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Charity Registration Number: 208223

## Meeting Summary: Centre on Global Health Security

# Social Protection Interventions for Tuberculosis Control: The Impact, the Challenges, and the Way Forward

May 2012

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## INTRODUCTION

On 16-17 February 2012 Chatham House, in collaboration with the London School of Hygiene & Tropical Medicine, promoted and hosted the expert consultation 'Social Protection Intervention for Tuberculosis Control: The Impact, the Challenges and the Way Forward'. This event, co-sponsored by the World Health Organization, the Bill & Melinda Gates Foundation, the United Nations Development Programme and the UK Health Protection Agency, was aimed at exploring how current tuberculosis (TB) prevention, care and control efforts can be strengthened through social protection initiatives able to address the social determinants of TB and the urgent needs of those already affected by TB.

This event was preceded by an open symposium 'Action on the social protection of tuberculosis: are social protection interventions the way forward?' held at the London School of Hygiene & Tropical Medicine on the 15<sup>th</sup> of February 2012. This symposium offered an opportunity to share experience and knowledge about the use of social protection for public health purposes and allow the dissemination of the preliminary – mainly unpublished – evidence of the impact of these interventions on TB control.

Social protection has been defined as '*the set of all initiatives, both formal and informal, that provide: social assistance to extremely poor individuals and households; social services to special groups who need special care and access to basic services that would be otherwise denied; social insurance to protect people against the risk and consequences of livelihood shocks; and social equity to protect people against social risks such as discrimination or abuse*' [Deveroux et al]. By securing basic consumption needs, mitigating the impacts of stresses and shocks, supporting people suffering from chronic incapacities (including illnesses, disabilities and discrimination), enabling people to save, invest in and accumulate assets, social protection interventions are meant to support people to move structurally out of poverty [Adato, 2010].

Because of their demonstrated impact on human and financial capital, social protection interventions have triggered significant interest in their potential application for public health purposes [Adato, 2008]. For instance, the potential role of economic empowerment and cash incentives to strengthen HIV / AIDS control, has now become central to debate on the global response to this epidemic [aids2031, 2010; Kim, 2009; Kim et al, 2011; Nolan et al, 2009; Temin, 2010; UNAIDS, 2010; Yetes, 2010]. UNAIDS has recently advocated for social protection measures to be 'HIV-sensitive', that is designing social protection interventions so to ensure the inclusion of people

living with HIV, populations at higher risk and vulnerable households in order to allow a better and more equitable access to the services and entitlements they need more [UNAIDS, 2010]. This is in contrast with 'HIV-specific' measures that are specifically targeted at people living with HIV / AIDS. The ultimate goal is to promote policies and programmes that are inclusive, non-stigmatising and non-discriminatory and that ensure equity [UNAIDS, 2010].

Even in the history of TB control the use of different forms of social support is not new: it is known that in the early 1900s the decline of TB mortality in Europe and North America was essentially driven by two parallel streams including a series of public health measures and socioeconomic development resulting in improved quality of life, especially nutrition and housing conditions. Nonetheless, after the introduction of antibiotics this integrated approach switched towards a curative focus and led to the modern TB control framework based on early case detection and successful treatment. This approach has saved millions of lives, but its impact on TB transmission and incidence has been less than anticipated. There is consensus that further actions are needed, both to develop better biomedical tools, delivery and social support mechanisms, and to tackle the root causes of TB, including poverty and other socioeconomic determinants of health.

Given the well known biological and epidemiological commonalities shared by HIV / AIDS and TB and acknowledged importance of socioeconomic interventions for TB control, there is a real opportunity to influence social protection globally in order to ensure they become more inclusive for TB patients and thus useful to the achievements of TB elimination goals.

This expert consultation aimed to move this agenda forward by bringing together experts from different sectors to foster multidisciplinary collaborations across many regions of the world. For this purpose a panel of more than 40 TB experts, economists, social protection analysts, civil society representatives, development, public health and financing agencies were invited to share their knowledge and experience and to identify means to: (a) increase evidence to inform policies for a more rapid adoption and scale-up of these integrated approaches; and, (b) to help further support effective initiatives and collaborations under way.

## **OBJECTIVES OF THE EXPERT CONSULTATION**

- To produce a synthesis paper on the implementation and evaluation of social protection interventions supporting TB prevention, care and control and to discuss how these interventions can be best integrated within current strategies and programmes.
- To discuss the creation of an international collaborative network of researchers, policy-makers and social protection experts working together on the design, implementation and evaluation of innovative social protection initiatives to improve TB prevention, care and control in a variety of settings.

## FORMAT

This expert consultation used a combination of plenary and group work sessions together with a limited number of individual presentations. Participants shared experiences from different social and epidemiological contexts, such as Eastern Europe, Peru, Pakistan, Zambia, South Africa, Brazil and India and represented different institutions including policy-makers, academia, development and public health and financing organizations.

As mentioned above, this consultation followed a symposium in which the potential of social protection in the field of TB, HIV / AIDS and health in general was presented by experts and shared with a broader audience. The key messages and lessons learnt during this symposium informed the main discussion points of the expert consultation.

The aim of the first day of the expert consultation was to develop a list of interim recommendations for the design and implementation of social protection interventions to improve TB control according to specific TB and social protection contexts. Participants were divided in country groups and were invited to brainstorm on the design of potential social protection interventions for TB control based on country-specific needs. In the second part of the day participants discussed the emerged commonalities, challenges and potential solutions across different settings and discussed how to best synthesise and disseminate these lessons.

The following half-day was spent discussing the creation of the collaborative network. Key discussion points were the scope and specific objectives of this new network, the most appropriate format and potential funding mechanisms as well as the identification of the focal points and participant members.

## GENERAL POINTS

### Policy development

- Social determinants are an important driver of global TB.
- It is important to think of social protection broadly, as it can encompass areas such as: abolition /exemption of user fees for health services and development of universal health coverage financing and insurance schemes; cash transfers; food packages; travel vouchers; employment guarantees; supporting income generating activities; addressing stigma and discrimination in service delivery; housing support; and support for mental health issues.
- Social protection targeting people with TB and TB-affected households is one of many entry points to improve socioeconomic conditions in the population. Evidence already exists that such interventions mitigate adverse social and financial consequences of disease, but evidence is less clear on whether this would lead to improvements in TB-specific outcomes or increase impact. However, it was agreed that enough evidence exists to warrant early policy guidance recommending ways that that National TB Programmes (NTPs) can incorporate social protection into their work and that they build links with existing social protection schemes through interaction with relevant ministries and stakeholders involved in social protection.

### Research Needs

The current knowledge gaps are two-fold: a) despite the indirect evidence gathered in a recent review from Boccia et al<sup>1</sup>, the actual impact of social protection on TB indicators (e.g. incidence, mortality, case finding, TB treatment adherence) remains unknown; b) it is unclear how social protection initiatives may be best integrated with current TB control activities and which

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<sup>1</sup> Boccia D, Hargreaves JR, Lonroth K, Jaramillo E, Weiss J, Uplekar M, Porter JDH, Evans C. The impact of cash transfer and microfinance interventions on tuberculosis risk factors: review of the evidence and policy implications. *International Journal of Tuberculosis and Lung Disease* 2011;15(Supplement 2):S37-S49

forms of social protection are most likely to be successful, depending on the objectives posed.

Two priority research areas were proposed: (a) to document and examine situations where social protection interventions are already linked with TB interventions to provide lessons learnt and (b) prospective studies to determine how best to link social protection and TB efforts, to improve TB prevention, care and control and to further reach highly vulnerable individuals, groups and communities. Specific research questions would include:

- Whether to focus on 'TB-specific' or 'TB-sensitive' social protection schemes;
- How to effectively integrate within or build on broad social protection schemes (ie, making social protection schemes 'TB-sensitive')
- How to, or if to, target social protection schemes at specific groups of TB patients;
- Should conditionality/ies be included;
- What are the resource implications and the cost effectiveness of specific approaches;
- Whether social protection interventions work better or worse in good versus failing health systems and what may be the factors affecting this;
- What is the impact of social protection on improving TB diagnosis, cure and/or prevention: does social protection only benefit persons currently ill or affected by TB, or can approaches play a role in TB prevention, too?

Each country will have different needs and priorities and therefore will prioritize different research questions. This country specificity must be taken into account both in the research and the policy area.

Research would need to be multidisciplinary in nature and research teams must include representatives from both the TB and social protection communities, as well as TB-affected representatives.

## CASE STUDIES DISCUSSION

Participants were divided into break-out groups of approximately 7 people. Within each group, participants were asked to identify the specific TB control and social protection needs at country level. Specifically they were asked to address the following questions:

- What barriers and opportunities exist to the creation of strategic partnerships between social protection schemes and TB control programmes?
- Are TB-specific or TB-sensitive social protection interventions more suitable considering the country TB epidemic profile and social protection environment?

Based on the above, participants were asked to envisage a potential social protection (SP) intervention for TB control. Each group presented the results in the plenary in a matrix provided by the facilitators including: 1) country needs; 2) existing social protection interventions; 3) design of interventions combining social protection and biomedical activities.

The results of the discussion are summarised below by country:

### Pakistan

Pakistan is characterised by high TB burden including M/X-DR, driven in part by diabetes and other co-morbidities. The Pakistan NTP has been disbanded and decentralized to each of the five provinces and now TB control comes under the Poverty Alleviation Fund. Pakistan has many isolated, fragmented social protection programmes. The Indus Hospital has piloted providing food packages for MDR-TB patients, as well as housing assistance, psychological support and transport fees. This has expanded to five other centres and will expand to another five.

In this country it would seem logical to concentrate on the Indus Hospital project and therefore focus on the approximately 15,000 MDR-TB patients receiving food packages as an example of social support. It is necessary to understand the impact on treatment completion, costs and to identify other means of support that patients may receive. The Indus Hospital project is currently at its pilot stage and it is expected that scale-up will have logistical barriers. Another question to address is whether there is any role for mobile phone technology, e.g. for delivering vouchers. An alternative approach would be to assess the impact of other examples of isolated SP programmes on TB

outcomes to determine potential for scale-up. State run income support programme could include TB patients, but evidence are needed to sensitise the government to this.

Social support lies at government level, so will need to link this with provincial TB programmes – WHO can help provide an environment for sensitisation of provincial/government leaders and sharing of ideas and experiences. From a policy perspective an important question to address is whether the lack of a national TB control programme can affect the scale-up of social protection interventions.

## Zambia

The TB epidemic affecting Zambia is characterised by 70% TB-HIV co-infection rate, but good treatment success (>85%) for most of the country. The main risk factors for TB in Zambia are HIV and malnutrition. There is no nationwide SP scheme, but a lot of fragmented, bottom-up schemes. Recently, Zambia has piloted a number of cash transfer schemes targeting destitute households affected by HIV/AIDS that have been shown to have an impact on reducing incidence of illnesses, including TB, among the beneficiaries. There is a live debate around creating a comprehensive social protection strategy drawing on these pilots and the new relatively favourable political context provides a window of opportunity to build political commitment for social protection. There remains an ongoing problem of stigma, creating a barrier to access that needs to be addressed.

A key research question is whether conditional transfers can improve TB screening rates and/or subsequent linkage to care among HIV patients. Because of the TB epidemic profile in Zambia, the research focus should be prevention, not treatment, success, by going beyond TB patients to HIV patients. It has been suggested that among people living with HIV accessing care, tuberculin skin test positivity or low body mass index should be used to trigger referral to a social protection scheme for assistance. Cash alone would probably not be sufficient, but should be combined with social support, possibly using the Sputnik scheme of Partners in Health in Tomsk Oblast as an example. As for Pakistan, an important question to address is whether mobile phone technology can be used to help with delivery issues.

From a policy perspective a number of operational questions have been identified: How can any new SP scheme be made health-sensitive? Could participants in social protection schemes be simultaneously educated on health issues? Which is a more effective way to target social protection



schemes for TB control – biomedical criteria for the individual or poverty criteria (particularly food insecurity) for the household? There is an urgent need for stronger ties between the health sector and ministries that deal with social protection in order to build an information system that will identify HIV patients, for example, and target them as those with the highest TB risk.

## Peru

Peru is characterized by a strong TB programme with moderate TB burden, good treatment completion, but problems with high rates of drug resistance and poor infection control. Peru is also characterized by the absence of an integrated welfare system and institutional coordination, which affects effectiveness. JUNTOS is the main cash transfer programme targeting extreme poverty in rural areas, but TB is principally an urban/peri-urban problem. Consequently, there is very little overlap between TB and social protection programmes, either by design or by practice. The TB programme has some social policies, e.g. unconditional food transfers, but these are sometimes sacrificed due to resource constraints. Other integration barriers are: bureaucracy, which makes social protection hard to access; internal displacement and migration including urbanisation; and substance abuse (particularly alcohol).

Interim results from the Innovative Socioeconomic Interventions Against Tuberculosis (ISIAT) project suggest that social support leads to large impacts on a variety of TB programmes outcomes, but that economic support had more limited impact<sup>2</sup>. It was recommended to continue building on the work of the ISIAT study. It was also suggested to investigate the impact of current social protection policies where implemented using the strong in-country capacity for impact research. Finally, existing schemes should be identified that are either TB-specific or TB-sensitive in order to identify opportunities for integration with the national TB control programme.

Peru has a new social inclusion ministry (modelled on Brazil) – how can this be leveraged? There may be an opportunity to make TB an entry criterion for existing social protection programmes – this may be hard practically as social protection programmes currently target other regions of the country – what are the best ways to overcome these problems? There is already a strong

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<sup>2</sup> Rocha C, Montoya R, Zevallos K, et al. Innovative socioeconomic interventions against TB (ISIAT) – an operational assessment. *International Journal of Tuberculosis and Lung Disease* 2011;15:S50-S7.

capacity for impact evaluation research. This should be utilised to produce the required evidence.

## South Africa

South Africa has a relatively well functioning TB programme, with a long history of social assistance programmes. The universal national health insurance scheme will be piloted in certain areas for one year starting from April 2012. There is also a new and highly ambitious process of re-engineering primary health care, modelled in part on Brazil's experience. There exists strong political will to address high incidence of TB as well as the will to utilise strategies examining the social determinants of health. Therefore the priority seems to be building impact evidence and adapting existing programmes to TB control objectives. For example, how can existing programmes be adapted to target TB incidence? Can changes to the child support grant, temporary disability grant and old age pension produce better outcomes e.g. by changing the amount of money or changing the age focus?

The following opportunities were discussed:

- Public works: Government has a plan to provide work opportunities in high-poverty areas (geographically targeted) – could these also be targeted at very high TB areas and can impact be measured?
- TB-specific, e.g. disability grant. There are real concerns about delivering money to TB patients (perverse incentives), particularly if conditional, so there are worries about taking this forward.
- Incentives: would incentives be better e.g. for HIV testing, for giving sputum if symptomatic or for completion of treatment?
- Health insurance

## Eastern Europe

Eastern Europe comprises multiple states, each characterized by specific TB epidemic problems. However, broadly speaking, in the region the main problems are bad outcomes and very high MDR transmission. The region can be broadly divided in three: EU countries, non-EU countries (particularly Russia) and central Asian countries. The main risk groups are: (former) prisoners, migrants, Roma population, people living with HIV, drug/alcohol

users, elderly, homeless, other poor. An ongoing problem is that these vulnerable groups are used as an excuse to not address these issues because of social perceptions and lack of political will. Pension systems exist in some countries, some of which target TB patients, but there many problems, such as those linked to hospital stay, but it is probably better to discourage long hospital stays. Also, patients need to provide identification paperwork to apply and are often unable to do so. Some have compulsory treatment, but the Sputnik programme from Partners in Health in Tomsk Oblast showed that this was not necessary for most patients.

There is a need to investigate how to learn from existing support systems (provided by governments, NGOs and others e.g. World Bank) and how to adapt these systems to TB control in each country. There needs to be a rigorous assessment of the current programmes. One option would be to create partnerships with NGOs that work closely in the community. For example, a good candidate could be the International Committee of the Red Cross, which has a strong track record in Eastern Europe.

In terms of policy, some interesting health financing issues were raised: first, financing hospitals based on the number of full beds has encouraged long hospital stays for full treatment courses. While some have argued that this is necessary because patients have social problems, it is also true that hospitalization is very expensive and the question is: could this money be used for social support to help patients to tackle underlying social problems e.g. building housing projects and homeless shelters? Second, although each country has different priorities, most are former Soviet Union countries, which gives some commonalities, e.g. most have some pension schemes, but there are many communication problems between ministries (health and social) – how can these be worked out?

## **Brazil**

Brazil today represents an ideal context in terms of human and economic resources and data availability. TB burden is generally restricted to specific groups (e.g. drug users - recently an epidemic of crack use has been documented). There are about 70,000 TB patients diagnosed by the National TB control programme every year, of whom about 15,000 are covered by Bolsa Familia and some 60,000 are covered by other schemes.

It was suggested to compare the impact of Bolsa Familia on the 15,000 TB patients within this scheme with outcomes in the other 60,000 TB patients who are not included in this scheme, to assess the specific benefit of Bolsa

Familia. It is also desirable to determine numbers accessing other schemes and numbers eligible for SP schemes but not receiving them, and to investigate barriers to access for TB patients. Finally, the impact should be assessed of Bolsa Familia on intra-household transmission from contact tracing data and treatment completion. Assuming there was a spatially heterogeneous roll-out of Bolsa Familia then this may facilitate impact evaluation.

Brazil can provide a form of best practice, sustainable, scalable SP intervention for TB control. However, Brazil is unique in terms of resource availability and this makes it difficult to envisage how lessons learnt in Brazil can be applied to other settings.

## **AGREED PRODUCTS TO BE DEVELOPED AFTER THE MEETING**

### **Report and Policy / Recommendations Documents**

The following potential documents were suggested:

1. A meeting report (the current document), summarizing the main discussion points to inform those who could not attend.
2. A Chatham House briefing paper discussing the issues in broad policy terms, aimed at government ministries and funders. These briefing papers are typically short (10-12 pages), written by 1-2 people from Chatham House's Centre on Global Health Security, reflect independent policy analysis, are peer-reviewed and use the Chatham House 'brand' to ensure distribution to influential policy-makers.
3. A 'business case' for the need to consider TB in social protection agendas and vice versa and to outline the need for resources to further explore. The document should stimulate action based on available evidence while highlighting the need to improve the evidence base through careful monitoring and evaluation. This document would be produced by a small team, led by Dr Delia Boccia, with a timeline of two to three months for a first draft. This would be followed by a short-term consultative processes with input from both the TB-affected community and the social protection community being of particular importance. There is a nice example of such a document produced by UNAIDS and its partners. Following this consultative process, there should be a

discussion on how to brand social protection for TB care, prevention and control. The document should be aimed at the middle ground between TB control and social protection communities to spark discussion between them. It will include case studies and provide specific advice to help policy-makers prioritize. It needs to make the point that improving TB control will help achieve poverty reduction and equity aims. It would not be necessary to build full consensus before publishing the document – rather it will be part of a consensus-building process.

4. An interim policy document guiding countries in linking TB control programmes with social protection initiatives. This document will be the necessary first step towards a wider comprehension of the importance of social protection by those operating in TB control and some operating in health in general. For this purpose, such policy-oriented informative paper will be circulated widely among those who work on TB in NTPs, those responsible for communicable diseases above NTPs and any others (NGO, CSO etc) who are interested in TB;
5. The journal 'Epidemiology & Infection' expressed some interest in a special issue on the research projects presented at the symposium.

### **International Collaborative Network**

The second expected output from this consultation will be a network comprising stakeholders from both the TB and SP communities, including TB-affected representatives. It was agreed that this network should have both policy development and research objectives, including:

- To generate new, generalizable, policy-relevant scientific knowledge about the impact of social protection intervention on TB control in settings characterized by different resources and TB epidemic profile.
- To push for much better monitoring and evaluation of existing programmes as well as suggesting new research needs.
- To ensure that all those eligible for SP receive it, by empowering patients, families and healthcare workers.
- To disseminate impact evidence in a format that is useful for NTP managers, otherwise they will not want or be able to follow the TB/SP agenda.

- To build relationships with development agencies and other financing partners, to benefit from their intellectual input in addition to any funding.

It was agreed that it may be more successful to divide up the network objectives into packages, each tailored to a specific funder, rather than ask one funder to fund the whole network. This will also help focus the network on specifics, increasing the chances of success.

It was suggested to arrange a meeting of the network during the Union World Lung Conference in November in Kuala Lumpur as well as adding it to the agenda of the MDR working group one-day symposium.

There are many networks in TB so the niche of the network will need to be clearly defined within the structures of these other groups so they can mutually benefit from this collaboration. For example, research plans for the network can be fed into the research part of the MDR working group and the Stop TB Research Movement for input and buy-in, and with the network of those already working intensively on TB and poverty.

WHO participants expressed their commitment to help pursue the agenda through WHO's own policy development and technical assistance work, in close collaboration with the LSHTM and other network participants, and there are potential great benefits from collaboration across WHO teams – those working on tuberculosis and other public health priorities, on universal health coverage schemes, on the social determinants of disease, and the network of regional and country offices.