Can social protection improve tuberculosis control?

Whether current approaches to tackle tuberculosis can be integrated with social protection strategies was the subject of a recent meeting in London. Pamela Das reports.

Tuberculosis is a classic disease of poverty. Poor, vulnerable, and marginalised people carry the biggest burden of disease. Most experts agree that only by addressing the social and economic determinants of tuberculosis, will countries see substantial declines in incidence. But how can this goal be achieved?

Last month, a symposium—Social protection interventions for tuberculosis control: the impact, the challenges and the way forward—attempted to find answers to this question. Hosted by the London School of Hygiene and Tropical Medicine and co-sponsored by WHO, UNDP, the UK's Health Protection Agency, and the Bill & Melinda Gates Foundation, the meeting united experts from tuberculosis control and care with those working in the social determinants of health and health financing for the first time, in an attempt to merge both their agendas.

Social protection interventions are policies and programmes designed to reduce poverty and vulnerability among poor people; interventions include cash transfers and microfinance, as well as welfare, and psychosocial support. There is good evidence these programmes have a wide range of effects, including improved food security, income generation, and better health outcomes. But to date, little is known about the effectiveness and feasibility of social protection approaches for tuberculosis.

The meeting showcased several impressive examples of cash transfer pilots in Malawi and Nicaragua, and bigger studies from the HIV/AIDS field. The main challenges raised were around design, implementation, conditionality, cost-effectiveness and financing, and scaling up and sustainability. Lessons from HIV show that, "studies need to be designed rigorously, and piggyback on existing research with a multiplicity of impacts", said Brian Lutz, HIV Policy specialist at UNDP. "Working with other health and development partners in a multisectoral framework is critical."

Diana Weil from WHO Stop TB pointed out that a range of enablers and incentives already exist for many tuberculosis patients but in many cases the effect has not been measured or evaluated.

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Social protection schemes specific to tuberculosis were discussed. Provision of food assistance by the World Food Programme was shown to contribute to treatment success in many ways. Brazil, where tuberculosis incidence and mortality has been decreasing for more than 15 years, was held up as a model for having universal access to health care, country-wide social protection schemes, and political commitment to social change. And, in Peru, interim results of a large study showed the use of socioeconomic interventions increased access to tuberculosis care and equitable prevention.

More challenging are programmes targeting multidrug-resistant tuberculosis (MDR-TB) as was described in case studies of female patients in Pakistan, and in very impoverished patients in Tomsk Oblast in Russia. Both studies showed that patient-centric approaches and social support led to better treatment outcomes.

But Bertie Squires from the Liverpool School of Hygiene and Tropical Medicine challenged the speakers on cost. "This is a mass of very useful work, but what I am finding difficult is what has it taken for those programmes to run? We've been presented no data behind the cost inputs for each of these programmes. It feels difficult to see how cost effective these things are or how they relate to other interventions that will cost. In a current global climate that is a real problem." Salmaan Keshavjee from research and advocacy group Partners in Health insisted such programmes were cost effective. "Cost per patient in the Oblast programme was US$500 including cost of staff. MDR-TB treatment costs $4000 per year and given one patient will potentially affect five to ten other people, it makes $500 a bargain in this setting", he said.

Mario Raviglione, director of WHO Stop TB, concluded that more evidence for social protection and tuberculosis may be needed to promote bold and new policy recommendations, but sufficient information existed for interim guidance. He said that future work should be multisectoral, for example, engaging with stakeholders in social security and finance, and seen as part of strengthening and contributing to universal health care. "We should think creatively and merge individual tuberculosis care and poverty alleviation approaches at the microlevel with the public health aims of early case detection and cutting transmission. Such interventions will have an impact on the future burden of the disease and be measurable", he told delegates.

Following the symposium, key delegates attended a 2-day Chatham House workshop to discuss the issues further and how to take this work forward. A subsequent report will aim to define the issues in broader policy terms targeting government ministries and funders, and will be published by Chatham House later this year.

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For more on the **symposium** see http://tbsymposium.lshtm.ac.uk/presentations-2/