Reduce the delay in tuberculosis diagnosis in India

We read with interest the Comment by Jagat Prakash Nadda.[1] The measures being taken to overcome the challenges affecting the Tuberculosis Control Programme in India are truly noteworthy.

We want to re-emphasise the issue of delay in diagnosis of pulmonary tuberculosis in India. Symptomatic patients with low socioeconomic status report to non-qualified allopathy and AYUSH (Ayurveda, Yoga, Unani, Siddha, or Homoeopathic medicine) practising doctors, rather than to well trained, qualified doctors. These patients might be given drugs, including antibiotics, by doctors who might not follow standard protocol. Seeking treatment in the unorganised health sector can delay diagnosis of tuberculosis and might also cause antimicrobial resistance.[2]

This delay in diagnosis needs to be addressed in India. Ethiopia, Sierra Leone, and countries in Europe have successfully dealt with delays in disease diagnosis and, as a result, have seen a very fast decline in the incidence of HIV-negative pulmonary tuberculosis. These declines were achieved by building a political and social movement.

A 2016 WHO report[3] highlighted that out of all the doctors in India, 77·2% were allopathic doctors and 22·8% were AYUSH doctors. In a survey of practising allopathic doctors in Mumbai,[4] 31·4% were educated only up to secondary school level and did not have MBBS degrees, and 57·3% did not have a medical qualification.

To achieve the Indian Government's ambitious target of tuberculosis elimination in India by 2025,[5] efforts to improve training and retraining of traditional and private health providers, with a deterrant for doctors who are not fully trained to practise medicine, should be a priority, so that clinically suspected pulmonary tuberculosis can be detected early and patients can be referred to a standard health-care setting.

We declare no competing interests.

*Sougat Ray, Kavita Anand
sougatray@hotmail.com

Asvini Hospital, Colaba, Mumbai 400005, India

1 Nadda JP. India's leadership to end tuberculosis. *Lancet* 2019; **393:** 1270–72.
2 Central TB Division, Ministry of Health & Family Welfare, Government of India. Technical and operational guidelines for TB control in India 2016. 2016. https://tbcindia.gov.in/index1.php?lang=1&level=2&sublinkid=4573&lid=3177 (accessed March 29, 2019).
3 WHO. The health workforce in India. 2016. http://www.who.int/hrh/resources/16058health_workforce_India.pdf (accessed March 29, 2019).
4 McDowell A, Pai M. Alternative medicine: an ethnographic study of how practitioners of Indian medical systems manage TB in Mumbai. *Trans R Soc Trop Med Hyg* 2016; **110:** 192–98.
5 India Today Webdesk. Will make India tuberculosis-free by 2025: PM Modi at UNGA. Sept 27, 2019. https://www.indiatoday.in/india/story/pm-modi-unga-speech-tuberculosis-free-india-by-2025-1603998-2019-09-27 (accessed Oct 23, 2019).

A child's right to health

Richard Horton took issue with what he characterised as "the false narrative of 'tremendous progress'" on maternal and child survival and health.[1] While the immense progress achieved on reducing child mortality by more than half since 1990 is unquestionably worth celebrating,[2] Horton is correct in asserting that this progress remains inadequate and in reflecting on the remaining gross inequities. Certain population groups and regions lag well behind the majority, and 53 countries are unlikely to achieve the Sustainable Development Goal (SDG) 3 targets for maternal and child mortality unless progress is accelerated.[2]

However, Horton also asserted that "health is no longer prioritised by UNICEF's leadership".[1] This is incorrect. UNICEF continues to prioritise inequities and to reach the most vulnerable children with the health services they need to survive and thrive, but it is clear that multilateral agencies, including UNICEF, national governments, and the donor community, must do more to deliver better health outcomes for children.

Health is badly under-resourced globally, with many national health budgets well below recommended levels. In the ten countries with the highest median rates of child mortality in 2018 (where 1·55 million under-5s are estimated to have died),[3] average government expenditure on health in 2016 was a mere 1·4% of gross domestic product, much less than the recommended 5%.[4] To implement primary health care in low-income and middle-income countries (LMICs) requires an additional US$200 billion to $300 billion annually.[5] While the overwhelming majority of health expenditure in LMICs is domestic, UNICEF (and multilateral agencies more broadly) are unquestionably important in plugging funding gaps and complementing national efforts to improve outcomes, particularly in poorly performing or fragile contexts with major technical and operational constraints. With adequate domestic and donor allocation and efficient use of resources, we could be achieving much more.

As Horton notes,[1] the remaining mortality burden is concentrated in a handful of countries; these need a continued Millennium Development Goal-like response, with coordinated donor support focused on survival. At the same time, in most countries, the broader focus on health and wellbeing for all through the SDGs is also appropriate. Health challenges are growing in complexity and diversity; we need contextualised responses in which global health partners collaborate to encourage and support governments to prioritise and oversee effective, quality health services. Partners should contribute more broadly to the establishment of robust health systems that deliver quality primary health care near to where people live and work. Universal health coverage through primary health care should be assessed not

Associated Press/Ap Images

Published **Online**
October 24, 2019
https://doi.org/10.1016/S0140-6736(19)32476-6

Published **Online**
October 17, 2019
https://doi.org/10.1016/S0140-6736(19)32463-8

only through service coverage and financial protection, but for reductions in mortality, including from neglected diseases like pneumonia (still the primary cause of death in children), and through measures of child and adolescent wellbeing.

UNICEF is strongly committed to supporting this broader agenda of helping children to not only survive but to also thrive, throughout childhood and adolescence, and to leveraging its multisectoral engagement to do so. This is reflected in the agency's Strategic Plan 2018–21, developed under the leadership of the executive director and the senior management team. It is also reflected in our budget: more than two-fifths of UNICEF's budget is spent on maternal and child health in both development and humanitarian settings.

This year marks the 30th anniversary of the Convention on the Rights of the Child, and the right to health must be upheld and enforced in every country. The multilateral system and country governments should be held accountable for this right. Progress is always worth celebrating, but renewed efforts are indeed urgently required to rapidly reduce the millions of easily preventable child and maternal deaths that still occur every year and to ensure that all children reach their full potential.

We declare no competing interests.

*Stefan Peterson, Luwei Pearson, Robin Nandy, Debra Jackson, David Hipgrave
speterson@unicef.org

UNICEF, New York, NY 10017, USA

1 Horton R. Offline: The false narrative of "tremendous progress". *Lancet* 2019; **394:** 1129.
2 UNICEF. Levels and trends in child mortality. Sept 19, 2019. https://www.unicef.org/reports/levels-and-trends-child-mortality-report-2019 (accessed Oct 8, 2019).
3 Global Health Expenditure Database. NHA indicators. http://apps.who.int/nha/database/ViewData/Indicators/en (accessed Oct 15, 2019).
4 UN Inter-agency Group for Child Mortality Estimation. Child mortality estimates. Sept 19, 2019. https://childmortality.org/wp-content/uploads/2019/09/UNIGME-Rates-Deaths_Under5.xlsx (accessed Oct 15, 2019).
5 Stenberg K, Hanssen O, Bertram M, et al. Guide posts for investment in primary health care and projected resource needs in 67 low-income and middle-income countries: a modelling study. *Lancet Glob Health* 2019; **7:** e1500–10.

Published **Online** October 17, 2019 https://doi.org/10.1016/S0140-6736(19)32464-X

A perpendicular framing for global health

Richard Horton notes that the focus on reducing maternal and child mortality,[1] which was so strong in the Millennium Development Goal era has waned as the global health agenda has shifted towards the Sustainable Development Goals and universal health coverage (UHC).

Not long ago, the opposite was the concern—that global health was overly driven by vertical priorities like maternal and child health rather than horizontal coverage and systems that are supposed to encompass such priorities. And before that, primary health care for all, as envisioned in the 1978 Alma-Ata Declaration, was the organising principle for global health.

Yet, as others have argued, these are false dichotomies.[2] The HIV/AIDS response, for example, showed that horizontal systems are needed to effectively deliver vertical priorities and that vertical systems could inform horizontal ones.[3] Ultimately, these two frames are mutually reinforcing, if not mostly overlapping, and primary health care-based UHC should be inclusive of maternal and child health priorities.

Rather than pitting these frames against one another, and losing emphasis on important perspectives, global health should be reconceptualised as perpendicular, whereby vertical priorities are maintained but considered in terms of how they pragmatically insert into and are operationalised through horizontal systems and policies. Similarly, horizontal priorities, such as community health workers, should be pursued with particular attention and thought given to how they can advance vertical priorities like maternal and child health. This reconceptualisation allows UHC and maternal and child health to simultaneously and synergistically be the fashion du jour rather than competing agendas.

We declare no competing interests.

*Ranu S Dhillon, Abraar Karan, Robert Marten
rsdhillon@partners.org

Division of Global Health Equity, Brigham & Women's Hospital, Harvard Medical School, Boston, MA 02115, USA (RSD, AK); and London School of Hygiene & Tropical Medicine, London, UK (RM)

1 Horton R. Offline: The false narrative of "tremendous progress". *Lancet* 2019; **394:** 1129.
2 Ooms G, Flores W, Mulumba M, Sarker M, Van de Pas R, Jahn A. False and real, but avoidable, dichotomies. *Lancet* 2019; **390:** 647–48.
3 Pfeiffer J, Montoya P, Baptista AJ, et al. Integration of HIV/AIDS services into African primary health care: lessons learned for health system strengthening in Mozambique—a case study. *J Int AIDS Soc* 2010; **13:** 3.

The Global Fund impact

We read with interest Rocco Friebel and colleagues[1] critique of the Results Report 2018 from the Global Fund to Fight AIDS, Tuberculosis, and Malaria.[2] We disagree with two important principles in their perspective.

First, it is reasonable for a funder to report that they have contributed to the impact that has been achieved by the countries with which it works, rather than trying to claim credit for a particular fraction of that total impact.

Because multiple funders are intentionally coordinating their efforts to reap the considerable synergies of providing complementary services, analyses to dissect out those various efforts would be challenged by insufficient data and have little meaning, as pointed out by the authors.[1] For example, if the President's Emergency Plan for AIDS Relief funds medical staff, the Global Fund funds the drugs, and the government funds the running costs of clinics, which is responsible for the people receiving treatment?

Second, we do not agree with the authors that modelling is an "obscure"[1] method that "risks overstating the Global Fund's effects".[1] The simplicity