Social Determinants and Tuberculosis in South-East Asia

Regional Consultation on the Social Determinants of Health

WHO/SEARO, New Delhi, 15-16 September, 2005
INTRODUCTION

SOCIAL DETERMINANTS AND TB

RESPONSES

CONCLUSIONS
TB in the SEA Region

The SEA Region accounts for 34% of the world’s tuberculosis cases

- The Burden
  - 34% of the global burden
  - 3 million new cases, 600,000 TB deaths annually

- HIV and TB
  - Nearly 3 million co-infected

- MDR-TB
  - Multi-drug resistance: 2% overall, few ‘hotspots’
Social Determinants and TB
Why are poorer populations…

- Two times more likely to have TB?
- Three times less likely to access care for TB?
- Four times less likely to complete TB treatment?
- Five (?) times more likely to incur impoverishing payments for TB care?
Poverty and TB: A Vicious Cycle

Coping Strategies
- Decrease food intake
- Sell assets
- Borrowing
- Withdraw children from school
- Leave their families
- Delay seeking care

Direct Impact
- Loss of Income
- Stigmatization
- Homelessness

Poor housing:
- Overcrowding
- Poor ventilation
- Malnutrition

Risk Behaviour
Impact on Women

- Single leading cause of death among women of reproductive age
- Stigmatization and social ostracization
  - disease considered unmanageable
  - women divorced, rejected by families (15%)
- Ability to look after family, children undermined
  - activities of cooking, cleaning, household activities (↓50%)
  - child care (↓30%)
Effect on Children

- withdrawal from school (11%)
- employment (8%)
- children more likely to die
  - following maternal death; male - 50/1000, female - 144/1000
  - following paternal death: 6/1000
- life long impact of childhood malnutrition
TB is a relentless leveler, an equal opportunity killer, hard-working and persistent... going about its deadly business with cool disregard for IQ, sex, class, occupation or geographical boundaries”.

The Economist
(1999)
Layered influences--

- Overcrowded
- Poorly ventilated
- Insecure job/wages
- Illiterate
- Malnourished
- Marginalized
- Poverty
- Political commitment, resources where needed most?
- Sale of assets
- Borrowing
- Out-of-pocket expenses for care?
- Awareness?
- Access?
- Equity?
- Stigma
- Homeless
- Migrant
- Smoker, alcohol, drug abuse
- Non compliant
- MDR-TB
- TB-HIV
Are we doing enough to address the social determinants that affect TB control?
TB Control:
The 5 components of DOTS

- Political commitment
- Diagnosis by microscopy
- Adequate supply of anti-TB drugs
- Directly observed treatment
- Accountability
## Addressing social determinants

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political Commitment, resources</td>
<td>Amsterdam declaration; Washington commitment; GFATM, GDF, Stop TB Partnership, bilateral donor support; National commitment;</td>
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<tr>
<td>Access to quality services, health systems</td>
<td>DOTS Expansion; (geographic to 95% pop.; into other sectors; maintaining high treatment success rates; DOTS as entry point for VCT, overall lung health</td>
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<td>Risk behaviours, non-compliance</td>
<td>Directly observed treatment, innovative approaches to bring care ‘closest to home’</td>
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<td>Poverty, inability to pay</td>
<td>Free diagnosis and treatment under DOTS; Patient enablers; Community approaches to ensure equity; Community based health insurance; cost analyses to drive policy</td>
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<tr>
<td>Discrimination at workplaces</td>
<td>DOTS at workplaces; policy of non discrimination, job security; access to DOTS—need for wider application</td>
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Partnerships in Action in the SEA Region - country level

- **NGOs**
  - provide DOTS at community level—*Bangladesh, India, Indonesia, Myanmar, and Nepal*

- **Private medical sector**
  - Public-private partnership as policy—*India*
  - Pilot projects scaling up—*Bangladesh, Indonesia, Myanmar, Thailand and Nepal*
Partnerships in Action in the SEA Region - country level

- **Large employment sectors**
  - Employees benefit from DOTS
  - Tea Estates (*Sri Lanka*) Coffee plantations (*Timor Leste*) Railways (*Myanmar*) and Coal Fields (*India*)

- **Business and Industry**
  - DOTS at workplaces -- *Bangladesh, India* and *Myanmar*

- **Medical schools**
  - DOTS in teaching and practice: *Bangladesh, India, Indonesia, Nepal, Thailand* and *Sri Lanka*
Partnerships in Action in the SEA Region- country level

- With HIV/AIDS programmes
  - Nation-wide implementation of TB-HIV interventions - *Thailand*
  - Pilot projects at district level – *India, Indonesia and Myanmar*
## INITIATIVES: COMMUNITY INVOLVEMENT/EMPOWERMENT

<table>
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<th>SETTING</th>
<th>PROJECT</th>
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<tr>
<td>BRAC</td>
<td>RURAL AND URBAN AREAS IN BANGLADESH, VILLAGES IN NEPAL, SLUM AREAS IN AHMEDABAD, INDIA, RURAL AREAS, RAKHINE STATE, MYANMAR, CHENNAI, INDIA</td>
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<td>NTP NEPAL</td>
<td>VILLAGES IN NEPAL, SLUM AREAS IN AHMEDABAD, INDIA, RURAL AREAS, RAKHINE STATE, MYANMAR, CHENNAI, INDIA</td>
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<td>SEWA</td>
<td>WOMEN VOLUNTEERS “SEVIKAS”, “ANGEWANS”, VILLAGE CHIEFS AND VOLUNTEERS, TRADITIONAL HEALERS</td>
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<tr>
<td>INGO, MYANMAR</td>
<td>VILLAGE VOLUNTEERS “TB HEROES”, WOMEN VOLUNTEERS “SEVIKAS”, “ANGEWANS”</td>
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<td>ACT, MYANMAR</td>
<td>HOUSEWIVES</td>
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<tr>
<td>PEOPLE INVOLVED</td>
<td>RURAL WOMEN “SHASTHO SEVIKAS”, VILLAGE CHIEFS AND VOLUNTEERS, TRADITIONAL HEALERS</td>
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<tr>
<td>SERVICES</td>
<td>INCENTIVE SCHEME, RECOGNITION OF VILLAGE “DOTS COMMITTEES” ENTRY POINT FOR DISCUSSION OF OTHER PROBLEMS, SOLUTIONS</td>
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<tr>
<td>IDENTIFY SYMPTOMATICS</td>
<td>SELF-OWNED SUSTAINABLE COOPERATIVE MICRO-CREDIT, SELF-EMPLOYMENT, HOUSING LOANS</td>
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<tr>
<td>PROVIDE DOT RETRIEVE DEFAULTERS HEALTH EDUCATION</td>
<td>COMMUNITY SELF-FINANCING SCHEME</td>
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<td>PURELY VOLUNTARY- “BETTER OFF” SECTIONS OF SOCIETY</td>
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## Addressing social determinants

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<td>Lack of awareness, stigmatization</td>
<td>IEC strategies— ”COMBI”; increase in skills, (health and non-health staff) better HE materials</td>
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<td>Migration</td>
<td>Cross-border disease programmes; (but limited)</td>
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<td>Urban TB control</td>
<td>Still an issue; “DOTS in big cities” initiative</td>
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<td>Multi-drug resistant TB</td>
<td>“DOTS-Plus” – beginning, hard to implement</td>
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<td>TB-HIV</td>
<td>Early collaboration, joint planning</td>
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<tr>
<td>Gender and TB</td>
<td>Discussion, some studies, limited action</td>
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What the Commission could do for TB...

### Advocacy
- Influence the political environment
- Generate evidence for greater commitment, resources

### Target difficult settings
- Help mitigate adverse determinants
- Help civil society to identify key determinants, empower implementation of solutions
- Direct and personal relationships

### Address ‘system’ constraints
- Provide a forum for dialogue/disseminate experiences, powerful ideas to drive policy
- Develop monitoring & evaluation mechanisms that capture equitable access
- Support cost analyses, poverty reduction and cost sharing strategies

The Commission on Social Determinants of Health

Promote research for action
Conclusions

- Poor people get TB, TB makes people poor
- Poor countries get TB, TB makes countries poor
- It should be unacceptable that 2 million people - 98% in poorest countries - die every year from a preventable disease
- Addressing the TB pandemic means addressing issues of poverty, equity and social development as key elements