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Conclusion

A number of global surveys have confirmed suspicions that MDR TB is no longer a rare problem, nor is it one limited to only a small number of settings. Cases, and also epidemics, have been reported from throughout the world. As we have demonstrated in a companion volume to this manual, MDR TB is on the rise worldwide. Yet there exists no coherent global strategy as to how the disease, once unleashed, can be controlled. As with many health problems, an ounce of prevention is worth a pound of cure. But prevention comes too late for those already sick with drug-resistant tuberculosis. Treating the sick is of paramount importance not only to those patients and their families, but in order to prevent ongoing transmission of drug-resistant strains of *M. tuberculosis*. Effective treatment is prevention.

In this Handbook, we provide details of a successful treatment and control program initiated in urban Peru. Since 1996, we have been working in a shantytown in northern Lima. Already suffering from high rates of tuberculosis, northern Lima is also confronting an epidemic of drug-resistant disease. We believe the community-based program implemented in Peru is one successful means by which MDR TB can be addressed in “resource-poor settings” and hope, furthermore, that it might provide a model for other countries and communities facing this problem. Complex health interventions in poor settings – or “CHIPS,” as we have termed them – can be effective means of meeting the goals of public health and of responding to local demands for equity.

This Handbook is intended to lay out a series of guiding principles for the establishment of an MDR TB treatment program. In Chapter 1 we outline the nature of the global MDR TB situation, and conclude that skirting treatment of prevalent cases will only mean ongoing transmission and a death sentence for hundreds of thousands. Chapter 2 provides a roadmap to the manual and discusses some of the experiences we have had – in settings as diverse as Peru, Haiti and Russia – using a community-based “CHIPS” model. In Chapter 3 we outline briefly the necessary programmatic components which must be in place for an MDR TB treatment program delivering community-based care. Chapters 4 through 7 present the identification and clinical management of patients with MDR TB, including patient follow-up and the management of adverse effects. Chapter 8 discusses the intricate process of evaluating program performance.

The goals of these chapters, and of the Handbook, have been to provide comprehensive reviews with a focus on our work in Lima. They cannot, however, serve as substitutes for direct communication and contact with health care personnel who are dealing with this growing problem. Cooperation and coalition-building – locally and transnationally – are among the most important means of developing strategies to combat MDR TB effectively.

As the threat of MDR TB grows, so too should our commitment to addressing this scourge. Regions affected include many resource-poor settings, and a lack of readily available tools has hampered efforts to respond effectively. Discouragement and resignation are rife. Indeed, some have concluded that MDR TB is an untreatable disease. But two points need to be underlined in concluding this project in pragmatism: first, that resignation is more prevalent among policy makers than among patients and their families. Second, we do have tools to fight this plague, and need to bring them to bear in the areas most afflicted. The many individuals who have collaborated on this Handbook, and in the projects that inform it, are united in our belief that complex health interventions are possible even in settings of great privation. We dedicate this Handbook to our patients, who share this conviction.