities targeted for interventions are often large, covering a huge area, but often the poor frequent smaller private practitioners which can be more difficult to adequately reach through the public/private mix. Though large institutions may give a high yield in terms of number of additional cases notified and treated, these may not be the patients most in need. Targeting small private clinics in urban slums and remote rural areas might be more costly from a programme or public sector viewpoint, but may perhaps be more effective in reaching the poorest of the poor. More research is needed in this area.

2.3 Other issues

Discussion on manual "addressing poverty in TB control"
A presentation was made of the WHO manual "Addressing poverty in TB control – options for TB control managers". Additional points needed in the guide were recommended.

Firstly NTP managers needed practical solutions/ examples that they could utilise in their own context. There is therefore a need for a synthesis of information and the building of technical expertise. In the guide itself it was suggested that additional chapters in how to listen to the poor, the use of indicators and monitoring and how the NTP manager links to the MoH could be added.

The way forward in the promotion of the guide was recommended by the active involvement of stakeholders. This could be through workshops in each country to introduce the guide and gauge reaction from district managers and programme managers. The need to bring in additional expertise was expressed. This was particularly in the use of social scientists with gender and equity input. The guide needs to be integrated into the MoH plan through the proper systems. The NTP manager should be the one to lead this process. The launch of the Global Plan provides a useful impetus for integration to take place.

3 Way forward-conclusions from Bellagio

In the light of the imminent launch of the second global plan to stop TB and the new Stop TB strategy, the time is right for the preparation of an action plan to incorporate outcomes from the conference.

The problem of poverty is highly complicated and approaching from one angle alone will not be sufficient to make a lasting impact. Not only does it require involvement of many stakeholders at country level from communities, NGOs, human rights activist, businesses and government ministries but it also requires the commitment of international agencies such as the WHO and the STOP-TB partnership;

organisations such as FIND diagnostics and KNCV, research institutions and also the involvement of media and reporters.

The main areas highlighted for development were

a) building up the existing evidence base for pro-poor activities through research and the use of appropriate monitoring and evaluation indicators,
b) addressing the particular needs of poor patients with HIV/TB and MDR-TB, given the additional complexity of the health interventions they require
c) clearer actions to promote equity in the development and deployment of the new tools for TB control.

The main implications of the outcomes of the Bellagio conference are summarised in the box below.

Evidence base/research

- There is a need for a core set of standardised indicators including quantitative and qualitative measures, and meta analysis of approaches and best practices to reaching the poor and addressing equity concerns
- Additional efforts needed for surveying using defined equity indicators
- TB patients and the affected community must be involved in developing and communicating the evidence base and in monitoring policy change
- Increase in accountability through the use of equity indicators in programme management and shared responsibility amongst stakeholders
- Evidence has to be translated into policy and action

TB/HIV and MDR-TB

- TB/HIV and MDR-TB issues serve to magnify the particular challenges faced by vulnerable groups affected by TB
- Poor people with TB/HIV and MDR-TB face greater challenges and barriers in accessing care due to the increased complexity of the health interventions needed
- TB HIV and MDR-TB have a more devastating effect on affected people due to catastrophic expenditures and effects on livelihoods
- Community based approaches have the potential to benefit those affected by MDR-TB and TB/HIV, particularly the poor
- Accountability: TB patients and the affected communities equitable right to knowledge about their condition and services
- Sustainability: these interventions are more costly, so this is a crucial concern
- Worldwide issue, not restricted to the developing countries

New Tools for Equity

- Potential of diagnostics to address equity in the shorter term and the potential synergies with innovations in treatment regimens
- PPPs provide a means of addressing IP (patents) and profitability issues and willingness to pay by healthy systems/governments in developing new tools while ensuring access to those technologies by the poor
- The STOP-TB Partnership is a means to addressing health systems issues in the introduction of new tools, e.g. laboratory group interacting with diagnostics group, integrating new tools in the PPM process.
- Need to prioritise new tools that will promote equity
- Need for ensuring equitable access to new technologies

A framework of an initial action plan to tackle TB and Poverty was developed from the conference.

	Action
A	Series of Review / critical appraisal documents 1. Review, description and analysis of existing interventions to reach poor TB patients (including Fidelis, but perhaps focus on MDR-TB and HIV-TB) 2. Description of indicators most appropriate for monitoring and evaluation 3. Learning from other health interventions
B	Scaling up models/demonstration sites
C	Poverty specific data collection (see Group A's outputs from Day 2 Bellagio) • Socioeconomic surveys of TB patients plus inclusion of socio-economic data in prevalence surveys (30% missing cases – are they the poor?) • Specific opportunities
D	Promoting awareness of need for Poverty focus within TB control GLOBAL • CB o Input to re-tooling concept paper (for new tools – see Group B's outputs from Day 2 Bellagio) o Submission of a clear TB/Poverty action plan paper • STAG/WHO • Union conference – postgraduate course REGIONAL • NTP meeting o TB/Poverty guide promotion o Patient representative • Subgroup TB/Poverty meeting NATIONAL
E	Capacity building plus technical assistance. Needs to be defined to operationalize the TB/Poverty guide
F	Mobilise Resources (writing bids)

References

1 WHO 2006 "The Global Plan to Stop TB 2006-2015" http://www.stoptb.org/globalplan/plan_p1main.asp?p=1

2 Xu K, Evans DB, Kawabala K, Klavus J, Murray CJL. Household catastrophic health expenditure: a multi-country analysis. Lancet. 2003; 362:111-7

Annex A: Timetable

Monday 5th December: Participants arrive at Bellagio conference centre

Tuesday 6th December			
9.00 – 9.30	Welcome Objectives of workshop	B Squire EQUI – TB KP	Overall Chair: Ian Smith WHO
What is poverty?			
9.30 – 9.50	How do you measure the concept of poverty?	SM Ahmed BRAC	
9.50 – 10.10	TB and Poverty agenda in WPRO How can access to services be monitored by civil society?	B Thomas WPRO B S EQUINET	
10.10 – 10.30	Discussion		
10.30 – 11.00	*Tea Break*		
Addressing TB and Poverty in a wider context – what can be learnt from other initiatives? *(Applying the knowledge and lessons learnt from other initiatives to enhance equitable access to TB control)*			
11.00 – 11.20	Measuring and explaining Inequities in Health: Data needs and methods	A Hosseinpoor Health Equity Team, WHO	
11.20 – 11.40	Health system development for equity: Global Perspectives	R Sadana Evidence for Health Policy (EIP), WHO	
11.40 – 12.00	Health system development for equity: Bilateral Perspectives	B Stewart, DFID	
12.30 – 1.00	Discussion		
1. 00 – 2.00	*Lunch*		
2.00-2.30	TB and Poverty in The Global Plan to Stop TB 2006-2015	S England, V Diaz, K Lonnroth, & Giorgio Roscignio (STOP TB, WHO & FIND)	
2.30-2.40	Set up and purpose of Group sessions	B Squire	
	Tea Break		
3.00– 5.00	**Group A: Ensuring equity in DOTS Expansion and scale up of TB/HIV and DOTS+ as part of the implementation of the Global Plan to Stop TB 2006-15**	**Group B: Ensuring equity in developing and implementing New Tools for TB Control**	Group A Facilitator: K Lonnroth Group B Facilitator: G Roscigno

Wednesday 7th December			
9.00-10.00	Feedback from Group sessions	F Mugisha/ P Patrobas	
9.30-10.00	Discussion	I Smith (Chair)	
Are there effective implementable strategies? *(examples of how TB control does and does not reach the poor and vulnerable)*			
10.00 – 10.20	Are there effective implementable strategies	B Squire EQUI-TB, LSTM	
10.20 – 10.40	Examples of pro poor interventions in Sudan	A El Sony EPILAB/ Union President, Sudan	
10.40 – 11.10	Involving the informal health sector in Malawi	B Simwaka REACH, Malawi	
11.10 – 11.25	*Tea Break*		
11.25 – 11.55	Reaching the poor in Kenya	F Mugisha APHRC, Kenya	
11.55 - 12.10	Discussion		
12.10 - 12.40	Patient and community involvement in TB control - approaches and challenges in reaching the poor	T Torfoss/ P Tufail STOP-TB/ AMAL	
12.40 – 13.00	Discussion		
Support for poverty focused TB control			
12.30 – 12.50	Addressing Poverty in TB Control –The TB Poverty Guide?	B Squire & M Van Cleef TB & Poverty Core Group	
12.50 – 1.15	Discussion		
1.15 – 2.30	*Lunch*		
2.30 – 4.00	**Could National and International Policy Makers do more?** **Panel Discussion:** P Patrobas R Sadana P Tufail Bernard Tomas		Panel Chair: I Smith
4.00 – 5.00	Discussion		

<table>
<tr><th colspan="4">Thursday 8th December</th></tr>
<tr><td>9.30 – 9.45</td><td>Objectives of the day</td><td>B Squire
EQUI – TB KP</td><td>Ian Smith
WHO</td></tr>
<tr><td>9.45 – 11.00</td><td colspan="2">The Future: Where should our efforts lie?
(guided discussion with objective of approaching consensus about potential actions for inclusion in a workshop statement)</td><td>Sarah England – STOP TB</td></tr>
<tr><td>12.30 – 2.00</td><td colspan="3">Lunch</td></tr>
<tr><td></td><td colspan="3">Participants depart</td></tr>
</table>

Annex B: Participant List

Name	Address	Organisation
Syed Ahmed	BRAC University of Bangladesh 75 Mohakhali Dhaka 1212 Bangladesh Tel: +88-02-988 1265 Fax: +88-02-882 3542 Email: ahmed.sm@brac.net	BRAC
Valerie Diaz	Stop TB Department HIV/AIDS, Tuberculosis and Malaria World Health Organization 20 Avenue Appia 1211 Geneva 27 Switzerland Email: diazv@who.int Tel: +41 22 791 1527 Fax: +41 22 791 4886	(STOP TB)
Asma El Sony	EPILAB/ Academy of Medical Sciences and Technology Elriyadh – Obaid Khatim Street Khartoum 1111 Sudan Email: aelsony@iuatld.org or aelsony@yahoo.com Tel: +249 9 121 67862 Fax: +249 9 12305097	(EPILAB)
Sarah England	Scientist STOP TB Secretariat World Health Organization 20 Avenue Appia 1211 Geneva 27 Switzerland Email: englands@who.int Tel: +41 22 791 3975 Fax: +41 22 791 4886	(STOP TB)
Birte Holm Sorensen	Sr. Public Health Specialist SASHD Room MC 11- 251 World Bank 1818 H St. NW 20433 Washington DC Tel. + 1 202 458 5191	World Bank
Ahmad Hosseinpoor	Epidemiologist Health Equity Team World Health Organization 20 Avenue Appia 1211 Geneva 27 Switzerland Email: hosseinpoora@who.int Fax: +41 22 791 42 92	WHO

Knut Lonnroth	Medical Officer Stop TB Department HIV/AIDS, Tuberculosis and Malaria World Health Organization 20 Avenue Appia 1211 Geneva 27, Switzerland Tel: +4122 791 1628 Fax: +4122 791 4268 Email: lonnrothk@who.int	WHO
Frederick Mugisha	Associate Research Scientist African Population and Health Research Centre P.O. Box 10787, 00100 GPO Nairobi, Kenya www.aphrc.org Email: fmugisha@aphrc.org Tel:+ 254 020 2720400. Fax: 254 020 2720380	(APHRC)
Bertha Nhlema Simwaka	REACH Trust PO Box 1597, Lilongwe Malawi Email: bertha@equi-tb-malawi.org Tel: 00 265 1 751247 Fax: 00 265 1 751247	(REACH)
Philip Patrobas	WHO/AFRO World Health Organization UNFSCO,UN House PLot 617/618,Central Area District P.M.B 2851 Girki Abuja, Nigeria Email: ppatrobas@yahoo.com Mobile: +234 8037012458 Tel: 09-4618596 Fax:09-4618591, 09-4618592	(AFRO)
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Ian Smith	Adviser to the Director General World Health Organization 20 Avenue Appia 1211 Geneva 27 Switzerland Email: smithi@who.int	WHO
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Ted Torfoss	Technical Officer Stop TB Department HIV/AIDS, Tuberculosis and Malaria World Health Organization 20 Avenue Appia 1211 Geneva 27 Switzerland Email: TorfossT@who.int Tel: +41 22 791 1527 Fax: +41 22 791 4886	WHO
Pervaiz Tufail	Program Manager AMAL Human Development Network House # 7, G-6/4, Islamabad, Pakistan Post Code: 44000 Tel: +92 512827774/2824155 Fax: +92 51 2272491 pervaiz22@yahoo.ca	AMAL (Local NGO)

Maarten van Cleeff	Project Director TBCTA KNCV Parkstraat 17 2514 JD The Hague P.O. Box 146, 2501 CC The Hague Netherlands Tel : +31 70 416 7282 Fax: +31 70 358 40 04 Email : vanCleeffm@kncvtbc.nl	KNCV

Annex C: Resources

Organisations

African population and health research centre: www.aphrc.org/

BRAC: www.bracresearch.org, www.brac.net

DFID health resources centre: www.eldis.org/health

EQUINET: www.equinetafrica.org

EQUI-TB: www.equi-tb.org.uk

FIDELIS: www.fidelistb.org

FIND diagnostics: http://www.finddiagnostics.org/

Health metrics network: http://www.who.int/healthmetrics/en/

High level forum on health related MDGs: http://www.hlfhealthmdgs.org/

International journal for equity in health: http://www.equityhealthj.com/home/

IUATLD: www.iuatld.org

KNCV: http://www.kncv.nl/

STOP-TB partnership: http://www.stoptb.org/

WHO Procurement and distribution essential medicines program: http://www.who.int/medicines/en/

Documents

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Hanson C. ***'Tuberculosis poverty and equity: a review of literature and discussion of issues***. Washington DC World Bank 2002.

Nhlema B et al ***'A systematic analysis of tuberculosis and poverty'***. Geneva: TB and Poverty Advisory Committee of the Global STOP TB Partnership 2003.

WHO 2005***. 'Addressing poverty in TB control: options for national TB control programmes'*** WHO/HTM/TB/2005.352