# Editorial

World Health Organization estimates of the global burden of disease caused by TB were: 9.4 million incident cases (range, 8.9 million–9.9 million), 14 million prevalent cases (range, 12 million–16 million), 1.3 million deaths among HIV-negative people (range, 1.2 million–1.5 million) and 0.38 million deaths among HIV-positive people (range, 0.32 million–0.45 million) in the year 2009. The 22 High Burden Countries that have received particular attention at the global level since 2000 account for 81% of all estimated cases worldwide. Among these 22 High Burden Countries, four are from SAARC region (Afghanistan, Bangladesh, India & Pakistan). Globally, India alone accounts for an estimated one fifth (21%) of all TB cases.

Socially disadvantaged populations comprise, those living in absolute economic poverty, who have little access to health services because of the reasons that are ethnic group, geographical setting, gender, literacy level, living state, social segregation and migration. The World Bank defines absolute poverty as living on US$ 1 per person per day or less. The United Nations Millennium Development Goals (MDGs) call for a 50% reduction in the proportion of people living on less than US$ 1 a day between 1990 and 2015.

The World Health Assembly 2009 resolution on the prevention and control of drug-resistant TB emphasizes that TB control strategies must concentrate on a wider range of factors including the social determinants of health. The association between poverty and tuberculosis is well established. Even within the developed countries the highest rates of disease are seen in the poorest segments of the community. As the world population increases in some of the poorest areas of the world so the number of people living in poverty has increased.

World Health Organization has begun a process of intensified focus on the social determinants of health and the work of the Global Partnership to Stop TB to address poverty is especially important. In their document WHO, 2005, “Addressing poverty in TB Control*:* options for national TB control programmes” addresses the integration of pro-poor measures in TB control programmes and offers guidance for national TB control programmes on the practical issues involved and options for action. The six principal steps recommended are 1). Identify the poor and vulnerable groups in the country/region served by the national TB control programme. 2). Determine which barriers prevent access of the vulnerable groups to services that provide TB diagnosis and treatment. 3). Assess potential actions to overcome the barriers to access. 4). Review the situations and population groups requiring special consideration. 5). Explore possibilities for harnessing additional resources. 6). Evaluate the impact of pro-poor measures.

Much work needs to be done to encourage, pinpoint and implement comprehensive means to address the control of tuberculosis and other diseases through strategies to reduce poverty and encourage community development. There must be a coordinated struggle to deal with the poverty and to address the poor nutrition and poor living or working conditions that are responsible for vulnerability to TB. Innovative measures to make sure patients complete their course of drugs are needed to prevent drug resistance. National TB control programmes can and should explicitly include pro-poor objectives in their strategic plans and interventions. The pro-poor approach should augment and enhance the core objectives of national TB control programmes to identify and effectively treat more TB patients.