Partners In Health
ENGAGE

MDR-TB: Redefining Health Care Delivery

Reading: Optimism and Pessimism in Tuberculosis Control: Lessons from Rural Haiti, from *Partner to the Poor*, Paul Farmer

Discussion Guide

Goal: Use PIH's fight for treatment of MDR-TB in settings of poverty as a case study to redefine what it means to deliver health care and conduct equitable research interventions alongside the poor.

Suggested Discussion Questions:

1. How did Partners In Health ensure that the *Proje Veye Sante* intervention was conducted in an equitable manner? Consider the study design and how it benefited the community.

2. As described in this chapter, community health workers, who shared the living conditions of patients, and physicians and nurses, who did not, had two different ideas as to why the then current MDR-TB treatment system was not as effective as it should have been. What did each group blame for the treatment regimen's shortfall? What was right and what does this reveal about health care delivery in settings of poverty?

3. How was or could the success of this intervention be used to accomplish advocacy goals that amplify the lessons learned about health care delivery systems in settings of poverty?

Key Quotes:

"The factors that govern treatment success or failure there—factors such as initial exposure to mycobacteria, reactivation of endogenous tuberculosis infection, complications, access to therapy, length of convalescence, development of drug resistance, degree of tissue destruction, and, finally, mortality—are determined chiefly by economic variables" (202).

"Projects designed to prevent tuberculosis among the very poor must keep in mind a central maxim of tuberculosis control: treatment is prevention… In a sense, the high cure rate we achieved also shows that debates over whether to treat tuberculosis or to prevent it are essentially false debates, whose costs are borne, as usual, by the poor" (203).

"Although drug resistance represents a new and potentially significant problem, most studies of treatment failure agree that the problem is predominantly one of designing and implementing programs that are appropriate to the needs of the population to be served" (197).

Lesson Plan

Goal: Use PIH's fight for treatment of MDR-TB in settings of poverty as a case study to redefine what it means to deliver health care and conduct equitable research interventions alongside the poor.

Warm-Up: Haitian peasants have compared treating TB without providing food to "*lave men, sive até" (washing one's hands and wiping them in dirt).* How might this proverb inform PIH's approach to improving health or delivering care?

Diagnostic: Often, securing research funding and publishing results are the metrics used to measure faculty's success. What are important factors to consider when hoping to secure funding or get published? How might prioritizing these factors skew global health research away from projects that address poverty and local needs?

Teaching Bit: In extreme poverty, achieving health often requires much more than providing treatment. PIH believes that building health care systems and addressing education, nutrition, and unemployment—the symptoms of poverty—is key to improving health. Further, ensuring that all research is equitable, that is, fair and beneficial for local communities, when working to prove an intervention's success, is critical to PIH's mission of serving the poor.

The *Proje Veye Sante* intervention is a classic example and shows how PIH designed a trial for the benefit of the community. In the intervention to treat MDR-TB patients in Haiti, Sector 1 patients received "financial aid of thirty dollars per month… nutritional supplements… [and] were to receive a monthly reminder from their village health worker to attend clinic" (198). Sector 2 patients "were a 'control group' only in the sense that they did not benefit from… community-based services and financial aid" (199). The study addressed the health of the community by:

- Providing all participants free MDR-TB treatment
- Fighting poverty by providing employment through reliance on paid community health workers
- Building and testing a high-quality community-based health care delivery system to address preexisting issues

Guided Practice: In *Proje Veye Sante*, two groups were cited hypothesizing barriers to successful care: community health workers, who shared the living conditions of patients, and physicians and nurses who did not. Discuss what each group thought were barriers to treatment and why. The community health worker's hypothesis ultimately proved correct. Discuss the importance of community-based care in proving what is possible.

Hypotheses of Community Health Workers	Hypotheses of Physicians, Nurses
• TB patients with poor outcomes were the most economically impoverished and thus the sickest • Patients stopped chemotherapy once symptoms disappeared in order to provide for their families	• Poor compliance resulted from beliefs that TB resulted from sorcery, leading patients to abandon therapy • There was ignorance or misunderstanding of causes or treatments on the part of the patients

Independent Practice: For years, the argument of treatment vs. prevention dominated conversations in global health. Farmer makes the case for "a central maxim of tuberculosis control: treatment is prevention" (203). With a partner, discuss the treatment vs. prevention dichotomy. Which side normally prevails? Why? What are problems with seeing treatment and prevention as a dichotomy? What did Farmer mean that treatment is prevention? Consider equitability, effectiveness, research and program implementation and how treatment and prevention are inherently joined.

Assessment: This project showed what was possible in settings of poverty with health care delivery and TB. How can projects like this be used to accomplish advocacy goals, secure funding, and amplify this approach to global health?

Closer: This study proved that "high cure rates are possible in settings of extreme poverty in which hospital-based care is unavailable" (202). Prior to this intervention, conventional wisdom would have said that care was not possible. Have each person share where we, future leaders in global health, can fight currently prevailing notions of what is possible.