Editorial

In this issue qualitative study which was conducted by SAARC TB and HIV/AIDS Centre (STAC) on **'BARRIERS TO DIRECTLY OBSERVED TREATMENT FOR MDR-TB PATIENTS IN NEPAL**- revealed many important findings.

As revealed in the study that some patients need to sell their properties to take medicine and some have to borrow loans, which are frequently offered at exorbitant rates. Also in that study all participants of MDR-TB patients acknowledged difficulties, regarding transport costs to obtain treatment, although men were more concerned with the economic burden of treatment. Similarly, studies from Vietnam and Pakistan cite structural barriers such as financial constraints (direct and indirect cost) e.g. loss of income, cost of travel and lodging as the causes of non –adherence to TB treatment.

TB causes catastrophic economic effects on both the individual suffering the disease and their households. National economies are also affected with estimates suggesting significant impact that will hamper national development.

Majority of people in SAARC member states are under the poverty line and the urban poor are increasing. Most of the TB patients come from the lower socio-economic group. People cannot afford the travel cost and other expenses from their earnings. It has been observed consistently that poverty is associated with much higher risk of TB infection, prevalence of TB disease, and of adverse outcomes of treatment including mortality. Tuberculosis also worsens poverty, as the poor spend much higher proportion of their income on the direct and indirect costs associated with TB care.

Even though National TB Programmes provide free drugs and baseline diagnostic tests to the patients, many patients experience other associated health care costs, e.g. payment for ancillary drugs and extra diagnostic tests, as well as considerable non-medical costs, including expenditures for day to day transport and accommodation. Furthermore, patients and other household members who care for them may suffer reduced earnings due to loss of employment opportunities, and may experience the intangible costs related to social stigma associated with their illness.

Incentives are a valuable way to help a person to overcome the barriers to complete a long duration treatment like MDR-TB. Many studies conducted in other SAARC countries shows that modest incentives in a structured programme can produce an effective public health intervention in a typically poor and urban population. There are also other projects where cash and non-cash incentives have improved adherence.

Hence, member states of SAARC should identify these issues seriously and should provide solutions to these poor patients. Some member countries already have address those by providing nutritional support to TB patients and families, financial incentives to patients and providers, health system strengthening, and linking patients with existing social and financial support systems of the government.

Addressing poverty, requires inter departmental/ ministerial coordinated activities and the National TB Programme will proactively facilitate this coordination. National Programme will make active efforts to establish linkage with such services. These interventions at population level are expected to have additional impact on accelerating decline in incidence and mortality of TB.

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