A millennial cover-up: tuberculosis deaths in South Asia

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At the beginning of this millennium, on 23 July 2000, the United Kingdom led the G-8 commitment in Okinawa to reduce TB deaths and prevalence of the disease by 50% by 2010 (WHO Stop TB Initiative).¹ Less than two months later on 8 September, the UN General Assembly in New York adopted the United Nations Millennium Declaration with its commitment to: 'have, by (the year 2015), halted, and begun to reverse the spread of HIV/AIDS, the scourge of malaria and other major diseases that afflict humanity'.²

The millennium development goals (MDGs) have: (1) suppressed tuberculosis to the category of other diseases in the wording of Goal 6: HIV/AIDS, malaria and other diseases; (2) deferred the G-8 target deadline from 2010 to 2015; (3) changed the indicators from 'prevalence' and 'deaths' to 'prevalence rates' and 'death rates'; (4) revealed the dominant fear of contagious spread; and (5) focused attention on and yet deferred the 1991 World Health Assembly targets of '... attaining a global target of cure of 85% sputum-positive patients under treatment and detection of 70% of cases', both performance targets with a tendency to over-report, and both of which were meant to have been attained by the year 2000.³

The subsequent MDG cover-up may be considered in contrast to King Edward VII's (the later Vice Roy of Imperial India or approximately present-day South Asia) statement on tuberculosis in 1898: 'If preventable, why not prevented?' (Figure 1).

TB Alert proposes that the question to ask today is rather 'If curable, why not cured?'⁴ The logical non-sequitur in this move from King Edward's prevention to only medical cure and the consequent drug resistance⁵ is congruent with the vertical top-down programmes that characterize the commoditized architecture of contemporary glo-

bal health. Both the earlier vertical Scandinavian BCG vaccine approach to tuberculosis control⁶ and the vertical magic bullet approach of chemotherapy to control tuberculosis have been 'tried' in South Asia.⁷

The Medical Research Council of Great Britain along with the Indian Medical Research Council and the World Health Organization (WHO) conducted anti-tuberculosis chemotherapy trials in the slums of Madras (modern-day Chennai).⁸ The trials of a standard oral combination of anti-tuberculosis drugs, isoniazid plus the sodium salt of p-amino salicylic acid (sodium PAS) were found to successfully treat patients at home even if the levels of dietary intake were low.⁹ Henceforward tuberculosis sanatoria for the rich closed down in favour of home-based treatment. It appears, however, that no-one raised the question as to why so many patients with active tuberculosis were already clustered¹⁰ in the slums of Madras making it an excellent laboratory for the trial. The immunocompromising stresses of poverty, migration, poor living conditions, decent employment and food security addressed by Millennium Development Goal 1 were occluded – they are not health MDGs.

By 2004 *The Lancet* was reporting from a meeting in South Asia, that the 'Tuberculosis (MDG) Goals' (by 'Goals' they meant the vertical chemotherapy approach applied to sputum positive patients) were unlikely to be met¹¹ by the deferred date of 2005. The Stop TB department of the WHO was already predicting in 2005 that the MDG mortality rate global targets were not going to be reached by 2015.¹²

In December 2008, the UK's Department For International Development (DFID) issued the Millennial Cover-Up, the widely available *Tuberculosis (TB) Fact Sheet* in the context of Millennium Development Goal 6.¹³ The fact sheet first posed

Figure 1
King Edward VII

the question 'Are we on track to meet the target?' This target was defined as 'Progress in halting and reversing the spread of tuberculosis'. Contrary to the DFID's repeated White Papers on poverty elimination,¹⁴ securitization is privileged in line with the DFID Health Strategy's¹⁵ commitment not to lower incidence, but rather to stop the spread of infection. Poor men and women, and particularly children¹⁶ who are dying of poverty-induced tuberculosis and other opportunistic diseases of poverty, or couples who are infertile because of reproductive tuberculosis, but not potentially contagious, are all occluded from the Health Strategy and from the interpretation of the MDG tuberculosis target.

In terms of Southern Asia, the MDG Tuberculosis Fact Sheet¹³ includes special boxes that highlight the fact that in India, 'DFID's support of the National TB programme has helped achieve considerable progress in disease control. The programme has treated 6.3 million patients and saved 1.1 million lives since 1997. The drug supply has improved with nationwide monitoring of drug stocks, logistics, distribution and quality procurement of quality TB drugs.' In Pakistan, 'the case detection rate increased from 51% in 2006 to 69% in 2007 (compared to 13% in 2002) and treatment success is 87%.' For Southern Asia in general, the light green, or green light, colour in the header table shows that the 'Progress in halting and reversing the spread of tuberculosis' is 'almost met, or on target'. Mortality is 'Moderate'.¹³

This analysis of moderate mortality in South Asia may be compared with analysis of the WHO estimates of tuberculosis mortality, an updated series of WHO's earlier data published in JAMA¹² and disaggregated by the countries of South Asia (Table 1).¹⁷ The various methodologies underpinning, and the limitations inherent in, the series of WHO tuberculosis mortality estimates have been critically reviewed recently, but without national vital registration systems in all countries, they remain the only standardized estimate.¹⁸

The term 'Moderate mortality' covers up an annual tuberculosis death toll, estimated by WHO, of almost half a million people (460,003), mostly poor, in South Asia. The vast majority of these deaths occur in India, but preventable tuberculosis deaths in other South Asian countries are also more than millennial. It is now 2010, the deadline for the G-8 millennial commitment. The latest

Table 1
Tuberculosis mortality in South Asia

Country	1990	2007	Reduction	Reduction (%)
India	360,835	331,268	-29,567	-8%
Bangladesh	87,087	70,901	-16,180	-19%
Pakistan	55,749	47,587	-8162	-15%
Nepal	9712	6436	-3276	-34%
Sri Lanka	1724	1504	-220	-13%
Bhutan	550	288	-262	-48%
Maldives	16	12	-4	-25%
	515,673	460,003	-55,670	-11%

WHO report (2009) suggests that the G-8 target of reducing tuberculosis deaths by 50% has resulted in only an 11% reduction (Table 1 – lower right) – neither almost met, nor on target.

The Millennium Development Goals should not be used as a figleaf for the vertical global programme that is under-funded and failing to eradicate, or root out, the scourge of poverty and the risks underpinning preventable tuberculosis.¹⁹ As King Edward VII and the Raj knew: pills against structural poverty^{20,21} are insufficient and unsustainable.

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