A change in direction for tuberculosis control

In Thomas Mann’s classic *The magic mountain*, a young Hans Castorp goes to visit his cousin at a tuberculosis sanatorium in the mountain town of Davos, Switzerland. There he embarks on a unique journey and ponders over the great questions surrounding life and death. Thus it seems fitting that the 2006 World Economic Forum in Davos provided the venue for the WHO’s STOP TB department to launch its global plan for tackling tuberculosis for 2006–2015.

*Actions for life*—towards a world free of tuberculosis sets out clearly the actions needed to achieve the global targets for tuberculosis control and at what cost. The new plan is much broader than before and signals a real shift from the traditional narrow approach to fighting tuberculosis. The WHO and others have focused heavily on directly observed therapy short-course (DOTS) as the mainstay of tuberculosis control and treatment. But the plan recognises that this strategy is not enough, and that research and development into new drugs, diagnostics, and vaccines are now essential. That tuberculosis/HIV coinfection and multidrug-resistant tuberculosis are addressed in the new plan is particularly welcome. These forms of tuberculosis are thought to be the main drivers of increasing incidence of the disease in some parts of the world.

Absence of an activist movement in tuberculosis has held back progress. The lack of involvement of civil society activists is a symptom of the depoliticisation of tuberculosis—from a social justice issue that needs multi-sectoral engagement to a narrowly defined public-health issue with DOTS being its solution. Both of these mindsets were disempowering to communities in most instances. Community education and leadership strengthening were not seen as vital parts of solving the problem of tuberculosis. But, thankfully, as reflected in the new plan, this thinking has now changed.

Among the immediate challenges for implementing the plan will be to galvanise political will and to urge countries to develop their own national plans, health system strengthening, building human resources, securing financing, and donor harmonisation.

DOTS expansion will continue to be a challenge. A long treatment duration of up to 8 months, poor adherence, and lack of awareness and information among communities is compounded by the poor availability of good quality drugs in most countries. Surprisingly, there has been no new drug against tuberculosis for 40 years or vaccine for over 100 years. New diagnostics have also lagged behind. Dealing with paediatric, sputum smear negative, and extrapulmonary tuberculosis have all been hampered by the absence of a quick and accurate diagnostic tool.

In terms of treatment hope is now pinned on the fluoroquinolones (moxifloxacin and gatifloxacin), which will reduce treatment duration to 3 months. However, there is not sufficient clinical trials capacity to do the studies needed, so the first new tuberculosis drug is not expected to reach the market until 2010 at the earliest. Although the current drug pipeline has 27 new candidates, compared with none 5 years ago, these drugs will have to be used in combination to combat emerging resistance. Poor scientific understanding of latent tuberculosis means that there are no candidate drugs for this disease. It is clear much greater attention needs to be paid to basic science if robust new tools are to be developed.

In terms of research funding, Bill Gates’ $600 million donation, announced at Davos, is a good start but needs to be complimented by the public sector. The current budget gap for tuberculosis diagnostics is more than 80% of that needed ($516 million need and $436 million gap). To meet the plan’s funding gap, donor countries will have to increase their support by eight times, and high-burden countries will have to double their investment. There needs to be a civil society advocacy movement to ensure this funding happens.

What is most encouraging is the strengthening of collaborations between the tuberculosis and HIV communities. Both diseases are beginning to feature highly on each others’ agenda. Grants from the Global Fund to Fight AIDS, Tuberculosis, and Malaria for combined programmes have gradually increased in each funding round. Furthermore, that tuberculosis services can serve as an entry point for antiretroviral therapy, as shown in Malawi and Rwanda, is slowly being realised.

The tuberculosis community still needs to be more open to change, to move away from its vertical programmes, and to engage with other sectors it has not previously reached out to. The plan heralds a promising first step in the right direction.

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