

with high HIV infection rates, a large burden of therapeutically destitute patients reside in the community, often in overcrowded single-roomed or informal housing, continue to seek employment, travel for social and other reasons, and are often admitted to local health facilities (not equipped with infection control measures) for acute symptomatic deterioration as the disease worsens. Our own experience is that many patients realise the implications of their disease and want to minimise harm to others, but have no alternatives. Currently, there is no nationwide programme to fund and facilitate infection control within households in South Africa.

Even in eastern Europe, an important proportion of these patients have alcohol use disorders or inject drugs, and live outside both the hospital system and traditional homes. The preference in some eastern European countries to redirect, whenever possible, management of these patients to home-care services is promising.

A multipronged approach is needed. We believe that there is an urgent need to improve health services supporting XDR tuberculosis treatment and to offer palliative care when appropriate. Thus, integrated models are necessary to tackle this growing problem in different settings, including domiciliary care, community-supported housing, and specialised institutional facilities (if we want to abolish the word "sanatoria") offering appropriate care. We all have a common enemy in XDR tuberculosis.

We declare that we have no conflicts of interest.

**Keertan Dheda, Giovanni B Migliori*
keertan.dheda@uct.ac.za

Lung Infection and Immunity Unit, University of Cape Town, Groote Schuur Hospital, Observatory, Cape Town, Western Cape 7925, South Africa (KD); and WHO Collaborating Centre for TB and Lung Diseases, Fondazione S Maugeri, Care and Research Institute, Tradate, Italy (GBM)

- 1 Falzon D, Jaramillo E, Schünemann HJ, et al. WHO guidelines for the programmatic management of drug-resistant tuberculosis: 2011 update. *Eur Respir J* 2011; **38**: 516–28.
- 2 Migliori GB, Zellweger JP, Abubakar I, et al. European Union standards for tuberculosis care. *Eur Respir J* 2012; **39**: 807–19.

- 3 Sotgiu G, D'Ambrosio L, Centis R, et al. Infection control for TB and MDR/XDR-TB in selected European TB reference centres: the Achilles's heel? *Eur Respir J* 2011; **38**: 1221–23.

Tuberculosis control in China: striving for sustainability

In their Review (March 3, p 833),¹ Winnie Yip and colleagues give an early appraisal of China's health-care reform, reporting that China is giving priority to prevention of illness and to primary health care via increased insurance reimbursement of specific non-communicable diseases. However, infectious diseases are not included. Tuberculosis is a major chronic and infectious disease and should also be listed, especially since China has recently issued several important reports on tuberculosis.^{2,3}

Tuberculosis has historically been endemic in China, mainly because of limited health-care resources and government neglect. However, in recent years, political commitment to public health, including tuberculosis, has increased. The central government's spending on tuberculosis control increased from CN¥40 million in 2001 to ¥580 million in 2010.³ The total cumulative investment over this period amounted to ¥8.4 billion, of which ¥2.4 billion (31%) came from external support.³ China achieved major accomplishments in the fight against tuberculosis between 2001 and 2010.³ However, external funding has now either ended (World Bank) or is rapidly decreasing (Global Fund).⁴ There is a risk that these achievements will be neutralised.

Encouragingly, China is moving towards primary health care based on community services.⁴ The Government will pay ¥25 per person for prevention of disease, of which ¥4.64 is allotted to (but not limited to) tuberculosis control. Tuberculosis control in China is a long-term public health challenge and needs the support of affordable

and sustainable health resources. Community health resources within a strengthened health system might be the best marriage for tuberculosis control and sustainability.⁵

We declare that we have no conflicts of interest.

**Zhongwei Jia, Shiming Cheng,*
Lixia Wang
urchinjj@163.com

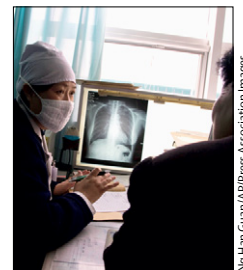
National Institute of Drug Dependence, Peking University, Beijing 100191, China (ZJ); and National Centre for Tuberculosis Control and Prevention, Chinese Center for Disease Control and Prevention, Beijing, China (SC, LW)

- 1 Yip WCM, Hsiao WC, Chen W, Hu S, Ma J, Maynard A. Early appraisal of China's huge and complex health-care reforms. *Lancet* 2012; **379**: 833–42.
- 2 Yu W. Report on fifth national epidemiological sampling survey of tuberculosis. Beijing: Military Medical Science Press, 2012.
- 3 Ministry of Health P R China, National Development and Reform Commission and Ministry of Finance P R China. Assessment on schemes of the national tuberculosis prevention and control plan (2001–2010). Beijing: Military Medical Science Press, 2012.
- 4 Ministry of Health P R China. National basic public health service standard (2011). <http://61.49.18.65/publicfiles///business/cmsresources/mohfybjysqsws/cmsrsdocument/doc12006.doc> (accessed March 8 2012).
- 5 Ravigliione M, Zumla A, Marais B, Horton R, Motsoaledi A. A sustainable agenda for tuberculosis control and research. *Lancet* 2012; **379**: 1077–78.

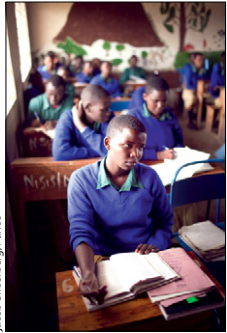
NTD control and health system strengthening

Access to drugs for neglected tropical diseases (NTD) is an essential part of the right to health care for all. The investments of pharmaceutical companies, global philanthropists, and product-developing public-private partnerships in research and development and NTD control are particularly welcome. However, the endeavour to secure global alliances for this noble cause does not obviate the need for sound evidence and interdisciplinary approaches.

Tim Allen and Melissa Parker (March 24, p1097)¹ studied community perceptions related to mass drug administration campaigns in Tanzania. We also reported some negative



Ng Han Guan/AP/Press Association Images



effects of mass drug administration on fragile health services in Mali during the startup of this campaign.² Although David Molyneux and Mwelecele Malecela³ dismiss both case studies as empty rhetoric, other evidence shows that the fight against poverty-related diseases cannot be reduced to a technical quick fix.

For example, visceral leishmaniasis strikes the poorest families in Bihar—economically one of India's weakest states.⁴ Caste is a risk factor for visceral leishmaniasis as well as for failing to reach health services promptly. In the Democratic Republic of Congo, people refrain from participating in screening campaigns for sleeping sickness because of, for instance, fear of drug toxicity or distrust towards mobile teams.⁵

If we fail to address this social dimension and the wider health system context, we fail the very same poorest of the poor targeted by our NTD campaigns. A true interdisciplinary dialogue is needed, and an end to quibbling. A community of practice on NTD control should involve, among others, biologists, social scientists, and public health experts from endemic countries and international constituencies. Those most in need deserve the best science.

We declare that we have no conflicts of interest.

*Filip Meheus, Suman Rijal, Pascal Lutumba, David Hendrickx, Marleen Boelaert
fmeheus@itg.be

Department of Public Health, Institute of Tropical Medicine, 2000 Antwerp, Belgium (FM, DH, MB); Department of Internal Medicine, BP Koirala Institute of Health Sciences, Dharan, Nepal (SR); Strategic Network for Neglected Diseases, Nepal (SR, PL, DH); Institut Nationale de Recherche Biomédicale, Kinshasa, Democratic Republic of Congo (PL); and Université de Kinshasa, Kinshasa, Democratic Republic of Congo (PL)

- Allen T, Parker M. Will increased funding for neglected tropical diseases really make poverty history? *Lancet* 2012; **379**: 1097–98.
- Cavalli A, Bamba SI, Traore MN, et al. Interactions between global health initiatives and country health systems: the case of a neglected tropical diseases control program in Mali. *PLoS Neglect Trop Dis* 2010; **4**: e798.
- Molyneux DH, Malecela MN. Neglected tropical diseases and the Millennium Development Goals—why the “other diseases” matter: reality versus rhetoric. *Parasites Vectors* 2011; **4**: 234.

- Boelaert M, Meheus F, Sanchez A, et al. The poorest of the poor: a poverty appraisal of households affected by visceral leishmaniasis in Bihar, India. *Trop Med Int Health* 2009; **14**: 639–44.
- Mpanya A, Hendrickx D, Vuna M, et al. Should I get screened for sleeping sickness? A qualitative study in Kasai province, Democratic Republic of Congo. *PLoS Neglect Trop Dis* 2012; **6**: e1467.

Paying girls to stay in school: a good return on HIV investment?

Sarah Baird and colleagues (April 7, p 1320),¹ in their study of the HIV effect of cash transfers to keep girls in school, underscore the importance of structural interventions in addressing the social and economic drivers of HIV. With only 31% of girls in sub-Saharan Africa attending secondary school,² and 26% of new HIV infections globally occurring in young women aged 15–24 years,³ investments in both education and HIV are essential.

Despite the potential of such synergistic interventions, they might be overlooked in an era of greater resource scarcity if HIV and other development sectors prioritise approaches in silos. Baird and colleagues estimate a cost per infection averted of US\$5000–12 500 (or \$284–711 per disability-adjusted life-year [DALY] averted⁴), suggesting that the intervention is less cost effective than some alternative HIV prevention options, particularly on the upper cost bound, but potentially more so than HIV treatment as prevention. Yet, HIV funds need not cover the entire cost of such a programme, given its multiple benefits across sectors. For example, if the Malawi HIV programme contributed \$310 per DALY averted, which is the equivalent of gross domestic product per capita and WHO's cost-effectiveness threshold, this would finance at least 44% of the intervention's scale-up. Other sectors, such as education, could then potentially finance the rest. Such co-financing would make the cash transfer programme much better value for money from an HIV perspective.

We therefore suggest that HIV programmes actively seek opportunities to co-finance broader development efforts that yield direct HIV benefits, with the magnitude of these benefits being one way of determining the programme's contribution. This co-financing approach would help realise the promise of development synergies as envisioned in the UNAIDS Investment Framework and accelerate progress across the MDGs.⁵

MR, AV, and CW are members of the Social and Mathematical Epidemiology group at the London School of Hygiene & Tropical Medicine. All authors are members of the STRIVE (Tackling the Structural Drivers of the HIV Epidemic) Research Programme Consortium, funded by the UK Department for International Development. The opinions expressed are those of the authors and do not represent in any way the views of the organisations or consortia to which they are affiliated. We declare that we have no conflicts of interest.

*Michelle Remme, Anna Vassall, Brian Lutz, Charlotte Watts
michelle.remme@lshtm.ac.uk

London School of Hygiene & Tropical Medicine, London WC1H 9SH, UK (MR, AV, CW); and UN Development Programme, New York, NY, USA (BL)

- Baird SJ, Garfein RS, McIntosh CT, Ozler B. Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: a cluster randomised trial. *Lancet* 2012; **379**: 1320–29.
- UNESCO. Gender and education. <http://www.uis.unesco.org/Education/Pages/gender-education.aspx> (accessed March 7, 2012).
- UNAIDS. AIDS at 30 report: nations at the crossroads. Geneva: UNAIDS, 2011. <http://www.unaids.org/en/resources/publications/2011/> (accessed May 23, 2012).
- Vassall A, Remme M, Watts C. Social policy: going upstream. Copenhagen & Lausanne: Copenhagen Consensus Center & Rush Foundation, 2011.
- Schwartländer B, Stover J, Hallett T, et al. Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet* 2011; **377**: 2031–41.

Department of Error

Yang B, Zhou L, Peng B, Dai Y, Zheng J. Stem cells in a tissue-engineered human airway. *Lancet* 2012; **379**: 1487—In this Correspondence (April 21), the corresponding author should have been Junhua Zheng (email zhengjh0471@sina.com). This correction has been made to the online version as of June 8.