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Foreword

The World Health Organization (WHO) has set ambitious targets to end the tuberculosis (TB) epidemic, which include a 90% reduction in TB deaths, an 80% reduction in TB incidence, and the elimination of the catastrophic total costs incurred by people with TB and their households by 2030 compared with 2015, all in line with the United Nations (UN) Sustainable Development Goals (SDGs).

The inequities fuelling the TB epidemic have been accentuated by the COVID-19 pandemic, geopolitical instability, and global financial crises, making it even more urgent to implement policies that address the social determinants of TB. Social protection, a component of the WHO *End TB Strategy (1)*, has been upheld by WHO Member States as an essential component of the response to TB in the 2017 Moscow Declaration to End TB (2) and in the *2023 Political Declaration of the High-level Meeting of the United Nations General Assembly on the Fight Against Tuberculosis (3)*. This recognition is reflected in the new target in the 2023 political declaration, to ensure that 100 per cent of people with TB have access to a health and social benefits package so they do not have to endure financial hardship because of their illness. Similarly, the political declaration of the 2023 United Nations High-level Meeting on Universal Health Coverage includes a commitment to reverse the trend of rising catastrophic out-of-pocket health expenditure by providing measures to ensure financial risk protection and eliminate impoverishment due to health-related expenses, with special emphasis on the poor as well as those who are vulnerable or in vulnerable situations.

In 2021, delegates of the 109th International Labour Conference asked the International Labour Organization (ILO) to take urgent action towards universal social protection to accelerate the reduction of inequalities and address the financial and societal consequences of the COVID-19 pandemic. This call built on International Social Security Standards and in particular the *Social Security (Minimum Standards) Convention, 1952 (No. 102)* and the *Social Protection Floors Recommendation, 2012 (No. 202)*, which include the establishment of national social protection systems accessible to all to guarantee that people have effective access to health care without hardship, and to income security across the life course (4,5).

Social protection is a human right. However, most of the global population is not yet covered by any form of social protection, leaving billions of people unprotected. Likewise, most WHO Member States are not yet including social protection in the programmatic response to TB in a comprehensive and sustainable way.

Recognizing these significant challenges, the WHO Global Tuberculosis Programme and the ILO have jointly developed this technical guidance to assist countries with the adaptation and implementation of social protection programmes to maximize their coverage and impact on people affected by TB.

This guidance is intended to be implemented as part of the multistakeholder and multisectoral response to TB. The translation of social protection policies that serve the needs of people affected by TB requires a coordinated effort within and beyond the health sector, with strong accountability of all actors involved. Through this guidance providers of TB services, including staff and managers in TB programmes and in ministries of health, and relevant social protection stakeholders, will be equipped with both the conceptual and operational tools to plan and implement social protection programmes to accelerate progress towards ending the TB epidemic, while protecting the human rights of people affected by TB.

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Abbreviations and acronyms

CBOs	community-based organizations
CI	confidence interval
DR-TB	drug-resistant tuberculosis
HiAP	Health in All Policies
ILO	International Labour Organization
MAF-TB	multisectoral accountability framework to end tuberculosis
MDR-TB	multidrug-resistant tuberculosis
NGO	non-governmental organization
NTP	national tuberculosis programme
SDGs	Sustainable Development Goals
TB	tuberculosis
UN	United Nations
UNDG	United Nations Development Group
WFP	World Food Programme
WHO	World Health Organization

Executive summary

Universal social protection is at the core of the 2030 Agenda for Sustainable Development and is also reflected in Pillar 2 of the WHO End TB Strategy (1), which acknowledges social protection and poverty alleviation as integral and essential parts of the global response to TB. During the *2023 High level Meeting of the United Nations General Assembly on the Fight Against Tuberculosis (3)* world leaders approved a new political declaration that re-emphasises the critical role of social determinants in perpetuating the cycle of TB and poverty and how these determinants and the socioeconomic consequences of TB are triggered or exacerbated by health and humanitarian crises, including pandemics, disasters and climate change. The 2023 political declaration further emphasises the continued importance of multisectoral action and accountability across the health, nutrition, finance, labour, education and social protection.

The need of mobilising sufficient and sustainable financing towards universal health coverage and social protection strategies in order to alleviate the health and non-health related financial burden experienced by households affected by TB was acknowledged in both the 2023 United Nations General Assembly High Level Meeting on TB and Universal Health Coverage. In particular, the one on Tuberculosis approved a new ambitious target to have, by 2027, all people affected by TB provided with health and social benefits packages to mitigate the financial hardships incurred due to the disease (3).

The COVID-19 pandemic clearly illustrated the extent to which social protection systems can be stretched by global crises, and how these systems can also be leveraged to support ambitious global public health efforts. The role of social protection in this multisectoral response to TB is supported by an increasing body of evidence consistently showing the positive impact of social protection on TB incidence, treatment and catastrophic total costs (defined as direct medical expenditures, direct nonmedical expenditures and indirect costs, e.g. income losses, that sum to > 20% of household income), and, ultimately, the life and wellbeing of people affected by TB.

This guidance aims to translate existing best practices and current WHO and ILO policies into programmatic actions by providing staff and managers in TB programmes and in ministries of health, along with relevant social protection stakeholders, with:

1. essential notions and the base of evidence **to understand** how social protection can contribute to ending the TB epidemic;
2. practical advice **to plan** for inclusive and locally appropriate social protection programmes able to respond to the needs of people affected by TB; and
3. key steps **to implement** effective social protection strategies and establish strong and sustainable synergies across sectors.

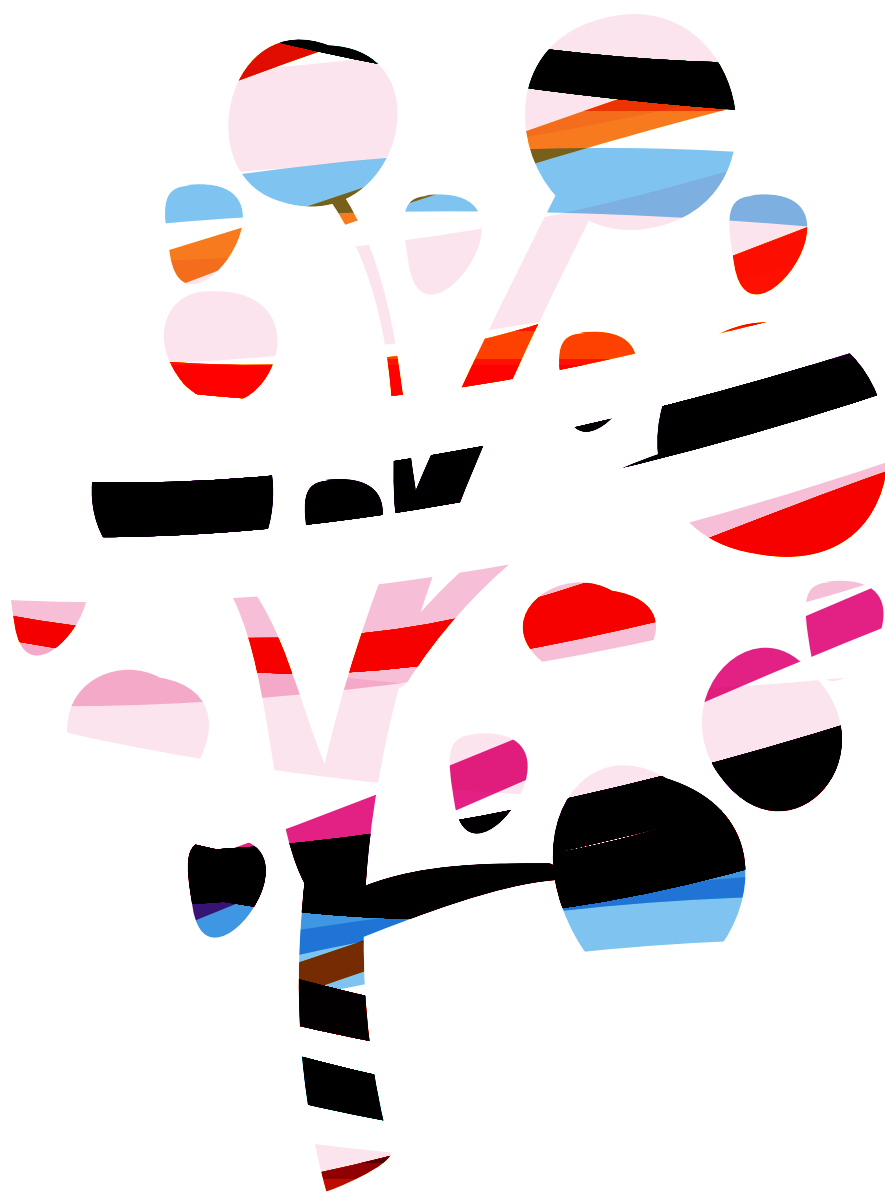


More specifically:

- **Section 1** presents social protection in the context of the *End TB Strategy (1)* and provides key operational definitions and concepts. The section presents a conceptual framework describing the way social protection is expected to impact TB, and a synthesis of the best available evidence on the impact of social protection on TB incidence, TB treatment outcomes and costs incurred by people with TB.
- **Section 2** provides guidance on the planning of social protection for people affected by TB, including the mapping of the existing social protection landscape and an assessment of the needs for social protection programmes and barriers to access faced by people affected by TB. The section presents two complementary approaches to delivering social protection in the context of the TB epidemic (that is TB-sensitive and TB-specific).

Sections 3, 4 and 5 provide guidance on the implementation of social protection:

- » **Section 3** presents ways to enhance the impact of existing social protection programmes on TB by making them more responsive to the needs of people affected by TB. The section illustrates the role TB programmes can play in shaping the TB-sensitivity of social protection programmes by actively engaging with relevant ministries and other social protection stakeholders to increase access to these programmes by people affected by TB.
- » **Section 4** provides guidance for the design and implementation of TB-specific social protection programmes that aim to address income and food security needs of people affected by TB. The section outlines generic protocols and actions to implement material and nutritional support alongside established or new monitoring and evaluation practices. The section also presents a collection of current best practices to address TB stigma, a major cause of social exclusion of people affected by TB.
- » **Section 5** provides guidance on the formulation and establishment of partnership models to foster collaboration between TB programmes and social protection services to address the social determinants of TB. Starting with the central role of the WHO *Multisectoral Accountability Framework to Accelerate Progress to End Tuberculosis by 2030* (MAF-TB) (8) and building further upon the Health in All Policies (HiAP) principles, the section illustrates the operational features of effective and efficient multisectoral collaborations.





1. Social protection for people affected by TB: concepts, definitions, and impact



Credit: ILO / Crozet Marcel

This section introduces key concepts and definitions related to the social determinants of TB and social protection in the context of the *End TB Strategy* (1). The section also presents a conceptual framework to describe the expected impact of social protection on the TB epidemic, and possible entry points for intervention. The section concludes by discussing the extent to which the available evidence supports this conceptual framework.

1.1 The social determinants of TB and social protection in the context of the End TB Strategy

The TB epidemic is strongly influenced by social and economic development (9,10), including health-related risk factors (such as undernutrition, diabetes, HIV, alcohol use disorders, and smoking) (11), as well health systems weaknesses and inadequate investment in social protection (12).

Evidence from Europe and North America suggests that TB mortality was in widespread decline from the middle decades of the nineteenth century onwards, mainly because of wider socioeconomic and nutrition advances rather than specific medical interventions (13). The role of social determinants in the TB epidemic still stands: nutrition remains a major driver of the TB epidemic, with an estimated 2.2 million incident cases of TB attributable to undernutrition in 2021 (11). Furthermore, a 2023 analysis confirms that low human development and social protection spending are still major contributing factors to TB incidence in low- and lower middle-income countries (10).

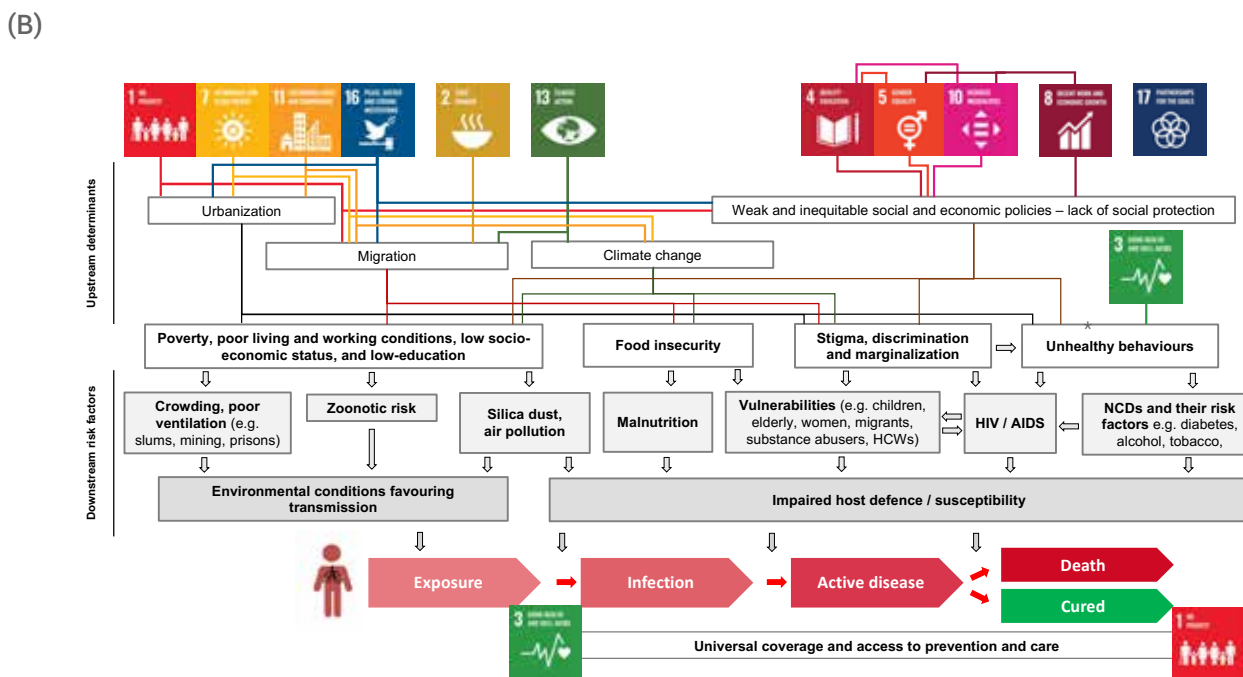
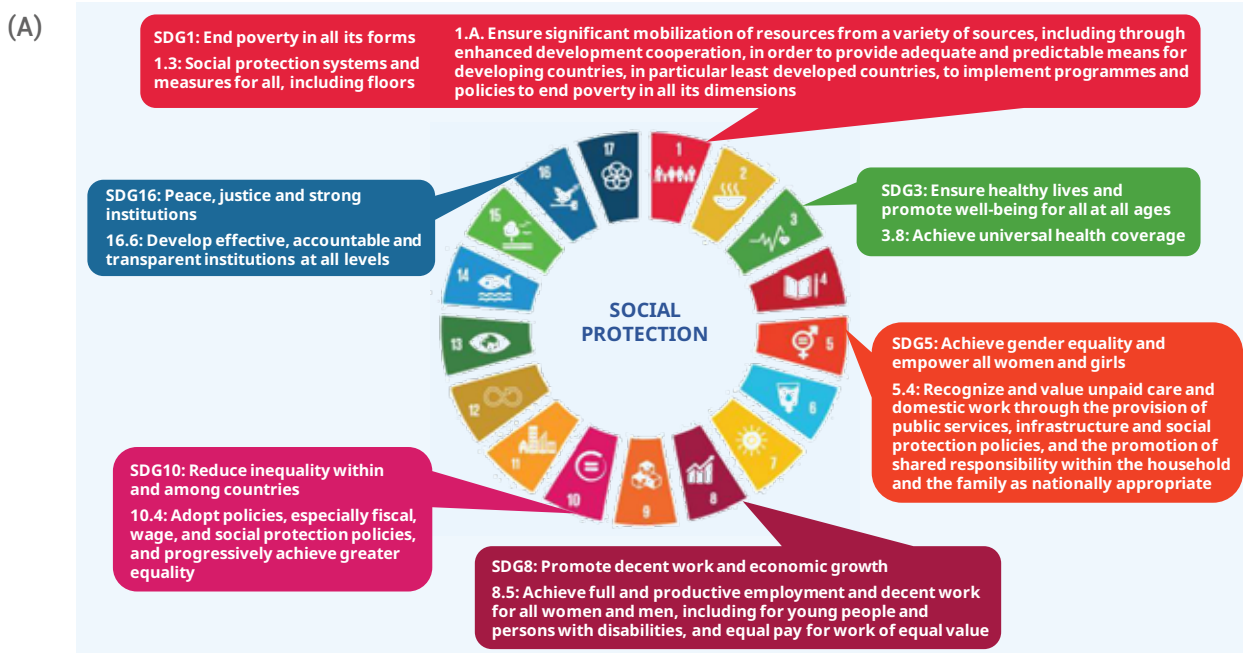
Ending the TB epidemic requires implementing a mix of biomedical, public health and socioeconomic interventions along with research and innovation as outlined in the WHO *End TB Strategy* (1,7). Pillar 2 of the strategy calls for bold policies and supportive systems, including social protection and poverty alleviation, to address the social determinants of TB. This vision is consistent with other global strategies that, over the past few decades, have gradually been adapted in response to the need to complement biomedical approaches with social protection programmes (see Annex 1 for a compendium of key policy guidance and recommendations developed by UN agencies in the context of social protection and health including occupational health, maternal/child health, and migrant and refugee health).

The *End TB Strategy* (1) is founded on promoting, protecting and fulfilling all human rights and the dignity of all people affected by TB. A person affected by TB is defined as “any person with TB infection or disease or who previously had TB disease, as well as their caregivers and immediate family members, and members of TB key and vulnerable populations, such as children, healthcare workers, indigenous peoples, people living with HIV, people who use drugs, prisoners, miners, mobile and migrant populations, women, and the urban and rural poor” (14). One of the core principles of the strategy is the protection and promotion of human rights, ethics and equity. Aligned with the SDGs, the WHO *End TB Strategy* (1) encompasses strategic actions within and beyond the health sector and considers social protection as a human right. The political declaration of the *2023 UN General Assembly High-level Meeting on the Fight Against TB* supports the WHO Multisectoral Accountability Framework for tuberculosis, asking to establish or strengthen high-level multisectoral accountability and review mechanisms (3). This framework provides a mechanism to address the broader determinants of TB through a holistic approach with multisectoral action and accountability.

The WHO *Multisectoral Accountability Framework to Accelerate Progress to End Tuberculosis by 2030* (MAF-TB) (8) is aligned with the 2030 Agenda for Sustainable Development (6), which seeks to build synergies between stakeholders of different SDGs. Fig. 1.1 illustrates how at least 12 SDGs are linked with *End TB Strategy* (1) targets and shows the linkages between social protection and the other SDG targets. In particular, the linkage between social protection and Target 3.3 (by 2030 end the epidemics of AIDS, TB, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases) reaffirms the need for social protection for people affected by TB.



Fig. 1.1 Social protection (A) and TB (B) in the 2030 Agenda for Sustainable Development: relevant goals and targets



* Non-communicable diseases

Sources: (A) *Building the future of social protection for a human-centred world of work*. International Labour Conference 109th Session, 2021. Geneva: International Labour Organization, 2021 (https://www.ilo.org/ilc/ILCSessions/109/reports/reports-to-the-conference/WCMS_780953/lang--en/index.htm). (B) *Essential Tuberculosis*, Raviglione MC & Migliori GB (co-editors), chapter 38, page 354, 2021 (under authorization from the publisher Springer).

1.2 What is social protection?

Social protection refers to the set of policies and corresponding programmes designed to prevent and reduce poverty, vulnerability and social exclusion throughout the life course (15). The right to social security (used interchangeably with “social protection”) is reflected in Article 22 of the Universal Declaration of Human Rights of 1948 which states that “everyone, as a member of society, has the right to social security” (16), and also in other human rights instruments, in particular the 1966 International Covenant on Economic, Social and Cultural Rights (17). International social security standards – developed under the auspices of the ILO – complement this normative commitment by setting out principles and minimum requirements for national social protection systems. According to the Office of the High Commissioner for Human Rights, the right to social security encompasses “the right to access and maintain benefits without discrimination, in order to secure protection from:

- a lack of work-related income caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member;
- unaffordable health care; and
- insufficient family support, particularly for children and adult dependents” (18).

Universal social protection refers to comprehensive, sustainable and adequate protection for all, over the life cycle, along three core dimensions::

- **Universal coverage** in terms of persons protected means all should have effective access to social protection throughout the life cycle when needed.
- **Comprehensive protection** refers to the social risks and contingencies that are covered including access to health care and income security. The Social Security (Minimum Standards) Convention, 1952 (No. 102) defines the nine contingencies that all human beings may face over their life course: the need for medical care and the need for benefits in the event of sickness, unemployment, old age, employment injury, family responsibilities, maternity, invalidity and survivorship (acknowledging the needs of widows and orphans). It also includes protection against new and emerging risks, such as long-term care needs (4).
- **Adequate protection** means benefits provided need to be set at a level that effectively prevents poverty, vulnerability and social exclusion, maintains decent standards of living, and allows people to lead healthy and dignified lives (19).

With these broad objectives, social protection policies encompass a wide range of programmes of different types, in which benefits are social transfers financed via social contributions, taxes or a mix of those financing sources (20). Social transfers (all social protection benefits) comprise transfers either in cash or in kind; that is, they represent a transfer of income, goods or services (for example, health care or social care services). This transfer may be from the economically active to the retired, the healthy to the sick, or the affluent to the poor, among others. The recipients of such transfers may be eligible to receive them because they have contributed to such a programme (contributory programme), or because they are residents (universal programmes for all residents), because they fulfil specific age criteria (categorical programmes), meet specific resource conditions (means-tested programmes), or because they fulfil several of these conditions (21). Most social protection programmes are mandatory (for example health insurance is mandatory for all residents in many countries), but some are voluntary (21).

An overview of the different types of social protection programmes and their main characteristics is provided below, drawing on the ILO *World Social Protection Report 2020–2022* (15). A glossary of key social protection terms as well as other terms relevant for this guidance is provided in Annex 2. Such definitions are not universal, but they are meant to provide conceptual clarity in the context of this guidance.



Overall, social protection measures include the following types of programmes (15).

- **Contributory programmes:** programmes in which contributions made by protected persons (actual or potential beneficiaries) directly determine entitlement to benefits (acquired rights). The most common example of contributory social security programmes are statutory social insurance programmes, usually covering workers in (formal) wage employment and, in some countries, the self-employed, and in many cases also their families and categories of the population who are exempt from contributions for certain reasons (for example, due to caring for children).
 - » **Social insurance:** a contributory social protection programme that guarantees protection through an insurance mechanism, based on: (1) the payment of contributions before the occurrence of the contingency; (2) the sharing or “pooling” of risk; and (3) the notion of a guarantee. The contributions paid by (or for) insured people are pooled together, and the resulting fund is used to cover the expenses incurred exclusively by those individuals affected by the occurrence of the contingency. In contrast to commercial insurance, risk-pooling in social insurance is based on the principle of solidarity, with contributions typically related to people’s capacity to pay (often proportional to earnings) as opposed to premiums that reflect individual risks. For example, social health insurance is typically a health insurance programme with public stewardship and at least some insurance contributions from and/or on behalf of the protected persons or some categories of protected persons.
- **Non-contributory programmes:** programmes that require no direct contribution from beneficiaries or their employers as a condition of entitlement to receive relevant benefits. The term covers a broad range of programmes, for example:
 - » **universal** non-contributory services for all residents (such as national health services);
 - » **categorical** programmes for certain broad groups of the population (such as universal pensions for all older people above a certain age, or universal child benefits for all children below a certain age);
 - » **means-tested** programmes in which only persons below a certain income level are eligible to receive the benefit (such as family benefits targeted only at poor families);
 - » **benefit-tested** programmes in which only persons who are not already receiving benefits from another programme are eligible (for example social pensions for older persons not already receiving a pension from a social insurance programme because they were not able to meet the minimum contributory requirements over their working life); and
 - » **social assistance** programmes that provide benefits to vulnerable groups of the population, especially households living in poverty. Most social assistance programmes are means-tested. Some are targeted based on categories of vulnerability, while others are targeted to low-income households. They can take several forms, for example non-contributory social pensions, fee waivers and exemptions for health care, schooling or utilities. Conditional cash transfers, for example, are programmes that provide cash to families if they fulfil specific behavioural requirements. Beneficiaries may be required to ensure that their children attend school regularly, or to use basic preventive nutrition and healthcare services. Almost all countries at all income levels have at least one form of social assistance programme.

In addition, **labour market or livelihoods support programmes such as public employment programmes** provide employment opportunities for people who are able to work, with the aim of facilitating their inclusion in the labour market and ensuring a basic level of earnings (22). For instance, public employment guarantee programmes provide a guaranteed number of days' work per year to poor households, generally providing wages at a relatively low level (typically at the minimum wage level if this is adequately defined).

In-kind benefits can include **social care programmes** for those facing social risks such as violence, abuse, exploitation, discrimination and social exclusion, and may range from psychosocial support to linkages with needed medical and social services.

1.3 Strategies for the delivery of social protections programmes for people affected by TB

In the context of TB, two social protection delivery models can be recognized: TB-sensitive programmes and TB-specific programmes (23). This guidance uses the following working definitions for these two approaches, as illustrated in Table 1.1.

TB-specific social protection programmes are programmes exclusively addressed to people with TB and their households. Typically, these programmes are initiated by and are under the responsibility of TB programmes and are intended to respond to specific needs not covered by the mainstream social protection system. Such programmes have the explicit objective of reducing TB incidence, mortality and patient costs by mitigating the impact of poverty, vulnerability and social exclusion on households and individuals affected by TB. For instance, in some low- and middle-income countries, national social protection systems are at an early stage of development or may be financially constrained, and therefore they may be unable to offer benefits suitable for people affected by TB (such as cash benefits that could cover transport or nutrition costs). In these instances, TB-specific social protection programmes can help cover such needs. The budget for this type of programme typically lies with the TB programme and therefore it is important to consider progressively linking TB-specific social protection programmes to the national social protection system, with a view to ensuring their long-term financial sustainability.

TB-sensitive social protection programmes are programmes not targeted specifically at households or individuals affected by TB. While not designed intentionally to address any TB-related objective, these programmes can potentially affect the TB epidemic by including among their eligibility criteria people with, at risk of, and/or affected by the consequences of TB. Typically, these programmes are *not* initiated by TB programmes and are *not* under the direct control and management of the health sector. However, TB programmes can play a critical role in ensuring that these programmes also address the needs of people affected by TB and ultimately have a stronger impact on the TB epidemic.

Table 1.1 Models for the delivery of social protection for people affected by TB

	Definition	Examples
TB-specific social protection	Programmes focused on people with TB and their households with the specific aim of improving TB prevention, care and support	A monthly voucher to support TB treatment in South Africa (24)
TB-sensitive social protection	Programmes that are not limited to households and individuals affected by TB but that can potentially affect the TB epidemic by covering people with TB, at risk of TB, and/or affected by the consequences of TB	A conditional cash transfer programme in Brazil (25)

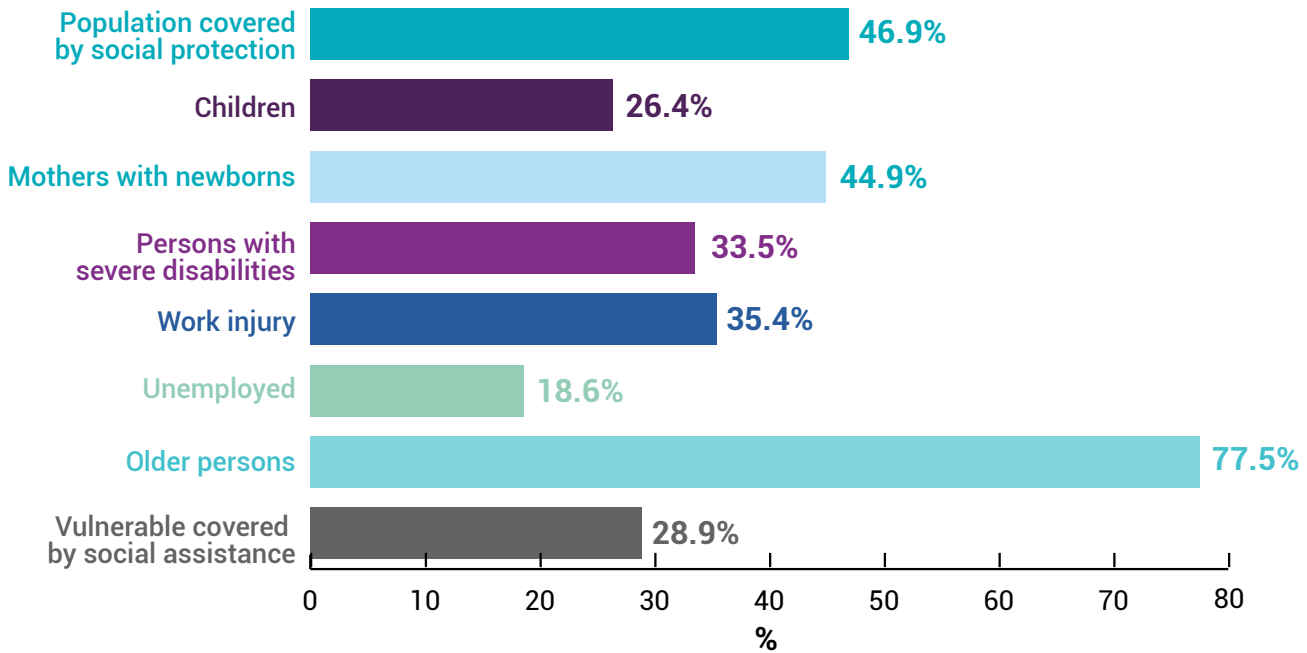


These two approaches are complementary for the delivery of social protection programmes and should not be considered as mutually exclusive. Depending on resources available, the local TB epidemic profile, as well as the available social protection programmes, these approaches could be considered either in combination or in a sequential manner.

Both approaches have strengths and limitations. For example, TB-sensitive social protection programmes contribute to reinforcing the social protection system as a whole and therefore address social determinants of health broadly. Universal social protection should be seen as a priority and, therefore, programmes should seek broad coverage and avoid narrow eligibility criteria. TB-sensitive social protection programmes are also usually more cost-effective because they leverage resources already in place rather than requiring a new budget to sustain administrative and delivery structures specifically for people affected by TB. Reinforcing national social protection systems can be a more sustainable approach to TB prevention, considering most TB-specific social protection programmes would target people who already have TB. Finally, they help to minimize the stigma related to TB, which can unintentionally be reinforced by TB-specific social protection programmes.

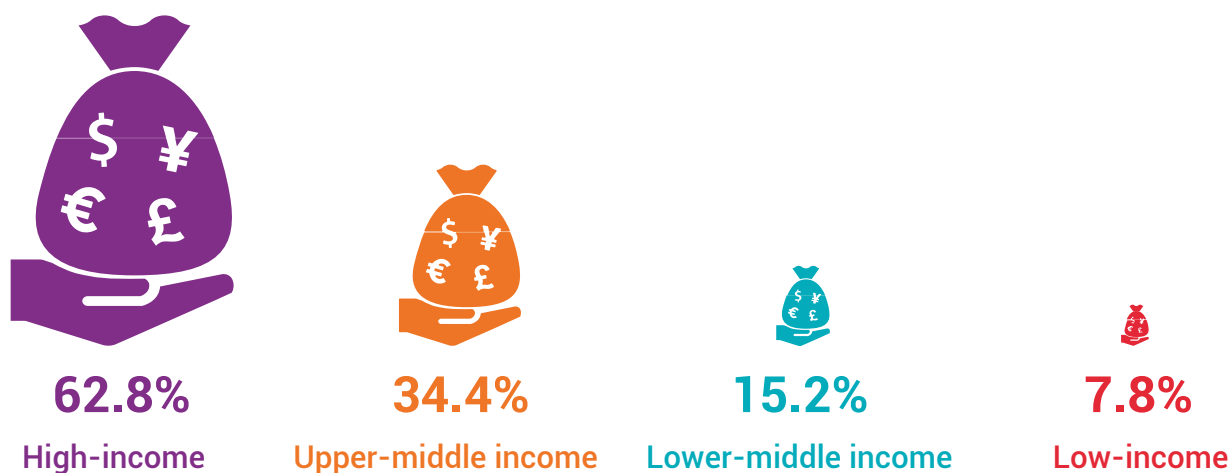
On the other hand, in most countries social protection systems – even when TB-sensitive – are often in their infancy and not yet complete in terms of both the range of benefits offered and the extent of the population they effectively cover in high TB-burden countries. Indeed, while the development and roll out of social protection policies, systems and programmes is improving in many countries, comprehensive social protection coverage is still low, as Figs. 1.2 and 1.3 illustrate (15).

Fig. 1.2 Coverage of effective social protection through social assistance programmes: global and regional estimates by function, 2020 (%)



Sources: World social protection database [online database]. Geneva: ILO; 2021 (<https://www.social-protection.org/gimi/WSPDB.action?id=32>); based on the ILO Social Security Inquiry; ILOSTAT; national sources.

Fig. 1.3 Percentage of vulnerable persons receiving cash benefits by country income level, 2020 or latest available year (SDG indicator 1.3.1)



Sources: World social protection database [online database]. Geneva: ILO; 2021 (<https://www.social-protection.org/gimi/WSPDB.action?id=32>); based on the ILO Social Security Inquiry; ILOSTAT; national sources.

Behind this global coverage average, the ILO *World Social Protection Report 2020-2022 (15)* highlights significant variations across and within regions, with Asia and the Pacific, the Arab States and Africa having pronounced coverage gaps relative to the global average. Those regions also include the majority of countries with a high burden of TB. Several high TB burden countries have tried to expand coverage of existing social protection programmes to people with TB (26).

Given the above, in many high TB burden countries, TB-specific social protection programmes may be necessary to complement existing social protection benefits and provide people with TB with social protection through TB programmes or through ad hoc social assistance programmes developed by national social protection authorities. For example, in Ecuador a conditional cash transfer was made available to people with drug-resistant TB (DR-TB), which provided cash benefits linked to adherence to treatment for up to 24 months, funded through the national tuberculosis programme (NTP) (27). In some circumstances, a two-pronged approach may be considered as a strong basis for advocacy, consisting of continuous advocacy for the extension of TB-sensitive social protection while implementing TB-specific programmes and generating evidence thereof.



1.4 The role of social protection in ending the TB epidemic: a conceptual framework

The impact of social protection programmes is a result of a combination of both structural and individual-level determinants which influence their implementation, effectiveness and accessibility for those most in need, as illustrated in Fig. 1.4.

In any given context where social protection systems exist, operate effectively and are equitable and accessible for people in need, social protection is expected to affect the burden of TB by:

- reducing the risk of exposure to TB and transmission of TB;
- reducing the risk of developing TB disease; and
- reducing the risks of both poor TB treatment outcomes and adverse consequences of TB.

The impact of social protection on the burden of TB is achieved via several pathways. However, in the context of this guidance only three pathways will be considered: the material, the psychological/cognitive and the biological pathways (see Fig. 1.4).

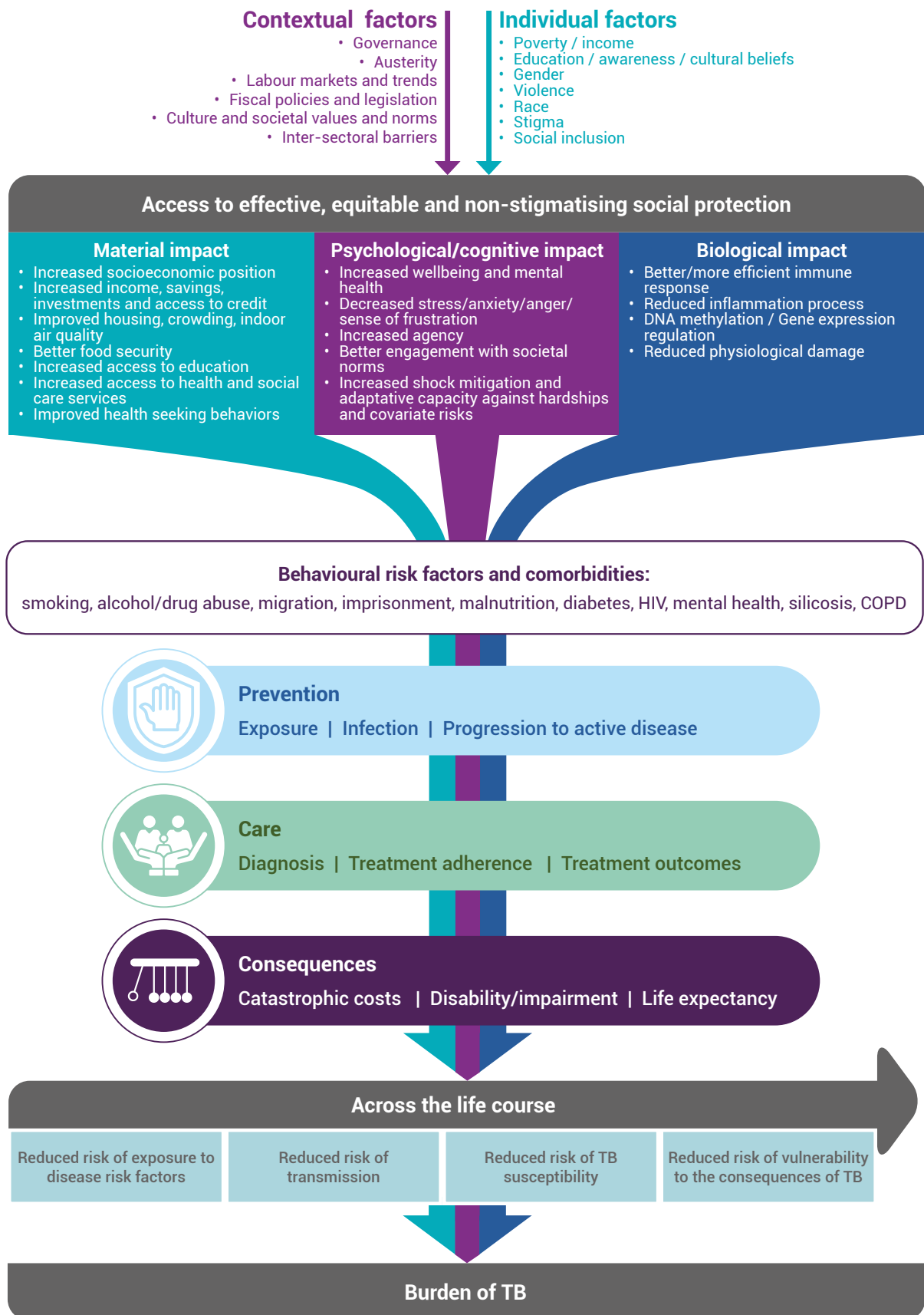
A. The material pathway: this pathway operates through living conditions and economic circumstances (including income, housing and working conditions, and food security) and can affect the risk of exposure to TB, the likelihood of disease progression after infection and the outcomes of TB treatment. A strong body of evidence confirms that social protection, especially in the form of cash transfers, can significantly improve people's material living conditions that are known driving factors of the TB epidemic in most countries.

B. The psychological/cognitive pathway: according to this pathway, the distribution of TB in the general population is not attributable just to a differential exposure to material hazards and economic circumstances, but it may depend on feelings and emotions triggered by these inequalities, including stress, anxiety, anger, shame, distrust and depression. These negative emotions can translate into an alteration of psycho-neuro-endocrine mechanisms that ultimately make people more vulnerable to developing TB infection or diseases. By affecting people's mental health and wellbeing, social protection can alter these neuro-endocrine mechanisms and ultimately influence beneficiaries' vulnerability to diseases, including TB.

C. The biological pathway: while not yet fully demonstrated, it can be speculated that social protection benefits, and in general, income support interventions, may affect genetic, physiologic and immunologic processes that in turn influence the likelihood of developing TB infection and TB disease, as well as the outcomes of TB treatment.

These three pathways that influence the impact of social protection on TB burden likely happen simultaneously, and collectively can influence people's behaviours and the probability of developing comorbidities. This in turn can affect TB prevention, care and consequences and ultimately the overall burden of TB in a given community. All the above pathways operate across an individual's life course and social protection may have a differential impact across critical life stages depending on the type of benefits delivered and when the social protection benefits are provided. In particular, social protection programmes can play a role in reducing the burden of TB through the life course by ensuring a healthy start for children, promoting labour market participation and social inclusion during adulthood, and ensuring secure aging among the elderly.

Fig. 1.4 Understanding the impact of social protection on TB: a conceptual framework





1.5 The impact of social protection on TB: the evidence

This section provides an overview of the evidence base for the impact of social protection programmes on several *End TB Strategy* (1) targets, including TB incidence, TB treatment outcomes, and people with TB and their households experiencing catastrophic total costs. Evidence related both to the impact on TB prevention (that is, initiation and adherence to TB preventive treatment, as well as the uptake and efficacy of Bacillus Calmette-Guérin vaccination) and the impact on TB diagnosis, is very limited, therefore will not be presented in this guidance despite its critical importance.

1.5.1 The impact of social protection on TB incidence

Modelling studies confirm that increasing social protection coverage can significantly contribute to improvement in key TB indicators. A global ecological study estimates that social protection spending levels are inversely associated with TB incidence, prevalence and mortality (12). Similarly, a modelling study suggests that expanding social protection coverage to all those in need could result in a 9% annual decline in TB incidence, and a cumulative reduction in TB incidence of 76.1% by 2035 (28).

1.5.2 The impact of social protection on TB treatment outcomes

Material support, in the form of food or financial enablers is recommended by WHO for the care and support of people with DR-TB (29). A growing body of evidence also confirms the positive impact of social protection on treatment outcomes of people with drug-susceptible TB. Three systematic reviews conducted during the period 2018–2021 confirm the positive effect of social protection, mainly in the form of social assistance, on TB treatment outcomes in a variety of low- and middle-income settings (30–32). This effect is consistent across studies, although its magnitude may be context specific.

Financial incentives as low as \$US 1 have been shown to improve TB treatment outcomes (33–38). Cash transfers have been particularly studied in Latin America, with positive impacts (up to a 10% increase in TB treatment success) shown across the region (25,39–46). Food baskets or vouchers – sometimes delivered in combination with other interventions – also demonstrated positive impacts in the similarly middle-income settings of Brazil, Russia, Peru and India (46–54). Transportation vouchers also showed positive but smaller impacts on TB treatment outcomes in two studies in China (51,52). Notably, interventions in Peru, Nepal and Thailand suggest that their impact can be enhanced when paired with counselling, psychological and other forms of material support (“cash plus” approaches) (35,44,53,54).

1.5.3 The impact of social protection on patient costs due to TB

A pooled analysis of findings from 27 national TB patient cost surveys showed that the percentage of people with TB and their households that experienced catastrophic total costs (defined as direct medical expenditures, direct nonmedical expenditures and indirect costs, e.g., income loss that sum to >20% of household income) ranged from 13% to 92% with a pooled average of 48%: that is, about half of all people affected by TB faced catastrophic total costs (17). These figures have been further confirmed in a recent meta-analysis (55). Finally, increasing evidence suggests that TB exerts a severe socioeconomic impact also on children and adolescents affected by TB, as Box 1.1 illustrates.

These figures are alarming, considering the *End TB Strategy* target (1) of zero catastrophic total costs and the known association of these catastrophic costs with poor TB treatment outcomes (56). Unlike the health expenditures considered in the related [SDG indicator 3.8.2](#) that are restricted to direct health payments (also known as out-of-pocket health payments and concern the whole population), costs faced by people with TB encompass *medical costs*, including in settings where TB diagnosis and treatment are provided free of charge, *direct non-medical costs* (such as transportation, accommodation, food and nutritional supplements) and *indirect costs* (such as productivity and economic costs incurred by a patient or household due to TB healthcare visits and hospitalization

during the TB episode). Although the composition of cost drivers differs by country, direct non-medical and indirect costs consistently represent the largest proportion of the economic burden of TB on individuals and households. Accordingly, simply accelerating universal health coverage policies (that is, by making TB care services available and accessible geographically and financially through, for example, the provision of free TB care services and/or the expansion of health insurance) may be insufficient to completely defray costs (57).

The greatest costs incurred by people with TB occur early in their interactions with the healthcare system, suggesting that social protection programmes may need to be delivered at the time of diagnosis to eliminate catastrophic total costs (37,57,58) and improve TB treatment outcomes. Depending on the specific type of programme considered, social protection is expected to mitigate catastrophic total costs either by defraying direct medical costs (through health insurance mechanisms) or by compensating any income loss due to inability to work and/or unexpected household expenditures (e.g. through sick leave benefits and cash transfers). Transport and food costs are commonly cited as non-medical costs incurred by people with TB, and a useful TB-specific intervention is to provide transport and food vouchers – even amounts as small as 3–6% of household income have been demonstrated to improve TB treatment outcomes (31).

Evidence from Peru suggests that 30% of households affected by TB receiving social protection incurred TB-related catastrophic total costs; compared to 42% of households affected by TB who were not receiving social protection benefits (59). This effect also translated into improved TB treatment outcomes (60). Similar findings are available from Indonesia, where the chances of an unsuccessful treatment outcome were up to four times higher among patients who experienced catastrophic costs compared with those who had not experienced catastrophic total costs (56,61). Finally, a 2017 economic model has demonstrated that both TB-sensitive and TB-specific social protection programmes can partly defray catastrophic total costs across a variety of settings in low- and middle-income countries (62).

Box 1.1 The socioeconomic impact of TB on children and adolescents

A 2021 sub-analysis from 10 national TB patient cost surveys, including almost 1,500 children and adolescents, provided valuable insights on the financial burden of TB in households with this age group. This analysis showed that if the person with TB was a child or an adolescent, the proportion of households that experienced catastrophic total costs was lower (41.8%, 95% confidence interval (CI) 22.9–60.8%) than if the person was an adult (56.2%, 95% CI 44.4–68.1%) (63).

School disruption was one of the major consequences noted among children (8.4%, 95% CI: 3.4–13.4%) and adolescents with TB (18.7%, 95% CI: 8.8–28.7%). Food insecurity was experienced by 19.8% of children with TB (95% CI: 3.7–35.8%) and 20.5% of adolescents with TB (95% CI: 11.5–29.8%).

Findings from a 2022 scoping review, including 36 different studies, confirm and further add to this analysis (64). In this review, the socioeconomic impact exerted by TB ranged from impoverishment, stigma and family separation to effects on nutrition and missed education opportunities. None of the studies included in this review provided sufficient follow-up to observe the long-term impact of TB on children and adolescents, and how TB can affect the life and work trajectory of this group, leaving a substantial gap in the understanding of the life course implications of developing TB during childhood or adolescence.

Overall, these findings emphasize the need for providing social protection for children and adolescents affected by TB. However, there is still limited knowledge of the extent to which different social protection programmes (in-kind, in-cash, or a combination of both approaches) can impact the short- or long-term socioeconomic consequences of TB, as well as how child-sensitive social protection programmes could support households affected by TB.



2. Planning social protection programmes for people affected by TB



Credit: WHO / Lindsay Mackenzie

The adoption of effective and efficient social protection measures for people affected by TB requires proper planning, encompassing the assessment of what social protection system and programmes are locally available, the understanding of the social protection needs of people and communities affected by TB, and finally the accurate identification of the individual- and structural-level barriers that people affected by TB face in accessing existing social protection programmes.

This section outlines the key steps of this planning phase: the proposed methodology is meant to support decisions and actions of TB programmes to design and implement locally appropriate social protection approaches. Specifically, this planning effort is key to identifying what the existing social protection system can offer, and what complement, if any, may be needed to meet the special needs of households affected by TB. Through this planning exercise, TB programmes can devise the most appropriate social protection investment (that is, TB-sensitive, TB-specific or a combination of both) that can most effectively and efficiently reduce the burden of TB in their setting.

2.1 Overview of the key steps for planning social protection programmes

The planning of effective and cost-effective social protection programmes is context specific and should be informed by a formal process comprising the following five steps:

1. establishing a multidisciplinary/multisectoral team
2. mapping the social protection landscape
3. assessing the social protection needs of people affected by TB
4. identifying barriers to social protection faced by people affected by TB
5. formulating solutions.

There are different approaches to conducting this planning exercise. The strategy chosen as well as the frequency of the activities can be calibrated based on resources available and the existing knowledge gaps. The methodology presented here draws largely upon the following resources:

- the HIV and social protection assessment tool developed by UNAIDS as part of the Inter-Agency Task Team on HIV-sensitive social protection for the identification of barriers to access (65); and
- the ILO global guide on social protection assessment-based national dialogue (66), the United Nations Development Group (UNDG) global toolkit on joint work on social protection (67) and the Interagency Social Protection Assessment (ISPA) *Core Diagnostic Instrument* (68) for the mapping and rapid assessment of existing social protection programmes.

Overall, this process should enable the understanding of existing challenges and opportunities that may affect availability and suitability of social protection programmes for people affected by TB and that may also ultimately influence the impact of these social protection programmes on TB. The knowledge and evidence generated through this assessment will inform the design and implementation of the social protection approach (that is, whether TB-sensitive or TB-specific) that best meets the needs of people affected by TB while respecting ethical, equity, feasibility and sustainability criteria. The breadth and scope of this planning exercise is dependent on the human and financial resources available, the sustainability requirements, and the extent of communication and integration across the health and social protection sectors. It is important to note that the assessment of the social protection system may already be available and/or have been conducted by social protection working groups, therefore TB programmes are encouraged to investigate as to whether that is the case and how they could build upon such processes.

Each of the proposed stages is adaptable to the local context and can be broken down into further steps. The next sections describe the process in detail, including objectives, expected outputs, required tools and useful references for each step, as illustrated in Fig. 2.1.



Fig. 2.1 Summary of key steps for the planning of social protection programmes for people affected by TB: the role of the coordinating team

Steps	Objectives	Activities	Outputs	Useful references and tools
<p>1</p> <p>Establishing a multi-disciplinary and multi-sectoral team of stakeholders</p>	To identify and engage with key stakeholders from the TB and social protection sector	Stakeholder mapping and agreement on the targeted engagement strategy	A clear and agreed planning roadmap	Guidance for National Strategic Planning for Tuberculosis (69)
<p>2</p> <p>Mapping the social protection landscape</p>	To systematically collect and appraise information (mainly in terms of coverage and adequacy) on the available social protection programmes operating in the country (whether TB-sensitive or TB-specific)	<ul style="list-style-type: none"> • Desk review of existing literature • Key informant interviews • Secondary analysis of existing data 	A list of 2–3 priority social protection programmes to be further explored for their TB-sensitivity (their responsiveness to and inclusiveness of people affected by TB)	<ul style="list-style-type: none"> • ILO Assessment Based National Dialogue guide (66) • UNDG global toolkit on joint work on social protection (67) • ISPA Core Diagnostic Instrument for the mapping and rapid assessment of existing social protection programmes (68)
<p>3</p> <p>Identifying the social protection needs of people affected by TB</p>	To describe the social protection needs of people with TB along the continuum of care as well as the social protection needs of all their household members that may be indirectly affected by TB (including children, adolescents, caregivers, elderly)	Data collection on social protection needs, ideally at different points in time (that is, at the start of treatment and monitored until treatment completion)	A clear understanding of the type, size, timing and frequency of the social protection benefits needed by people affected by TB	<ul style="list-style-type: none"> • Tuberculosis patient cost surveys: a handbook (70)
<p>4</p> <p>Identifying the barriers to access to social protection faced by people affected by TB</p>	To assess the supply- and demand-side barriers hampering access to social protection programmes by people affected by TB	Triangulation and integration of data from: <ul style="list-style-type: none"> • Quantitative survey among key stakeholders from the multidisciplinary and multisectoral team • Focus group discussions with key multidisciplinary and multisectoral stakeholders 	A clear understanding of the obstacles and bottlenecks hampering a wider and more equitable access to social protection programmes by people affected by TB	HIV and social protection assessment tool. Generating evidence for policy and action on HIV and social protection* (65)
<p>5</p> <p>Designing appropriate social protection programmes</p>	To discuss the findings from the previous steps and design locally appropriate social protection programmes for people affected by TB	Consultation with key members of the multidisciplinary and multisectoral stakeholders	Consensus on the most appropriate social protection strategy to maximize the impact on TB in the country, while acknowledging its cost, feasibility and acceptability	Guidance for National Strategic Planning for Tuberculosis (69)

* This tool could be adapted to best meet the objectives of the assessment

2.2 Establishing a multidisciplinary/multisectoral team

Under the leadership and coordination of the TB programme, a core group is needed to coordinate all stages of the planning exercise. This coordinating team will be responsible for:

- A. outlining the TB-related objectives to be prioritized and achieved through social protection;
- B. identifying the key literature and sources of information to map the local social protection landscape;
- C. coordinating the assessment of social protection needs and barriers to access to social protection services; and
- D. finalizing the social protection strategy that can most effectively impact TB in the country, based on the findings from the planning process.

The coordinating team should be supported and complemented by the knowledge and expertise of a multidisciplinary and multisectoral group of key stakeholders (maximum 15–20) engaged at various stages of the planning process. Stakeholders in this context are defined as people or groups who are affected by, can influence or may have an interest in a strategic activity (69).

To ensure adequate representation of skills and expertise, this multidisciplinary and multisectoral group should include representation from the following domains:

- TB care staff (that is, nurses, doctors, community health workers and other care providers);
- civil society and communities affected by TB and TB comorbidities, and advocates of the social determinants of TB;
- the ministry of social affairs or social security;
- key policy and implementation partners, including UN agencies (such as ILO, World Food Programme (WFP), International Organization for Migration (IOM), United Nations International Children's Emergency Fund (UNICEF)) and non-governmental organizations (NGOs);
- the national statistics office; and
- others as necessary based on country needs.

Mapping the appropriate stakeholders is a dynamic process which can start with a predetermined list of core experts who, through their networks, may help to identify other relevant stakeholders to invite to be part of the group. The approaches to inviting stakeholders to take part to this planning exercise will vary depending on the role and seniority of the stakeholder but will also depend on whether these experts have already been engaged with TB-related activities and/or have had previous contacts with the TB programme.

The principles of meaningful engagement with the identified stakeholders build upon a number of principles that have been described elsewhere, including the importance of an early engagement with stakeholders in the process and throughout all its steps, the need for engaging with stakeholders as equals, and the role of existing collaborative platforms when establishing stable and close partnerships (69).

Overall, the strength of this multisectoral collaboration will heavily depend on the capacity of the TB programme to identify in advance how the planning of social protection programmes for people affected by TB can also potentially progress the agenda of the respective stakeholders. Stakeholders are likely to be more actively involved if this engagement contributes also to the achievement of their own objectives (69).



2.3 Mapping the social protection landscape

Mapping the local social protection landscape is essential to understanding the extent to which existing programmes are responsive to the needs of people affected by TB and the extent to which they are inclusive enough to reach those most in need. In settings where mapping of the social protection landscape is already planned or underway, efforts should be made to ensure that social protection for people affected by TB is streamlined in these exercises.

Mapping of the social protection landscape requires an in-depth review of the existing published and unpublished literature, including peer-reviewed articles, reports and policy briefs. People affected by TB are usually confronted with several social stressors; thus, when undertaking this social protection mapping exercise, the following programmes and benefits should be prioritized:

- cash or in-kind benefits that address key risk factors for TB, including income and food insecurity, poor housing and unemployment;
- healthcare benefits that cover the cost of medical care, and that cover both transportation and nutrition needs, as well as long-term care if needed;
- sickness cash benefits and, when the disease results in permanent loss of function to one's health, disability benefits to compensate income loss due to the temporary inability to work or the opportunity cost of seeking care;
- occupational diseases benefits (often part of employment injury insurance programmes) to compensate for the loss of income and restore the health of people who contracted TB through their work (such as health workers, for example);
- income support for caregivers and children in affected households (including survivors' benefits) to compensate for the opportunity cost or any income loss due to care-giving responsibilities within the affected households; and
- access to resources to counteract and be protected from the social exclusion that can result from the stigma attached to TB, TB comorbidities (such as HIV and mental disorders) and being a beneficiary of social protection.

The scope of this desk review should include a critical appraisal of the priority programmes and benefits along the following dimensions:

- *coverage*: the extent to which the eligibility criteria of existing social protection programmes result in inclusion of people affected by TB at national or sub-national level;
- *adequacy*: the extent to which the benefit packages provided meet the needs of people affected by TB, in terms of scope, type, size, frequency, place of delivery as well as delivery modality (assessing adequacy of benefits against the needs of people/households affected by TB is of particular importance because they often incur costs related to the disease that are very high and that existing social insurance or social assistance programmes may not entirely cover (26,71); and
- *implementation and operational issues*: the extent to which, for example, insufficient funding, limited geographical access of the institution running the programme, or administrative bottlenecks hamper the enrolment into the programme and/or access to the benefits.

International human rights instruments and international social security standards provide useful references and benchmarks for assessing coverage and adequacy of social protection benefits (see Box 2.1). For example, ILO Conventions on social security establish minimum levels of benefits (72).

Box 2.1 International human rights instruments and social security standards resources

- ILO Social protection data dashboards monitor coverage across countries and regions (73);
- ILO World Social Protection Report provides a global overview of recent developments in social protection systems (15);
- ILO Social Protection Monitor announces social protection measures throughout the world (74);
- ILO Social protection response to the COVID-19 crisis and bi-monthly outlook (75,76);
- International Social Security Association (ISSA) Social Security Programs Throughout the World series highlights social security programmes in 183 countries and territories (77); and
- The UNDG Social Protection Floor Initiative aims to integrate social protection floors into national, regional and global development strategies (67).

Data and evidence gathered through the desk review could be further consolidated and complemented by:

- analysis of secondary data if available and/or
- interviews with key informants from the multisectoral and multidisciplinary stakeholders.

Overall, these additional sources of information could be used to address persisting knowledge gaps, including:

- cost-effectiveness and equity of the local social protection programmes;
- evaluation of the impact of existing social protection programmes on health outcomes and/or health seeking behaviour and/or relevant TB risk factors; and
- examples of multisectoral collaborations, including participation and engagement of these programmes with public or private health sector players.

The expected output from this mapping exercise is the identification of 2–3 priority programmes to further investigate for their suitability for, and accessibility by people affected by TB.

2.4 Assessing the social protection needs of people affected by TB

Social protection needs of people with TB vary across the continuum of care and need to be considered in their entirety. Half of costs incurred by people with TB are experienced before starting TB treatment and most of these costs are opportunity costs linked to loss of employment or income because of inability to work (58). Increasing evidence shows that TB-associated disabilities may also affect people beyond the completion of TB treatment, making TB survivors unable to return to work either in the short or long term. Understanding the social protection needs along the continuum of care, including the needs of members of a household affected by TB (especially women, children and adolescents, elders, and those on palliative/end-of-life care) will be key to identifying who to best target with social protection programmes and when these should be provided.



Data on social protection needs can be collected through questionnaires administered by purposely trained staff to determine the health and socioeconomic challenges people with TB are likely to experience, including:

- individual and household socio-economic position (measured through econometric or asset-based indices) (78)
- sources of income (employment status in the formal or informal economy)
- education (years of schooling, literacy)
- food insecurity (see section 4.2)
- other relevant social determinants of TB (such as housing, living in slums, migration status)
- TB comorbidities and TB-associated disabilities (79)
- TB-associated stigma (see section 4.3), and
- receipt of any form of social protection.

The questionnaires may be administered at the start of treatment, during it and at the end to monitor how social protection needs change over the continuum of care. In addition to people with TB, the assessment of needs may also be extended to their household members that are indirectly affected by TB (such as caregivers, women, elderly people, children and adolescents). This could facilitate provision of social protection benefits with potentially high preventive impact considering the high risk of TB among recent contacts of someone with TB.

Alternatively, data on social protection needs may be inferred from information collected as part of ongoing or completed patient cost surveys (see Box 2.2).

Box 2.2 Assessing social protection needs: the role of TB patient cost surveys

TB patient cost surveys measure the direct and indirect costs incurred by people with TB and their households to inform policies to mitigate the financial hardship and economic burden imposed by TB on these households. WHO has established standard methods for conducting national surveys to assess these costs (80).

TB patient cost surveys could be a useful entry point to investigate the social protection needs of people affected by TB and can serve as tools to advocate for the extension of coverage of existing social protection programmes to people affected by TB.

Data from a TB patient cost survey may be used to identify sub-populations to be prioritized and the interventions needed to mitigate costs and reduce or eliminate the proportion of households experiencing catastrophic total costs. Data from these surveys may also be used to infer information on the size and type of support needed by households affected by TB. Data such as household socio-economic status, nutritional and food security, occupation, ongoing receipt of any form of social protection benefits, and drivers of patient costs as well as coping mechanisms adopted in response to health expenditures, can inform the design and implementation of TB-specific social protection programmes. The analysis of this data can further contribute to improving the co-programming and reciprocal referral system across local TB care and social protection programmes.

2.5 Identifying barriers to social protection faced by people affected by TB

There are various supply-side and demand-side barriers to accessing social protection faced by people affected by TB.

Supply-side barriers: These are policy or programmatic barriers that hinder access by implicitly or explicitly excluding populations at high risk of TB (such as migrants, the homeless, people with substance abuse disorders, or people living with HIV) or households affected by TB, by limiting coverage, or by not providing sufficient or timely benefits. Programmatic barriers include lengthy or inefficient administrative procedures that may discourage enrolment or delay access to benefits. People at high risk of TB may also be excluded from access because of stigma or discriminatory practices: migrants, ethnic minorities, indigenous people, substance users, homeless, and other marginalized groups may face challenges accessing local social protection services even when they are eligible. Finally, sometimes eligibility criteria based only on income or other econometric measures (such as purchase power or monthly expenditures) may not be sufficiently sensitive to capture people's vulnerability and can lead to the exclusion of people in need (40).

Demand-side barriers: These are barriers that may hamper access to social protection because of individual level factors. They include, for example, lack of information about existing social protection programmes, lack of national identity cards, not having a permanent address, lack of documentation of residence status, as well as not having a bank account. While social protection programmes are free at the point of use, the process of accessing them may impose costs that are unaffordable to eligible recipients, such as travel costs, administrative costs, and waiting times resulting in hours of work lost.

The assessment of the above barriers requires collecting information to identify:

1. the population groups at high risk of TB in the country, and the social determinants driving the local TB epidemic;
2. whether people affected by TB may be eligible for the priority programmes identified through the desk review and to what extent (that is, their estimated coverage among people affected by TB, if available); and
3. the main demand- and supply-side barriers limiting access to these programmes by people affected by TB.

These data can be collected through:

- a bespoke quantitative survey among a selected list of stakeholders such as staff from social protection and TB programmes, social workers, civil society, and communities affected by TB (while there is currently no standard tool for this assessment the HIV-sensitive social protection assessment tool developed by UNAIDS (65) may be adapted for this purpose); and
- a qualitative focus group discussion with selected key informants to discuss and share their opinions and knowledge (this may require some planning, higher costs and the involvement of researchers with expertise in qualitative methods).

Ideally both approaches should be undertaken sequentially: after the collection of quantitative data through the surveys, focus group discussion with key informants can be used to validate and further discuss the information obtained through the questionnaire. While more time consuming, this triangulation of qualitative and quantitative information may significantly enhance the understanding of the actual or perceived barriers to social protection experienced by people affected by TB.



2.6 Synthesis of the evidence and formulation of social protection interventions

Evidence resulting from the above steps should be synthesized and appraised to inform the design and implementation of locally appropriate social protection interventions to best address the needs of people affected by TB. Emerging themes and possible solutions can be shared during consultation with the multidisciplinary and multisectoral team of stakeholders, aiming to:

- comprehensively list social protection options emerging through the assessment process;
- facilitate discussion and understanding of the feasibility and pros and cons of the various social protection options;
- reach consensus on interventions to improve accessibility and responsiveness of the social protection options and maximize their impact on people affected by TB; and
- devise a strategy for action, including the identification of actors to engage (for instance, agencies and ministries implementing specific social protection schemes).

This consultation will require appropriate representation of all key stakeholders, particularly representatives of affected communities and civil society. The discussions should focus on:

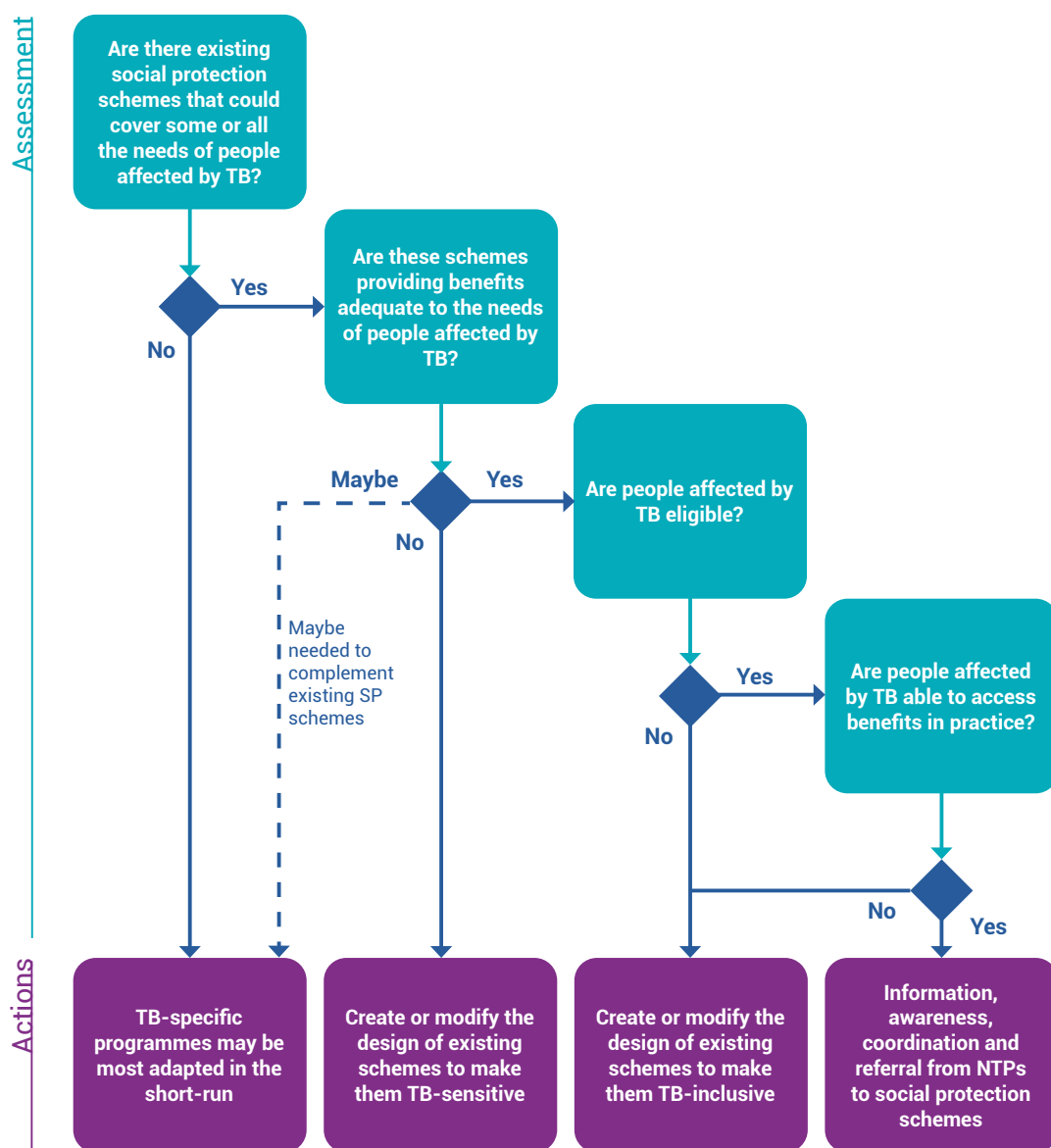
- identifying and prioritizing interventions considering existing policies and available resources, through an approach that is TB-sensitive, TB-specific, or a combination of the two;
- defining goals and objectives of the interventions – which may imply defining a broader long-term goal and a series of more specific objectives that collectively can contribute to achieving the long-term goal (an example of a long-term goal would be to ensure that no TB-affected households face catastrophic costs, which may be achieved by ensuring that 100% of people with TB who are eligible for social protection are referred to the most appropriate social protection services and supported to enrol into the social protection system); and
- discussing key criteria that may affect the impact of the proposed interventions, including:
 1. magnitude and type of the identified needs and barriers to access – for example, what proportion of people with TB are in need of social protection and can they be realistically supported either through TB-sensitive or TB-specific social protection programmes;
 2. effectiveness of the intervention – that is, the likelihood that the intervention will lead to the expected impact;
 3. equity of the intervention – for example, whether the intervention is likely to benefit those most in need;
 4. acceptability of the intervention – such as the extent to which both implementers and target populations are likely to consider the intervention appropriate based on anticipated or experienced cognitive and emotional response to the intervention (81);
 5. feasibility of the intervention – for example, the practicality and adequacy of the logistical and operational requirements to deliver the intervention, including costs of the intervention; and
 6. sustainability over time of the intervention – that is, the likelihood that the intervention is taken up by the social protection system and can be implemented by the responsible agencies over time.

All the steps described in this section collectively contribute to the formulation of locally appropriate and potentially effective social protection programmes for people affected by TB. From piloting work in countries in the WHO Western Pacific region, it is estimated that the completion of the proposed planning process in a given country may require an average of 2–3 months of work for the coordinating team and approximately US\$ 30 000, primarily for any consultancy fees to undertake the desk review of existing social protection programmes, and for any costs associated with the planning and organization of the focus group discussion (if conducted in person). Should

these resources not be available, countries may use a simple decision process like the one outlined in Fig. 2.2. This approach does not necessarily require the involvement of external stakeholders and/or the formal acquisition of new data through qualitative or quantitative methods. Instead, staff of the TB programme may embark on this planning exercise based on their best knowledge and understanding of the social protection floor in their own country. While less accurate, this approach may be sufficient in countries where either the social protection and TB sector are already collaborating and examples of multisectoral collaborations are well documented (that is, TB-sensitive programmes have been already tested); or where the limited social protection floor leaves little room for the expansion of the scope and remit of the existing programmes (in other words, TB-sensitive programmes are not an option).

The following sections provide guidance on the next steps once a strategy to meet the social protection needs of people affected by TB has been devised, whether TB-sensitive, TB-specific or a combination of both.

Fig. 2.2 Simplified decision tree for selecting the most appropriate social protection delivery strategy to maximize TB impact





3 Implementing TB-sensitive social protection programmes



Credit: ILO / Crozet Marce

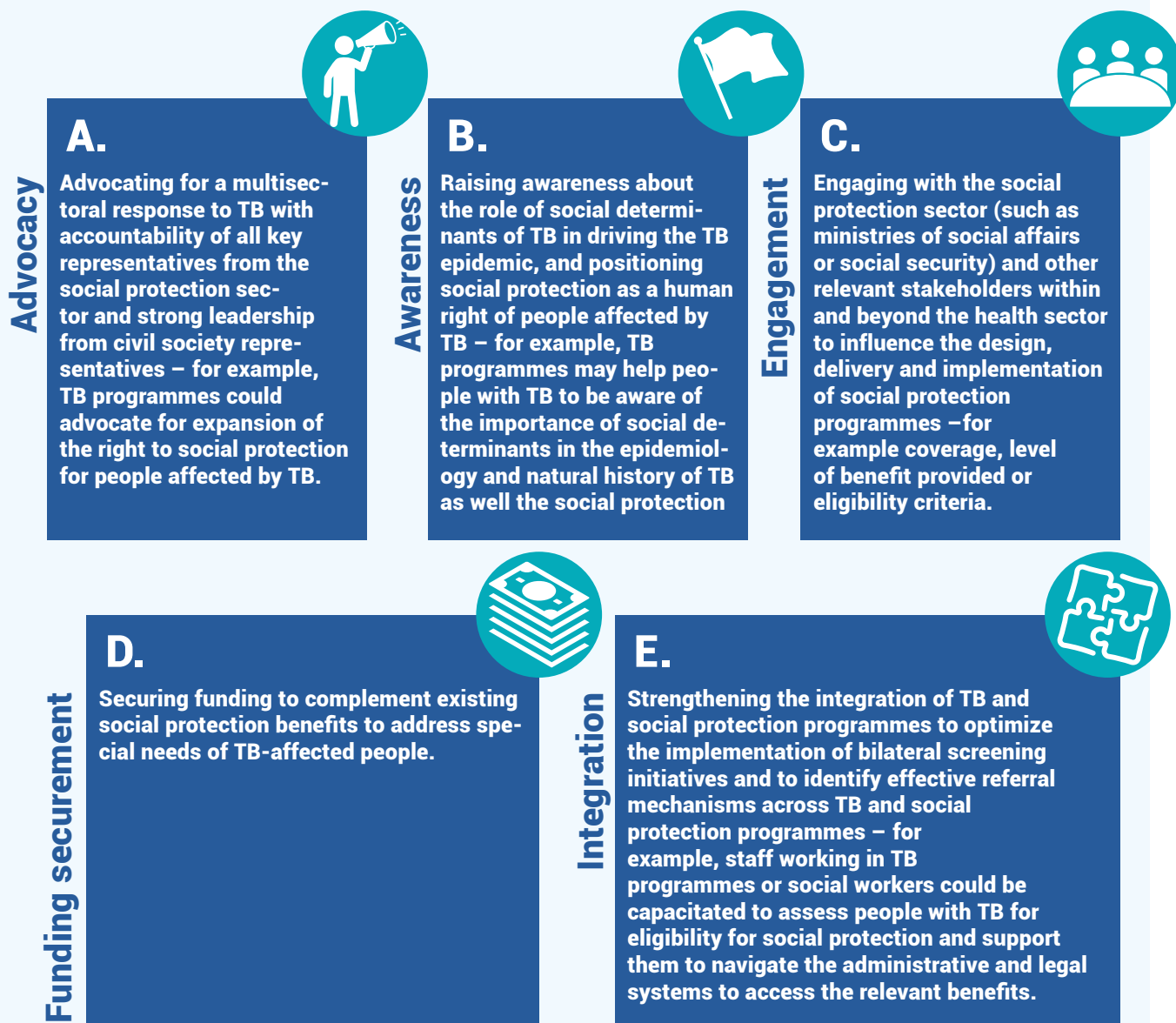
This section describes how existing social protection programmes can be leveraged and adapted to make them more sensitive to the needs of people affected by TB. The section builds upon the example of income security and applicable labour protection norms. In particular it illustrates how TB programmes can engage with the social protection sector and overcome important underlying constraints – such as informal employment or discriminatory labour legislation and employment policies – which may significantly limit access to existing social protection benefits by people affected by TB.

3.1 Promoting TB-sensitive social protection programmes

TB-sensitive social protection programmes can be utilized to provide social protection for people affected by TB. Planning and implementation of TB-sensitive social protection programmes requires close collaboration between TB programmes and the social protection sector (see Box 3.1).

Box 3.1 Promoting the TB-sensitivity of existing social protection programmes in TB services

TB programmes can promote the TB-sensitivity of existing social protection programmes by:





3.2 Overcoming programmatic barriers to expanding coverage of social protection programmes

Programmatic barriers include administrative and operational barriers that limit access to existing social protection programmes by eligible beneficiaries. Possible interventions to address these barriers are informed by the context and underlying causes. Box 3.2 provides examples of approaches to improve the accessibility of these programmes for people affected by TB.

Box 3.2 Expanding social protection coverage for people affected by TB

TB programmes can support the coverage expansion of existing social protection programmes by:

Negotiation

A.

Negotiating with local stakeholders responsible for social protection policies and their implementation to:

1. revise the eligibility criteria adopted by the programmes (Box 3.3 provides examples of how access to existing social protection programmes can be enhanced by including TB as one of the eligibility criteria of the programme);
2. expand geographical coverage of the social protection programme to areas where the burden of TB is higher; and
3. simplify and enable administrative and logistic processes to enrol for social protection services (this may involve collaboration with relevant offices to facilitate the process for people with TB to obtain required documents, such as national identity cards, or systematically collecting basic.



Awareness

B.

Creating awareness among people affected by TB of the social protection services available and promoting social protection as a human right.



Training

C.

Developing training materials for staff in charge of planning, delivery and administration of social protection programmes to improve their awareness of the social protection needs of people affected by TB.



Collaboration and partnership between social protection partners and community-based organizations (CBOs) can help to address some of the programmatic barriers. CBOs are close to the community, and they can ensure that the voice of people affected by TB in need of social protection is properly represented and acknowledged. They can support the identification of eligible people and promote awareness of social protection entitlements and procedures. Finally, CBOs can also contribute to the establishment of adequate and effective bilateral referral mechanisms across the TB and social protection sectors. Existing coordination and collaboration systems for TB programmes and civil society organizations can be leveraged to improve access to existing social protection programmes for people affected by TB, and to improve their responsiveness to the needs of people affected by TB.

Box 3.3 Examples of strategies to expand coverage of social protection programmes

Several countries have introduced initiatives to expand coverage of existing social protection programmes to people with TB, using various strategies to increase access as the following examples show.

- *Granting access to existing disability benefits:* disability benefits are short- or long-term cash benefits provided as full or partial income replacement to those unable to engage in paid work due to a disability (mostly permanent). In South Africa, a short-term, universal disability grant is provided to individuals of working age if they are deemed to be permanently or temporarily unable to work because of a physical disability or chronic illness such as DR-TB (82). However, people with TB still face challenges to accessing benefits, including limited awareness, timing of the benefit and the requirement for assessment by a specific doctor who may be based in a different health facility (83,84).
- *Granting access to social assistance programmes to households with at least one member affected by TB:* This involves establishing new eligibility criteria to receive benefits based on having a household member with a long-term or chronic disease, as was the case of the programme *Bono Joaquim* in Ecuador (85).

When exploring avenues to expand social protection services for people affected by TB, it is important to consider the following aspects.

1. In most high TB burden countries, social protection systems and programmes are largely underfunded, which limits their scope for further expansion. There is therefore need for advocacy and resource mobilization for adequate, equitable and sustainable financing of social protection.
2. The design of social protection programmes has profound implications on their coverage for populations at high risk of TB, through key variables including:
 - the target population and geographic coverage of the programme;
 - the adequacy of social protection benefits (including the range of benefits covered and the extent of financial protection);
 - the inclusion of workers in the informal economy and their families, who often face difficulties in accessing social protection programmes; and
 - the inclusion of adequate sickness benefits that are not based on employer's liability (whereby the employer is required to continue paying the wage of his employees while the worker is not able to work).

Addressing these issues requires engagement of TB programmes with the social protection sector to adapt existing systems to increase access to social protection services by people affected by TB. These changes and adaptation may include:

- extending the eligibility in specific areas where people affected by TB are more likely to be resident;
- topping-up existing benefits to meet the needs of people with TB, usually through funding from international and local funding bodies; and
- increasing awareness of the multiple returns of social protection beyond TB, including positive effects on poverty and on TB-related comorbidities and risk factors such as HIV, diabetes, and undernourishment.



3.3 Protecting the income security of people affected by TB

As highlighted in Section 2, people affected by TB are vulnerable to impoverishment due to: (i) medical costs; (ii) non-medical costs (such as transportation to/from healthcare facilities, additional nutrition costs); and (iii) income loss. In low- and middle-income countries, income loss represents on average 60% of the total costs associated with TB care (58).

Loss of employment and income is one of the major causes of economic burden in households affected by TB (see Box 3.4) and can be caused by:

- the absence and/or insufficient implementation of legal provisions for social protection benefits in case of sickness, resulting in people with TB losing their income when unable to work because of care seeking or sickness;
- TB not being considered as an occupational disease (such as for health workers, miners, etc.) and the consequent lack of appropriate benefits to cover employment injuries; and
- discriminatory practices against people with TB in the workplace, resulting in the termination of their employment.

Loss of income and employment is more likely among those in informal employment, which represents 70% of total employment in low- and middle- income countries (86). Informal employment refers to working arrangements that are de facto or by law not subject to national labour and social security legislation, income taxation or entitlement to social protection or certain employment benefits (87). It includes both wage employment and self-employment. Workers in informal employment are defined as those who work in informal jobs, whether carried out in formal sector enterprises, informal sector enterprises, or households (87). A significant proportion of the poor are in the informal economy.

People with TB who work in the informal economy are usually not included in the labour and social protection systems and typically have limited access to social insurance and other forms of benefits that secure their income when they are unable to work. Therefore, measures to extend social protection coverage to those in the informal economy are essential. Further, transitioning to the formal economy is highly desirable as it contributes to ensuring that TB is contained at the workplace and that people with TB can access social protection without discrimination (88).

A range of labour policies to protect the employment and incomes of households affected by TB are applicable and potentially impactful. Possible entry points include measures to:

1. prevent the loss of employment through non-discrimination laws, labour code, and labour inspection;
2. use the workplace for TB prevention activities; and
3. ensure protection in case of incapacitation or job loss through unemployment insurance, and sickness and disability benefits.

Box 3.4 Impact of TB on employment of people with TB in the Democratic Republic of Congo and the Lao People's Democratic Republic

The first nationally representative TB patient cost surveys for the Democratic Republic of the Congo and the Lao People's Democratic Republic were carried out from 2018–2019 (89,90). These facility-based, cross-sectional surveys of TB patients collected information on direct medical, direct non-medical and indirect costs of living with TB, as well as coping mechanisms. Results of the two surveys highlight the following economic impact of TB on patients:

- In the Democratic Republic of the Congo, employment of any form among people with TB dropped from 65% to 43% for people on TB treatment; this drop was more severe among people with TB working in the informal economy with the proportion of employment going from 45% to 31%. Overall, 23% of patients lost their jobs due to TB and 78% lost working days (89).
- In the Lao People's Democratic Republic, the proportion of people with TB who became unemployed more than doubled during TB treatment (from 16.8% to 35.4%), while the proportion of employment in the informal economy decreased from 61.9% to 43.6%. The proportion of formal employment decreased from 10.8% to 8.8% and a very low level of benefits claimed (including sickness and unemployment benefits) was noted (90).

3.3.1 Ensuring a non-discriminatory work environment

Labour legislation and employment policies aim to ensure that people affected by a disease such as TB have their rights at work protected and do not suffer discrimination.

International Labour Standards specify that TB infection and treatment should not be the cause for discrimination at work nor termination of employment. Importantly, these standards are meant to be ratified and included into national labour legislation. Enforcement will require strengthening the actors of the labour sector, in particular workers' and employers' organizations, and labour inspectorates. The following are relevant ILO standards:

- the overarching Discrimination (Employment and Occupation) Convention, 1958 (No. 111) (91);
- the Termination of Employment Convention, 1982 (No. 158) Article 6, according to which temporary absence from work because of illness or injury shall not constitute a valid reason for termination of employment (92); and
- the HIV and AIDS Recommendation, 2010 (No. 200) which includes specific references to TB and calls for ending discrimination and promotion of equality and opportunity in employment settings, mentioning that workers should benefit from programmes aiming at preventing specific risks of occupational transmission of HIV and related transmissible diseases, such as TB; and should have access to available diagnostic and treatment services without facing any discrimination in their employment (93).

While these policies are essential tools to prevent and minimize discrimination in the workplace, it is also important to realize that social protection itself can also result in stigmatization of and discrimination against beneficiaries. Welfare or social protection stigma is defined as "the negative socio-physiological consequences or 'psychic costs' of being on welfare" (94). People with TB may go through stigmatizing or self-stigmatizing experiences associated with TB and/or with being a beneficiary of a form of legal protection or benefit. Discrimination linked to both conditions can be mutually reinforcing and can discourage people affected by TB from claiming the support they are entitled to, both inside and outside the workplace. In these circumstances the provision of adequate legal support is essential to address any discriminatory act, the violation of human rights, or any breach of the social protection policy in place (see Box 3.5).



Box 3.5 Providing legal support to people with TB in Kyrgyzstan and Kazakhstan

In Kyrgyzstan and Kazakhstan, legal support is provided to people with TB and other vulnerable populations by 'street lawyers', who have been mentored by a trained and experienced lawyer who then provides ongoing support and mentoring through information and counselling. This legal support programme also trains representatives from vulnerable populations on how to identify and document cases of human rights violations and to provide support on common issues such as receipt/renewal of identification documents, registration of citizenship (for migrants), help in formulating claim statements to the court, assistance in cases of stigma and discrimination from health care workers, discriminatory issues with landlords or employers, and obtaining cash benefits for people affected by TB.

Source: How legal aid helps end TB and HIV [website]. Kyrgyzstan: United Nations Development Programme; 2021 (<https://www.undp.org/kyrgyzstan/news/how-legal-aid-helps-end-tb-and-hiv>).

3.3.2 Building safe and healthy workplaces

In high TB burden settings, TB has implications for business operations, including decreased productivity, absenteeism, high turnover and the risk of further transmission (26). This negative impact can be mitigated in the workplace by programmes that comprehensively address TB prevention, diagnosis, treatment and care.

TB is particularly prevalent in certain occupational sectors, including in health workers and workers in the mining industry. The recognition of TB as an occupational disease is the first step for people to be entitled to any compensation, either by the employer or the social protection system. For example, in South Africa, TB is considered as an occupational disease for health workers in settings where the disease is most prevalent (95). This recognition also allows the prevention of specific risks of occupational transmission and enables workers with TB to seek timely diagnosis and appropriate treatment, and to receive adequate compensation. Importantly, beyond legal entitlement, benefits guaranteed through the occupational disease status should be made accessible, adequate and sensitive to the needs of workers with occupational TB. Box 3.6 provides examples of strategies to support building safe and healthy workplaces.

The Joint WHO-ILO-UNAIDS policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services (96) includes recommendations to develop specific policies that aim to:

- ensure priority access for health workers and their families to services for prevention, treatment, care and support; and
- prevent discrimination against health workers with TB and establish programmes for reasonable accommodation and compensation, including, as appropriate, paid leave, early retirement benefits and death benefits in the event of occupationally acquired disease.

Box 3.6 Examples of strategies to support building safe and healthy workplaces

TB programmes can support building safe and healthy workplaces for workers with TB by:

- A. advocating for legal recognition of TB as an occupational disease;
- B. collaborating with legislators to establish or improve laws that protect people with TB from stigma and discrimination and provide legal support to people affected by TB;
- C. engaging with companies, workers, labour inspectors and occupational health services to communicate adequately the value of engaging in TB care, and gain commitment from respective managements;
- D. ensuring that businesses and services that are already addressing HIV expand to also address TB, and vice versa; and
- E. negotiating for the expansion of well-functioning TB and TB/HIV workplace programmes in small and medium-sized enterprises and other formal and informal workplaces with the support of civil society and relevant partners.

3.3.3 Granting income security through universal social protection

Universal social protection encompasses effective access to health care without hardship, recognizing that healthcare costs and health status impact household income (via reduced productivity due to poor health status, impoverishment due to healthcare costs, etc). Numerous countries, such as Rwanda, have taken steps towards integrating TB-related services into national social health protection programmes, with varying degrees of success (26).

An ILO review of selected high TB burden countries showed that treatment for TB and DR-TB was very often integrated into the design of benefit packages. The level of inclusion of other services, particularly for TB prevention, varied widely across countries and programmes. Furthermore, costs associated with travelling to health providers, as well as costs of ancillary drugs, food supplements or specific examinations, are often not included in benefit packages (26).

Income security in case of sickness in many countries has been established as the employer's liability (whereby the employer is required to continue paying wages while the employee is unable to work) rather than as a proper social protection programme. This creates a disincentive for employers to employ or retain workers affected by TB, as they may not be able to afford to retain workers who are unable to work for extended periods of time. Similarly, this means that individuals who are self-employed and fall sick with TB must bear the costs of sickness alone. Sickness benefits anchored in law and granted by the social protection system are most effective in protecting all workers with TB.

While some countries have implemented universal sickness benefits, globally the effective coverage of these programmes remains low due to gaps in compliance and implementation. Only a third of the world's working-age population have their income security protected by law in the event of sickness (15). For people with TB this means limited income protection when they are unable to work due to their health status or treatment, which results in loss or reduction of their source of income and possible loss of livelihoods.

TB programmes can contribute to protecting the income security of people affected by TB through several interventions as outlined in Box 3.7.



Box 3.7 Protecting income security of people affected by TB

TB programmes can contribute to protecting the income security of people affected by TB through several means, including by:

No discrimination

A.

Promoting a non-discriminatory social protection environment through:

- raising awareness among people with TB about their social protection rights;
- communicating positively the eligibility for social protection programmes or proposing non-stigmatizing targeting strategies to challenge the narrative according to which beneficiaries of social protection programmes are a burden for society because they are unwilling to work and/or are not sufficiently proactive in changing their socioeconomic status;
- providing people with TB and their households with clear information about social protection programmes, including their scope and the value of the benefits (such as enabling treatment completion or mitigating further impoverishment); and
- increasing awareness of TB, its risk factors and its clinical and financial consequences among staff working in social protection services.



Safe workplaces

B.

Increasing both the coverage and responsiveness of existing social protection benefits (including sickness and disability benefits) to address the needs of people with TB.



Universal social protection

C.

Advocating for the transition from the informal economy to the formal economy to ensure that all workers with TB have access to employment and social protection.



3.4 Monitoring the coverage of TB-sensitive social protection programmes among people affected by TB

Monitoring the performance of TB-sensitive social protection programmes primarily focuses on tracking the coverage and responsiveness of these programmes in addressing the needs of people affected by TB. A comprehensive monitoring and evaluation framework and standard indicators for social protection for people affected by TB are not yet available. This section therefore focuses on highlighting aspects that could be monitored during implementation of TB-sensitive social protection programmes.

Monitoring should focus on one or a very limited number of indicators related to the performance of social protection programmes in addressing the needs of people affected by TB. Examples of elements to be monitored include:

- the proportion of people diagnosed with TB whose social protection needs have been assessed
- the proportion of people diagnosed with TB who were referred to a social protection scheme; and
- The proportion of people affected by TB that is covered by any form of social protection.

In the political declaration of the 2023 High-level Meeting of the United Nations General Assembly (3), a new ambitious target was agreed to have 100% of people with TB accessing a health and social benefits package so they do not have to endure financial hardships because of their illness.

There are three main options for collecting (or obtaining) the data required to monitor TB-sensitive social protection programmes, as follows.

1. Link data held in the national TB database with national databases related to social protection programmes.

If there are case-based digital databases for people diagnosed with TB and people enrolled in social protection programmes, and if these systems use unique identifiers that are common to both the health and social sectors, then an efficient option may be record-linkage between the two datasets (97). This option has the advantage of not requiring any additional collection of data. It does, however, rely on close collaboration between the national entities responsible for health and social protection. Analysis of data from such databases may allow disaggregation according to other relevant factors including age, gender, location, occupation and socio-economic status, and may thus enable monitoring of equity in access to social protection among people diagnosed with TB. This option of linking data held in different national databases is also highlighted in the latest WHO guidance on TB surveillance ([WHO Guidance on tuberculosis surveillance], [World Health Organization], in press, [2023]).

2. Collect data periodically, as part of other related studies. One of the three high-level targets of the WHO *End TB Strategy* (1) is to ensure that no TB patients or their households face catastrophic total costs as a result of TB disease. The recommended approach to measuring costs and assessing whether they are catastrophic is through nationally representative surveys of TB patients registered with the NTP (70). These surveys include in-depth interviews during which questions related to social protection could be asked.

3. Collect data as part of the routine TB surveillance system. This option is only feasible in countries with a case-based digital surveillance system. It is also important to consider whether such data collection is a good use of staff time and other resources. Periodic surveys or linkages between databases (as mentioned above) should be more efficient and less data collection intensive.



4

Implementing TB-specific social protection programmes



Credit: WFP/Francis Thawani

WHO recommends the provision of TB-specific social protection to individuals who have been diagnosed with TB to support them throughout the course of treatment (29). This recommendation is based on established evidence on the benefit of material support including meals, food baskets, food supplements, food vouchers, transport subsidies (such as reimbursements, tokens, vouchers or passes), living allowances, housing incentives or financial bonuses for people with TB (98). This list is not exhaustive and could be complemented by other forms of material support that contribute to improve the living conditions of people with TB and their households, if not adequately provided by the national social protection system. However, this section will focus mainly on the implementation of TB-specific social protection programmes in the form of socioeconomic and nutritional support.

Emerging evidence further suggests that some programmes for reducing social exclusion due to TB-associated stigma can be feasible and effective in high TB burden settings (99). Stigma reduction programmes have the potential to improve outcomes for people affected by TB, but there is currently limited evidence on the appropriate intervention packages and their impact.

It is important to note that even when TB programmes wish to implement TB-specific social protection programmes, in particular when TB-sensitive programmes are either not available or not comprehensive enough, they should still assess whether it may be possible to run such schemes in a manner that benefits from the delivery infrastructure of the national social protection systems.

4.1 Socioeconomic support

WHO recommends TB-specific social protection programmes to support TB treatment adherence and to reduce the impact that the disease and its treatment have on the quality of life of people with TB (29). These programmes are also recommended to reduce the risk of people with TB and their households incurring catastrophic total costs, and to mitigate the impoverishment effect of TB (29).

This section focuses on the provision of TB-specific social protection programmes in the form of socioeconomic support, such as cash or vouchers. Box 4.1 outlines steps for implementing TB-specific social protection programmes based on socioeconomic support. The design and implementation of these programmes should be people-centred and based on an assessment of the needs, preferences and values of the beneficiaries (100). Consulting people affected by TB, healthcare providers and policy-makers can shape the intervention around community needs and help the assessment of its acceptability while maximizing its impact.



Box 4.1 Key considerations for implementing TB-specific social protection programmes based on socioeconomic support

The following key aspects should be taken into consideration when implementing TB-specific social protection programmes based on socioeconomic support.

- 1** *Determine the best location and strategy for the delivery of the social protection benefits and services* – Social protection and TB services can be delivered at the same facility depending on the specific benefits and services provided and the local administrative arrangements, following a so-called single-window approach. The adoption of digital tools, such as the transfer of cash benefits through mobile phones, can help reduce further financial strain on people affected by TB while expanding the coverage of social protection. Regardless of the strategy, it is important for the delivery of transfers to be reliable and predictable for the intended beneficiaries.
- 2** *Determine the appropriate size and type of cash benefit, as well as the target populations* – The level of cash benefits may be informed by TB patient costs surveys, as well as national data on household expenditures, national poverty lines and wages, and can be adapted to respond to vulnerabilities determined in the social protection needs assessment.
- 3** *Assess whether any additional support is appropriate within a “cash-plus” framework* – The cash-plus model is an approach for delivering social assistance whereby cash benefits are combined with another form of social support (such as in-kind transfers or services) when income support is not deemed sufficient to reduce households' vulnerabilities, including those that are health-related (101-103). This “plus” component or “intensifier” could be a top-up of the cash benefit to account for specific costs incurred in a particular setting, or for a specific category of people with TB (such as people with multidrug-resistant tuberculosis (MDR-TB) or people affected by TB and other comorbidities), or it could be the provision of a food basket to improve nutritional outcomes and/or the provision of psychosocial support to further reinforce the retention of patients in TB care.

4.2 Nutrition support

The association between social protection, food insecurity, nutrition and TB is well established (104-106). Most of the incident TB globally can be attributed to undernourishment (106,107). People with TB who are undernourished are also at increased risk of poorer TB treatment outcomes, higher mortality rates and a lower speed of recovery (104,108,109). WHO considers the management of malnutrition/undernutrition through nutrition support a key intervention when managing people with TB, and recommends the inclusion of nutrition support as part of a standard treatment and care plan for TB (98).

Food security is a complex state consisting of four different dimensions: physical availability of food, economic and physical access to food, food utilization (ability of food to provide adequate energy and nutrient intake) and the stability of these dimensions over time. Both transitory and chronic food insecurity may be a cause or a consequence of TB (110). Food insecurity is also closely related to diabetes, a key driver of the TB epidemic in some settings, and often a comorbidity of TB (111). Food insecurity has been associated with poor mental health and substance use, both known risk factors for poor TB treatment outcomes (112,113).

Programmes to address undernutrition can either involve direct nutrition support, such as provision of nutritional supplements or food baskets, or can take the form of vouchers or other transfers of cash intended to be used for food (98). A combination of cash and food benefits may allow for a more flexible delivery and usage of the benefits. The direct provision of nutrition support has been found to improve TB treatment outcomes and adherence, and to reduce loss to follow-up in several low- and middle-income settings (114-117).

WHO *Guidelines on nutritional care and support for patients with tuberculosis* and the WHO *Framework for Collaborative Action on Tuberculosis and Comorbidities* provide further and more detailed guidance on ways to address undernourishment in people affected by TB, in collaboration with other agencies implementing social protection (79,118). Box 4.2 lists some of the key considerations for the design and implementation of TB-specific social protection programmes based on nutrition support.

Box 4.2 Considerations for implementing TB-specific social protection programmes based on nutrition support

The following are key considerations for the design and implementation of TB-specific social protection programmes based on nutrition support.

1. *Determine the prevalence and severity of undernutrition in people with TB* – Assessment of individual-specific food and nutrition needs is best undertaken at the primary care level. According to existing WHO and WFP guidelines on nutritional support (7,119) key variables useful to monitor nutrition status of people with TB include:
 - BMI in adults over the 18 years of age;
 - BMI-for-age and BMI-for-sex z-score for children and adolescents aged 5–19 years; and
 - weight-for-length or weight-for-height z-score for children who are less than 5 years of age, with mid-upper arm circumference being used to identify cases in need of life saving nutrition management.

These variables can be recorded at the time of diagnosis and monthly until completion of treatment. Data on nutrition status is essential to prioritize the beneficiaries and packages for nutritional support (120). Different delivery mechanisms and different combinations of direct food support and cash, for example, may be used. Considering the overlap in vulnerability to TB and undernutrition, collaboration with government and food support organizations (such as WFP or local NGOs) has synergistic benefits, as it allows the establishment of bilateral screening programmes whereby food support organizations can refer their clients for TB screening,



and TB programmes can refer people with TB to food support organizations for nutrition status screening. This approach may enable quantification of the extent to which the population entitled to food support matches with the people affected by TB, and thus can also inform co-programming decisions.

2. *Use participatory methods to understand nutritional needs and the agriculture landscape.* Programmes for addressing food insecurity and undernutrition can be more effective when cash or vouchers are combined with local nutrition support. Consultation with key stakeholders across sectors, including with affected communities and civil society, can inform the needs and barriers to accessing food (121). Specialized agencies can assist with market-based economic analysis to establish trends in prices, availability and seasonality, to inform decision making on nutritional support to people affected by TB. Establishing partnerships with multilateral organizations and local NGOs can be also helpful to explore economic and seasonality factors that may affect the nutritional needs of people affected by TB.
3. *Assess the appropriate size and type of benefit* – The appropriate size and type of benefit provided can be determined from various sources, including national TB patient cost surveys, national data on household expenditure and poverty lines, and by using the WFP's Omega Value tool (122). This tool was developed by WFP to allow policy-makers to compare direct food transfers, food vouchers and cash transfers to maximize value for money for better programme results, impact on beneficiaries and cost savings (122). Providing cash in addition to food can also account for spending on commodities like soap for hand washing and fuel for cooking, both essential to ensure food biosafety, a critical determinant of nutrition. WFP and the Food and Agriculture Organization of the UN (FAO) indices of food prices can be used to determine amounts of staple foods to provide. Nutrition experts can help to determine the adequacy of the food mix needed to address the nutritional needs of people with TB.
4. *Choose locally appropriate methods to deliver food support and appropriate communication material* – Food support can be delivered when people with TB are started on treatment, through the support of community health workers and/or the provision of electronic vouchers that households affected by TB can use to purchase food from the local markets. Providing nutritional support at the point of TB care may be more people-centred and convenient for the beneficiaries. A food support programme in East Timor was found to have no impact on treatment outcomes because the food was delivered at the clinic in the afternoon, requiring beneficiaries to forgo their work commitments to receive support (123).

People affected by TB should be informed of eligibility criteria, benefits, and delivery options and how to make the most of the benefits received to maximize nutritional impact.

5. *Strengthen procurement options through collaboration with local actors* – Collaboration with providers of available and affordable foods must be undertaken at all levels of the health system where nutritional support is delivered (for example, as part of TB clinics). Further, establishing procurement agreements with the private sector (including market owners) and reaching out to smallholder farmers is encouraged to strengthen synergistic development and ensure sustainable food supplies across seasons.

4.3 Interventions to reduce TB-associated stigma

Stigma and associated discrimination and social exclusion are major contributors to the vulnerability of people affected by TB. They may significantly increase costs incurred by people with TB, for example when people with TB are evicted from their homes, or when they lose their jobs.

While the effects of stigma resulting from TB are widely reported, there is a dearth of quality evidence to inform the development of guidelines on interventions to reduce TB-associated stigma (99). Some of the best practices and tools presented in this section are based on experiences in several countries, as the following examples illustrate.

Examples of interventions with potential to reduce self-stigma

TB PhotoVoice (<https://tbphotovoice.org>) (124) – TB PhotoVoice is both an intervention and a participatory research method. It empowers people affected by TB to express and communicate their experiences through photography. Photography is a fast, easy and relatively inexpensive tool to explore and document the manifestations and impact of TB stigma (whether social, emotional or economic) on the individual, their families and the wider community. The material produced contributes to advocacy, helps sensitize key audiences such as decision makers, civil society and health staff, and allows a form of peer support for other people with TB, for example through media campaigns, exhibitions, cultural events and outreach to schools and women's groups.

From the Inside Out: Dealing with TB-related self-stigma and shame (125) – This training toolkit was developed by Beyond Stigma and KNCV Tuberculosis Foundation to assist people to identify, understand and address self-stigma and anticipated stigma related to TB. It is intended for use by national programmes, NGOs and TB support groups, and requires adaptation and testing in the local context.

Example of intervention to reduce TB-associated stigma among healthcare providers

The Allies Approach (126) – The Allies Approach, also developed by the KNCV Tuberculosis Foundation, is an intervention package aimed at front-line health workers and healthcare facilities, focusing on TB stigma at the emotional, cognitive, and practical level. It aims to address self-stigma in healthcare workers providing TB services, along with stigmatizing behaviour of healthcare workers and the policies in healthcare facilities that may contribute to stigma. The Allies Approach is designed to foster a dynamic and mutually supportive alliance between people with TB and care providers.

Examples of interventions to reduce community TB-associated stigma

The Right to Breathe (127) – This training tool was developed to address TB-related stigma in communities. It provides training to enhance community awareness and sustainable engagement in rights-based TB responses. The training manual, titled *The Right to Breathe: Human Rights Training for TB Survivors and Affected Communities*, aims to strengthen the capacity of people affected by TB in seeking accountability from governments and other duty bearers for their rights in the implementation of national TB strategies.

Understanding and challenging TB stigma: Toolkit for action (128) – This intervention is another tool to directly address stigma in the community. It was developed by and for trainers and can help trainers plan and organize participatory educational sessions with community leaders or organized groups to raise awareness and promote practical action to challenge HIV and TB-associated stigma and discrimination. It includes a range of participatory games, exercises, and picture-tools to help address TB-related stigma, suitable for a range of contexts and settings.

In addition, the products of **TB PhotoVoice**, made by people with TB expressing their experiences, as mentioned above, could support interventions to increase awareness of stigma in the community. There are currently no WHO recommendations on interventions to address TB-related stigma, and the above interventions implemented as operational research will contribute evidence to inform future WHO guidelines.



When such interventions are implemented, it is recommended to assess their feasibility and effectiveness under operational research conditions to inform national and global policies. If needed, interventions may be adapted to better fit into the local context and to best respond to local needs. Relevant local procedures for research, including obtaining ethical approval, should always be followed when implementing actions to address TB-associated stigma under operational research conditions, to generate solid evidence of impact to inform scale-up of the initiatives.

Box 4.3 provides a checklist of the key steps to follow when planning and implementing interventions to address TB-associated stigma.

Box 4.3 Steps for developing and evaluating interventions to address TB-related stigma

- Create a multidisciplinary team and seek buy-in from stakeholders:**
 - map and engage relevant stakeholders, including civil society and affected communities;
 - establish a multidisciplinary working group on TB-related stigma, which includes affected communities and other key stakeholders; and
 - undertake training and capacity building on the assessment of TB-associated stigma.
- Conduct a situation analysis of existing TB-related stigma:**
 - adapt and use stigma measurement tools for baseline assessments, such as those developed by the Stop TB Partnership and the KNCV Tuberculosis Foundation (129,130);
 - estimate the burden of TB-associated stigma and its impact on access to TB care and social protection services;
 - determine the extent to which existing laws protect people from TB-associated stigma; and
 - following this assessment compile a list of locally appropriate, suitable interventions.
- Plan and mobilize resources for interventions to reduce TB-related stigma:**
 - disseminate the results of baseline assessments, sensitizing stakeholders on TB-related stigma;
 - develop a roadmap and costed action plan, including operational research resources, to reduce TB stigma with the direct engagement of communities affected by TB;
 - develop a framework to measure progress against the roadmap; and
 - identify and mobilize resources for implementation of the roadmap.
- Monitor and evaluate progress of the TB stigma reduction interventions:**
 - organize periodic stakeholder meetings to review progress in implementation of the selected intervention to address TB-associated stigma in order to identify and address challenges; and
 - assess progress on key indicators for each intervention to build evidence on its effectiveness, feasibility and acceptability.
- Develop manuscripts for peer-reviewed literature:**
 - disseminate methodological and operational lessons as well as impact findings emerging from the interventions.

4.4 Monitoring the performance of TB-specific social protection programmes

The monitoring and evaluation of TB-specific social protection programmes is useful to allow their adaptation and refinement so as to optimize impact. As for TB-sensitive social protection programmes, a comprehensive monitoring and evaluation framework and standard indicators for TB-specific social protection for people affected by TB are not yet available. This section therefore focuses on highlighting aspects that could be monitored during implementation of TB-specific social protection programmes, including:

- coverage of benefits under the TB-specific intervention, which can be disaggregated by relevant socio-demographic indicators (age, gender, race, disability, geography and socioeconomic position) to monitor coverage and equity; In line with the latest 2023 political declaration of the High-level Meeting of the United Nations General Assembly (3), countries could set a provisional target of 100% coverage among those eligible for the proposed social protection benefits;
- the amount of cash benefits or food support received and duration of enrolment in the programme;
- the proportion of cash support spent on food, transport, additional TB care and other commodities;
- the proportion of households affected by TB classified as poor prior to and after the implementation of the intervention.¹
- the proportion of households affected by TB classified as food insecure (as measured through an established indicator of food insecurity such as the ones consolidated by the WFP) (132) prior to and after the implementation of the programme;
- the proportion of households affected by TB already covered by any other form of social protection programme (on top of the TB-specific one) and/or receiving any form of food supplementation or support at the start of TB treatment;
- the proportion of people with TB who completed TB treatment and were cured, stratified by beneficiary status (beneficiaries of the programme vs non beneficiaries);
- the proportion of people with TB who died, stratified by beneficiary status (beneficiaries of the programme vs non beneficiaries); and
- the proportion of households affected by TB who incurred catastrophic total costs, stratified by beneficiary status (beneficiaries of the programme vs non beneficiaries).

¹ The extent of poverty rates changes pre- and post-TB-disease are usually evaluated through quantitative or qualitative methods. Quantitative methods used in national TB patient cost surveys evaluate pre- and post-TB-disease household poverty rates by comparing respondent's daily income against the international poverty threshold (80). In addition, perceived impoverishment (qualitative method) is also enquired systematically as part of the social impact of TB episode questions (78,131).



5. Establishing and sustaining multisectoral collaborations between TB and social protection



Credit: ILO / Go J

TB programmes have a crucial role to play in promoting the inclusion of people affected by TB within existing social protection programmes and in the delivery of TB-specific social protection programmes. The integration of TB and social protection programmes is part of the multisectoral response to end TB, with actions by different sectors and stakeholders to holistically address the determinants of TB. The WHO MAF-TB (8) provides a mechanism through which this multisectoral response can be coordinated, monitored and reviewed. MAF-TB is aligned with the HiAP approach, which recognizes that health is not merely a responsibility of health sectors programmes but can be profoundly influenced by policies that guide actions beyond the health sector.

The HiAP literature assembles information on collaborative practices associated with positive experiences leading to health and improvements in health equity through addressing the social determinants of health (133). Several of the collaborative practices which are important to sustain intersectoral work are included in the MAF-TB (8). Additionally, the HiAP provides a generic assessment framework for understanding the important processes and functions needed to sustain collaboration between sectors with different goals, mandates and hierarchies (134).

This section provides an overview of the MAF-TB (8) and HiAP frameworks and how they can serve the establishment of effective multisectoral collaborations. It also includes a description of the operational features that characterize successful multisectoral collaborations building upon the HiAP approach.

5.1 Multisectoral collaboration for action on the social determinants of TB: challenges and opportunities

Multisectoral collaboration has been defined as “a recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient, or sustainable than could be achieved by the health sector acting alone” (135).

There is a strong rationale for closer integration of TB and social protection services. However, many barriers may hamper the full establishment and consolidation of effective collaboration between government ministries. For example, it may be difficult to achieve a common understanding of the issues, to define shared goals and to agree on criteria for success. Collaboration may need to be sustained for years to bring about the meaningful social change required to address the needs of people with TB, and this may require continuous and adequate funding and incentives. Government and social and healthcare workers need supportive, stable, and accountable relationships across their institutions, which because of their respective mandates, may not always prioritize the needs of people with TB.

Despite these challenges, opportunities and examples exist of successful multisectoral collaboration across the TB and social protection sectors. The Brazilian *Bolsa de Família* (family cash benefits) programme – now called *Auxílio Brasil* – is a conditional social protection programme in which patients undergoing treatment for TB and their households have been included. In this context the municipal government plays an important role to ensure people with TB are provided with food (particularly breakfast) in the establishments where they receive TB treatment. Similarly, in Colombia, the identification of different institutions and entities for social protection which could be used for empowerment of the TB programme in the neighbourhood of *Rafael Uribe* in Bogotá was a function the local governments performed (136). These implementation features at the local level mean that within TB and social protection collaboration, there is an important role for local authorities, whose line ministries are often different to those for social protection and health. A further important aspect of developing and maintaining multisectoral collaboration for furthering social protection coverage of people with TB is the focus on the integration of health and social services, as Colombia's experience showed (136). Good referral mechanisms are required across different social services to healthcare services, and vice versa. Again, this means



that multisectoral collaboration mechanisms need to embed participation of key service-level representatives from both social care and healthcare sectors and pay attention to the ways of working and resourcing that foster this collaboration.

5.2. The multisectoral accountability framework to accelerate progress to end TB

The WHO MAF-TB (8) aims to support effective collaboration within and beyond the health sector, and to support accountability of governments and all stakeholders at global, regional and country levels in order to accelerate progress to end the TB epidemic in line with the *End TB Strategy* (1) and the 2030 Agenda for Sustainable Development (6). The framework aims to establish the conceptual and operational foundation to foster multisectoral action, mutual accountability and measurement of progress towards *End TB Strategy* targets. It is a practical tool through which countries can establish and monitor multisectoral collaborations, and is comprised of four components: commitments, actions, monitoring and reporting, and review (137).

MAF-TB was developed in response to the acknowledgment that ending TB requires coordination of multiple sectors able to tackle the social and structural determinants of the epidemic. Engagement with the social protection sector and with social protection programmes for people affected by TB falls under the “actions” component of MAF-TB (8).

In fact, implementation of social protection programmes for people affected by TB represents one of the best examples of multisectoral response to TB. As such, social protection can be one of the most obvious areas through which countries can monitor progress and success of multisectoral collaboration to end of TB.

To facilitate implementation of MAF-TB (8) at country level, WHO developed the MAF-TB checklist and supported baseline assessments (137). Results from the assessments inform further steps to adapt and implement MAF-TB at national level. Findings from the related baseline assessments conducted in 2021 on a sample of 45 countries (138,139) suggest that countries are all making progress in the implementation, monitoring and evaluation of multisectoral collaboration. To further support countries in MAF-TB operationalization, WHO developed two documents – an operational guide and a compilation of best practices on MAF-TB adaptation and implementation (139,140). The operational guide provides practical advice on key approaches and interventions needed to establish the MAF-TB at the national and local levels, with concrete country examples, best practices and case studies under each suggested approach and intervention (140). The compilation of best practices includes 25 case studies from all six WHO regions. It provides important, valuable insight into how regions and countries are progressing with MAF-TB implementation and what has been learned along the way (139).

Since 2020 global data has been collected annually to track progress in MAF-TB adaptation and implementation in countries from all WHO regions (11). It is important to continue collecting data and in particular, more concrete examples of collaborative models between the TB and other sectors, in order to consolidate the lessons learned and maximize their generalizability to other contexts.

5.3 Establishing effective multisectoral collaboration: the Health in All Policies (HiAP) approach

Multi-, cross- or inter-sectoral approaches such as HiAP (see Box 5.1) are increasingly acknowledged as effective and evidence-based collaboration and governance strategies to tackle the social determinants of health for advancing health equity (141,142).

Box 5.1 Definition of the HiAP approach

HiAP is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity.

HiAP is founded on health-related rights and obligations and contributes to strengthening the accountability of policy-makers for health impacts at all levels of policy-making. It emphasizes the consequences of public policies on health systems, determinants of health, and wellbeing. It also contributes to sustainable development.

It is recognized that governments are faced with a range of priorities and that health and equity may not automatically gain precedence over other policy objectives. Nonetheless, health considerations do need to be taken into account in policy-making. Efforts must be made to capitalize on opportunities for co-benefits across sectors and for society at large. Effective safeguards to protect policies from distortion by commercial and vested interests and influence also need to be established (134).

Source: Health in all policies: Helsinki statement. Framework for country action. Geneva: World Health Organization; 2014 (<https://www.who.int/publications/i/item/9789241506908>).

The social determinants of health are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life (143). Social determinants of health have an important influence on health inequities – the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health (144). As discussed in Section 1, TB is typically characterized by deep inequalities with low socioeconomic position groups and marginalized segments of the population bearing the heaviest burden of TB.

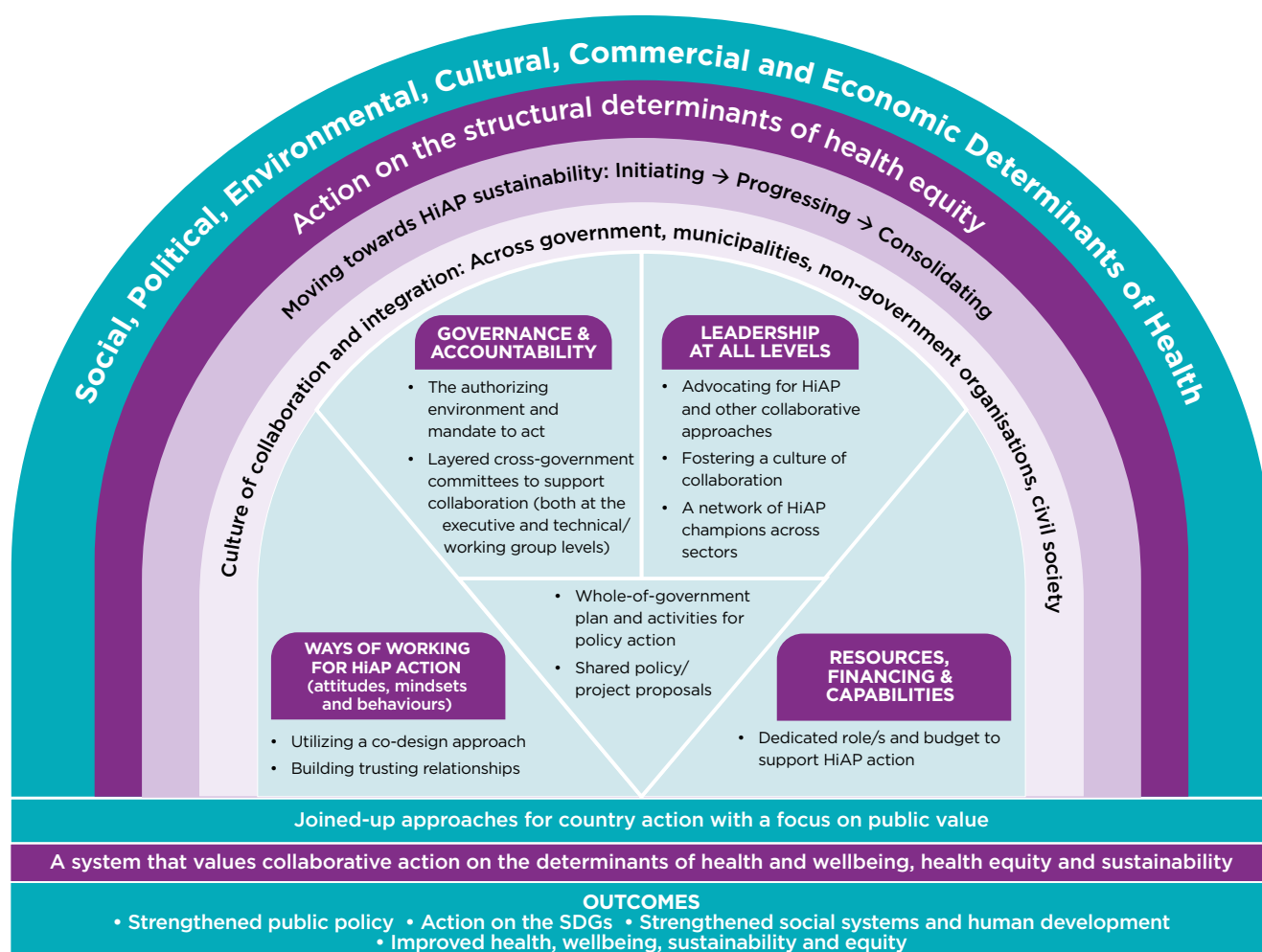
Social protection is one of the key policy domains to improve the social determinants of health, as well as addressing social inequality and human rights, and is protective for TB and other health conditions. While examples of multisectoral collaboration in TB already exist, new and innovative mechanisms for multisectoral collaboration may be especially needed to contrast emerging and potentially more dangerous variants of infectious pathogens, like MDR-TB. These resistant strains in particular have the potential to threaten global health and financial security and require coordinated efforts from multiple sectors to anticipate and mitigate their damaging effect.

Fig. 5.1 synthesizes important features underpinning effective multisectoral collaboration into a single HiAP model. These features are generically valid across different types of multisectoral work. The HiAP model provides a roadmap and checklist for the set-up of multisectoral work for health and social protection, giving ideas of what areas may need strengthening to improve performance of the collaboration. Notably, the HiAP approach requires working across different sectors but also across hierarchies within sectors, which are inherent in governmental, political, administrative and judicial systems. Across sectors and levels, the HiAP model organizes knowledge



on effective multisectoral collaboration into three main components: “foundations” representing values and principles; “arches” describing the context of determinants of health; and “pillars” which represent core features of the organizational and institutional environments ([Sustainable multisectoral collaboration to address the social determinants of health, equity and well-being. Practical guidance based on health-in-all policies approaches], [World Health Organization], unpublished, [2023]).

Fig. 5.1 The HiAP model for effective and sustainable multisectoral collaborations



Source: *Working together for equity and healthier populations: sustainable multisectoral collaboration based on Health in All Policies approaches*. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO. Page 21 <https://www.who.int/publications/i/item/9789240067530>.

5.3.1 Values and principles: the foundations

The foundations of the HiAP model bring together the values and principles that regulate collaborative efforts across different sectors. These values and principles focus on the public value of collaborations that promote health, health equity and sustainability, and align well with some of the equivalent principles outlined in the *Guidance for national strategic planning for tuberculosis* (69). Building upon this alignment, Table 5.1 gives examples that illustrate the concrete application of these principles and values in establishing strong and successful collaborations between the TB and social protection sectors. While these examples are useful to undertake concrete actions, it should be acknowledged that much of the success of multisectoral engagements starts with the mindsets of the stakeholders involved: both parties involved should commit to these principles and recognize the added value of and need for the multisectoral collaboration proposed.

Table 5.1 Key principles of successful multisectoral collaborations: concrete examples for TB and social protection

General principles	Areas of application for successful collaborations between the TB and social protection sectors
Building trust and relationships	<ul style="list-style-type: none"> • <i>Establishing high-level government leadership and oversight of the social protection planning and implementation stages:</i> both stages should be overseen by the highest possible government office hierarchically above the TB programme. This level of leadership provides the administrative authority to engage key decision-makers in other ministry of health departments and in other government ministries and agencies, as well as stakeholders beyond the health sector. • <i>Engagement of all key stakeholders throughout the planning, implementation and evaluation of social protection programmes for people affected by TB:</i> this engagement should give stakeholders opportunities to influence the course of the planning process and to be embedded in the multidisciplinary and multisectoral team (see Section 2) where possible.
Respectful and responsive to partners' needs	<ul style="list-style-type: none"> • <i>Understanding of the mandates and perspectives of the partners and stakeholders to establish respectful and sustainable collaborations:</i> there are often areas where TB programmes can meaningfully engage and contribute to the achievement of the mandates of the social protection sector, to create a symbiotic relationship with reciprocal benefits. This requires the provision of basic information and data to demonstrate the role of the social protection sector in the TB response, but also how a more TB-sensitive approach can be beneficial to best meet the goals of social protection programmes. For example, TB programmes may want to leverage the poverty alleviation mandate of social protection implementation agencies by presenting evidence on the impoverishment effect of TB. Also, as TB is an important tracer of health inequities, both declining TB rates and improving treatment outcomes are important signals of the capacity of existing social protection systems to be progressive and equity oriented.
Flexibility and adaptability	<ul style="list-style-type: none"> • <i>Building multisectoral collaborations using existing collaborative platforms:</i> engagement with social protection stakeholders should be done in a manner that does not create administrative or financial overload for them. Successful collaborations typically adapt and respond flexibly to existing resources and opportunities rather than creating new areas of work or investment – an excellent example of this is the rapid mobilization of health and social protection resources in response to the COVID-19 pandemic. TB programmes may follow this example by undertaking a comprehensive mapping of resources in order to explore available resources, propose more strategic and efficient co-funding mechanisms, and advocate for better financial resources to support a truly multisectoral TB response.
Transparent, open communication	<ul style="list-style-type: none"> • <i>Engaging in dialogue with stakeholders as equals – valuing their knowledge and perspectives:</i> stakeholders should be given the opportunity to have internal consultations and help to determine their own engagement in the planning and implementation process of social protection programmes for people affected by TB. • <i>Ensuring that communications can be easily understood by all stakeholders:</i> this can be achieved, for example, by avoiding complex or technical language during stakeholder engagement.
Build a skilled HiAP workforce	<ul style="list-style-type: none"> • <i>Developing educational material and joint training programmes involving TB programmes and social protection staff:</i> this step is important to foster a common vision and shared understanding of each other's domains, and to reinforce a mutual sense of responsibility.



5.3.2 The context of determinants of health: the arches

The arches show the broad contextual factors that shape and influence health and well-being. The first arch, which comprises social, political, environmental, cultural, commercial and economic determinants of health, reflects the powerful, comprehensive influence of determinants on health and well-being, as well as on social equity. The second arch, which comprises action on the structural determinants of health equity, highlights the importance of considering structural drivers of social equity that arise from different systems. Structural drivers include the distribution of power, money and resources and the role those forces play at all levels of society, including government, institutions and communities, in changing social equity and the burden of disease. The third arch – moving towards HiAP sustainability – acknowledges that it takes time to embed multisectoral collaboration so that it survives changing political and bureaucratic cycles. As confidence in the value of cross-sectoral collaboration increases, governments and services will be motivated to invest more to strengthen multisectoral work as part of daily business. The fourth and final arch – culture of collaboration and integration – is the label used to describe the four pillars of the HiAP model, as described below.

5.3.3 Core features of the organizational and institutional environments: the pillars

The four pillars at the heart of HiAP are: (i) governance and accountability, (ii) leadership at all levels, (iii) ways of working (working methods) and (iv) resources, financing and capabilities. All four pillars are heavily dependent on the involvement of concerned people from both the health and social protection sectors, for the implementation and monitoring of social protection policies relevant to public health. The ambition of the four pillars is to sustain an organizational and societal culture in which multisectoral collaboration thrives, to enable health and social protection policies and services to be comprehensive and aligned to populations needs. The 11 key action areas related to each pillar describe these ambitions in more detail and are further illustrated in the concrete examples below.

An authorizing environment and mandate to act

A mandate for HiAP from the highest level of government is needed because cross-sectoral collaboration operates outside of the normal hierarchy of command. This is consistent with one of the most important actions under MAF-TB (8), which demands the establishment of a multisectoral multistakeholder coordination and review mechanism under the highest possible leadership level. Authorizing governance instruments for multisectoral collaboration may include intercountry or presidential decrees or directives, enabling legislation or development strategies.

Example: An authorizing mandate to work multisectorally to address TB in mining worker populations came to Southern African governments from a supra-governmental regional gathering (145). Nonetheless, without translation into national mandates and collaborative structures, this opportunity has not delivered promised improvements for TB through improved social protection programmes (145,146).

Layered cross-government committees to support collaborations

Multisectoral governance structures provide ongoing authority and high-level executive oversight. Horizontal governance (between sectors, such as via memoranda of understanding) facilitates operational levels of policy-making and projects. Multi-level mechanisms facilitate coherent policy-making from the national level down to local levels, to ensure the realities at local level are addressed. Some government ministries with less sectoral focuses, such as ministries for social development for example, may be useful facilitators of multisectoral structures.

Example: The role of the Ministry of Social Development in early child development programmes in Chile showed how collaborative structures could facilitate delivery of multisectoral services on the ground (147).

Whole-of-government plan for policy action

A whole-of-government plan with a clear shared vision and objectives is a key vehicle to support collaboration and can drive investments in expanded services and coverage. Collaborations between health and social protection may connect to existing government plans or sponsor broader health development and well-being plans that then involve many more sectors. Well-conceived plans usually contain targets and obligations for measuring progress.

Example: The San Juan de Lurigancho Health Network in Lima, Peru, is an example of how a common evaluation was undertaken of the multiple activities and commitments made by the public and private institutions and organizations that formed the High Committee for the TB network. Having a transparent plan and evaluation improved accountability and facilitated making a strong case for continuing the work (148).

Support for collaboration on shared policies, projects and proposals

Shared policy or project proposals should be drawn up, outlining collaborative opportunities and responsibilities for improving coverage of social protection for people affected by TB. It is essential to establish a common understanding of the problem of TB early on in the collaboration, and the role that social protection can play in addressing it. This allows sectoral stakeholders to explore their positions, values and experiences such that joint service, project or policy proposals are fully owned by individual sectors. Leadership at all levels is important for these discussions, to facilitate coherent, cohesive and shared goals. A key part of this process will be to ensure that proposals are endorsed at both the highest level of government and by each agency or ministry. Updates on progress should be provided regularly.

Example: The reorienting health programmes initiative developed in Chile with WHO (INNOV8) prepares health programme managers to analyze multidisciplinary data, including how social inequities reduce and limit access to health services, and how the programmes can be designed differently. Investments in understanding the social determinants of TB and the health and financial challenges experienced by people with TB should be prioritized. This is essential for the development of a shared vision of the problem, which ultimately is critical for informing co-designed solutions (149).

Advocating for HiAP and other collaborative approaches

One of the first elements of HiAP leadership at all levels is advocacy. It requires decision-makers and policy officers and practitioners to advocate for new HiAP activities and to enable collaboration to continue. Ongoing advocacy should be undertaken by leaders at all levels. Effective advocacy for HiAP requires people with skills in diplomacy and negotiation and the ability to navigate the political and policy imperatives of other agencies. These advocates are usually policy entrepreneurs who are able to seize windows of opportunity. Characteristics of effective HiAP advocates are that they can communicate and articulate the vision of the benefits from collaboration and win others over to embrace and implement it.

Example: The recommendation of Brazil's National Health Council (the highest advocacy forum for health) in 2011 advocated an all-of-society approach to support collaboration to ensure social protection for people with TB, as encapsulated by the successful Brazil programme, Bolsa Familia. It recommended "...for the Ministry of Health joined with other areas of the Federal Government, with the participation and support of social movements, the National Congress and institutions from other sectors, to create and maintain social benefits for people with TB, so as to increase treatment adherence and reduce TB incidence rate" (150).



Fostering a culture of collaboration and involvement of civil society and affected people

Leaders ensure the conditions necessary to help others to collaborate. Fostering a culture of collaboration requires including incentives for individuals to collaborate, such as personal growth and career development incentives, as well as valuing the principles of HiAP (see Table 5.1). Fostering collaboration that supports involvement of civil society and disadvantaged communities is an essential contributor to change based on a clear understanding of community needs. Involvement of academics and clinicians can ensure timely access to evidence and the inclusion of perspectives of people working in different areas of TB care and prevention.

Example: A Peruvian evaluation of a social and community collaboration network aiming at improving the control of TB in the country showed how having common TB-related objectives across different sectoral actors helped to bring the different participants to find collective solutions to adverse situations and to produce social innovations (151).

A network of HiAP champions

A HiAP champion is a person who takes an interest in and advocates for the adoption, implementation and success of a HiAP cause, policy, programme or project and is generally willing to work on innovations within organizations rather than stay within existing lines. Networks provide semi-formal or informal mechanisms for troubleshooting and give innovators inspiration and forward momentum. In multisectoral work with the social protection sector, HiAP champions from the social protection sector are among the most important leaders for change. They recognize the potential public value of expanding social protection for improved health outcomes. Networks can involve collections of actors who may not normally formally interact through traditional organizational platforms.

Example: Wales has established a Future Generations Commissioner to champion the delivery of multisectoral well-being goals outlined in its Wellbeing of Future Generations Act (152). As a further example, Finland draws on an extensive research network to inform HiAP action at various levels of government (153).

Developing collaborative partnerships built on trust

As HiAP is based on the concepts of mutuality and reciprocity, the nature of relationships and partnerships, from long-term partnerships to networks and informal exchanges, is crucial. Open, trusting relationships and communication hold partnerships together; without trust and open communication, collaboration is not viable.

Example: Fairer Healthier Scotland led to a collaborative approach to addressing health inequity, whereby public health staff engage directly with various levels of government, departments and sectors to influence policy and practice (154).

Using a co-design approach and understanding the priorities of other sectors

To work across sectors, policy officers must know and navigate their agency's interests and priorities and also understand the motivations and interests of other agencies. It is not unusual that this creates tensions within government, with the emergence of conflicts about values and diverging interests. Co-designing policies, projects and activities can promote understanding and trust to discuss and resolve issues as they arise and ensure a clear direction for policy.

Example: Urban regeneration programmes have been found to have potential impacts on the web of social relationships and social organization within communities, and in turn influence individuals' health seeking behaviour and other attitudes to TB risks, for example, in relation to stigma (9,155).

Dedicated HiAP roles and budget

Dedicated roles are important for HiAP activities and approaches. Allocation of sufficient, appropriate resources is important. Collaboration takes time and some financial resources are needed for purposes of collaborative work (such as for joint workshops or joint trainings). The funds could include an allocation from the ministry of health as well as all the other relevant ministries, to convene workshops, collect evidence, develop communication materials and reports, and establish HiAP training programmes.

Example: Vocational rehabilitation services (geared towards assisting individuals with chronic health problems to return to or remain in work) were tested in Sweden as a focus of co-financing. The co-financing approach trialled was for sectors responsible for social security, social welfare and health services to voluntarily pool up to 5% of their sectoral budgets through the formation of financing associations to manage these joint budgets. Qualitative evaluations, however, found a positive effect on coordinated care, and staff working in health centres reported better collaboration (156).

Capabilities to act on the determinants of health

Leaders identify and create opportunities to support others within their circle of influence to gain the confidence and skills needed to work collaboratively, through mentoring and other means for developing capability.

Example: In the Colombia TB Network, human resources capabilities is a strong focus, with emphasis on the transfer of knowledge between professionals from different entities and territories (157).



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Annex 1. Summary of health-related social protection policies, guidelines and guidance developed by the UN

This annex provides a comprehensive, but non-systematic overview of some of the most prominent policies, guidelines and guidance on social protection and health developed by UN agencies that collaborate closely with WHO, namely the ILO, WFP, FAO, UNICEF, the United Nations High Commissioner for Refugees (UNHCR), and the IOM.

The annex aims to add to the information provided in this guidance by listing a selection of essential reading for NTP staff and healthcare workers willing to strengthen their knowledge on the impact and implementation of social protection programmes to address major public health challenges. While many of the references listed here do not necessarily pertain to TB, indirect lessons can be still transferred to TB.

Key references have been grouped under the following thematic areas:

1. Social health protection in the workplace
2. Social protection and nutrition
3. Social protection for key health outcomes including TB, HIV/AIDS, malaria, mental health, child and maternal health and COVID-19
4. Social protection and migration health

1. Social health protection and health promotion in the workplace

- *Health and Wellness at Work: guidelines for an integrated health testing approach under VCT@WORK.* Geneva: International Labour Organization; 2020.
https://www.ilo.org/wcmsp5/groups/public/---dgreports/---gender/documents/publication/wcms_762676.pdf
- *Sickness benefits during sick leave and quarantine: country responses and policy considerations in the context of COVID-19.* Geneva: International Labour Organization; 2020.
https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---soc_sec/documents/publication/wcms_744510.pdf
- *Social health protection [website].* Geneva: International Labour Organization; 2023.
<https://www.ilo.org/secsoc/areas-of-work/policy-development-and-applied-research/social-health-protection/lang--en/index.htm>

- *Working together with businesses: guidance on TB and TB/HIV prevention, diagnosis, treatment and care in the workplace.* Geneva: World Health Organization, Joint United Nations Programme on HIV/AIDS (UNAIDS), International Labour Organization; 2012.
<https://apps.who.int/iris/handle/10665/44833>
- *Joint WHO/ILO policy guidelines on improving health worker access to prevention, treatment and care services for HIV and TB.* Geneva: World Health Organization, International Labour Organization; 2010.
<https://apps.who.int/iris/handle/10665/44467>
https://www.ilo.org/sector/Resources/codes-of-practice-and-guidelines/WCMS_160898/lang--en/index.htm
- *The joint WHO-ILO-UNAIDS policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services: a guidance note.* Geneva: International Labour Organization; 2011.
https://www.ilo.org/global/topics/hiv-aids/publications/WCMS_149714/lang--en/index.htm
- Maher D, Boldrini F, Pathania V, Alli B, Gabriel P, et al. *Guidelines for workplace TB control activities: the contribution of workplace TB control activities to TB control in the community.* Geneva: World Health Organization, International Labour Organization; 2003.
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https://www.ilo.org/global/topics/hiv-aids/WCMS_142706/lang--en/index.htm

2. Social protection and nutrition

- *Building the blocks for nutrition-sensitive social protection systems in Asia: informing design, prompting implementation.* Bangkok: World Food Programme; 2017.
<https://docs.wfp.org/api/documents/WFP-0000022602/download/>
- *World Food Programme strategy for support to social protection.* Rome: World Food Programme; 2021.
<https://www.wfp.org/publications/world-food-programme-strategy-support-social-protection-2021>
- *Nutrition and Social Protection.* Rome: Food and Agriculture Organization of the United Nations; 2015.
www.fao.org/3/a-i4819e.pdf
- *Strengthening sector policies for better food security and nutrition results: social protection. Policy guidance note 4.* Rome: Food and Agriculture Organization of the United Nations, Directorate for International Cooperation and Development of the European Commission to boost food and nutrition security, sustainable agriculture and resilience; 2017.
<https://www.fao.org/policy-support/tools-and-publications/resources-details/en/c/885771/>



3. Social protection for key health outcomes including TB, HIV/AIDS, malaria, mental health, child and maternal health and COVID-19

- *Update on WFP's response to HIV and AIDS.* In: Proceedings. World Food Programme Executive Board Annual session, Rome, 10–14 June 2019; WFP/EB.A/2019/5-F.
https://executiveboard.wfp.org/document_download/WFP-0000104659
- *Leaving no-one behind how WFP's approach to HIV-sensitive social protection will help to achieve zero hunger in Eastern and Southern Africa. Policy Brief.* Rome: World Food Programme and the UKRI GCRF Accelerating Achievement for Africa's Adolescents (Accelerate) Hub; 2019.
https://docs.wfp.org/api/documents/WFP-0000108479/download/?_ga=2.163479033.411467165.1668700711-1700313855.1668700711
- *Providing cash transfers for vulnerable people living with HIV and key populations: lessons learned from a World Food Programme and UNAIDS initiative to mitigate the impact of COVID-19 in western and central Africa.* Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS), World Food Programme; 2022.
https://docs.wfp.org/api/documents/WFP-0000144277/download/?_ga=2.57700975.411467165.1668700711-1700313855.1668700711
- *How to make social protection inclusive of people living with HIV and key populations: a checklist.* Geneva: United Nations Development Programme, International Labour Organization; 2022.
https://www.ilo.org/wcmsp5/groups/public/---dgreports/---gender/documents/publication/wcms_852400.pdf
- *Global Dialogue and Online Consultation on Social Protection for People Living with HIV and Key Populations Most at Risk of HIV [website].* Geneva: United Nations Development Programme, International Labour Organization; 2021.
<https://www.sparkblue.org/PLHIV2021>
- *HIV and social protection guidance note.* Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014.
https://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_HIVandsocialprotection_en.pdf
- *Making universal social protection a reality for people living with, at the risk of, and affected by HIV or tuberculosis.* Geneva: International Labour Organization; 2021.
https://www.ilo.org/wcmsp5/groups/public/---dgreports/---gender/documents/publication/wcms_830750.pdf
- *The role of social protection in the elimination of child labour: evidence review and policy implications.* Geneva and Florence: International Labour Organization and UNICEF Office of Research – Innocenti; 2022.
https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---ipecc/documents/publication/wcms_845168.pdf
- *Being prepared and acting first: a series of case studies on UNICEF's role in the delivery of effective social protection responses to COVID-19.* New York: UNICEF; 2021.
<https://www.unicef.org/documents/being-prepared-and-acting-first>

- *Towards universal social protection for children: achieving SDG 1.3. ILO-UNICEF Joint Report on Social Protection for Children.* Geneva and New York: International Labour Organization, UNICEF; 2019.
<https://www.unicef.org/reports/towards-universal-social-protection-children-achieving-sdg-13>
- *UNICEF's Global social protection programme framework. A framework for child sensitive social protection.* New York: UNICEF; 2019.
<https://www.unicef.org/reports/global-social-protection-programme-framework-2019>

4. Social protection and migration health

- *Securing social protection for migrant workers and their families: challenges and options for building a better future.* In: Proceedings. International Labour Organization Governing Body 344th Session, Geneva, March 2022; GB.344/POL/1.
https://www.ilo.org/gb/GBSessions/GB344/pol/WCMS_837401/lang--en/index.htm
- *Handbook on social health protection for refugees: approaches, lessons learned and practical tools to assess coverage options.* Geneva: International Labour Organization, United Nations High Commission for Refugees; 2020.
https://www.ilo.org/global/programmes-and-projects/prospects/themes/social-protection/WCMS_760307/lang--en/index.htm
- UNHCR Mapping of Social Safety Nets for Refugees - Opportunities and Challenges [website]. Geneva: United Nations High Commission for Refugees; 2018.
<https://www.unhcr.org/5ad5b4084.pdf>



Annex 2. Glossary

Cash transfer programme: non-contributory scheme or programme providing cash benefits to individuals or households, usually financed out of taxation, other government revenue, or external grants or loans. Cash transfer programmes² may or may not include a means test.

Cash transfer programmes that provide cash to families subject to the condition that they fulfil specific behavioural requirements are referred to as **conditional cash transfer programmes (CCTs)**. This may mean, for example, that beneficiaries must ensure their children attend school regularly, or that they utilize basic preventative nutrition and healthcare services.

Contributory social protection programmes: programmes in which contributions made by protected persons (actual or potential beneficiaries) directly determine entitlement to benefits (acquired rights). The most common example of contributory social security programmes are statutory social insurance programmes, usually covering workers in (formal) wage employment and, in some countries, the self-employed, and in many cases also their families and categories of the population exempt from contributions for certain reasons (for example, caring for children).

Coping strategies: strategies or mechanisms which relieve the impact of the risk once it has occurred. The main forms of coping strategies consist of individual dis-saving/borrowing, migration, selling labour (including that of children), selling assets, reduction of food intake, or the reliance on public or private transfers. Governments have an important role in assisting people in coping, for example, where individual households have not saved enough to handle repeated or catastrophic risks, having been poor all their life with no possibility to accumulate assets. Governments should also establish other types of risk management mechanisms as a more efficient way to deal with risks (1).

Covariant risks: risks, or combination of risks, that affect a large number of people at the same time (for example, an earthquake or a major flood) (1).

Employed persons: all persons above a specified age who, during a specified reference period, were in the following categories: (i) paid employment, (ii) at work; or (iii) with a job but temporarily not at work (1).

Employment guarantee scheme: public employment programme which provides a guaranteed number of workdays per year to poor households, generally providing wages at a relatively low level (typically at the minimum wage level if this is adequately defined).

Informal economy: encompasses both work in the informal sector as well as informal work in the formal sector.

The term “**informal sector**” designates units engaged in the production of goods or services with the primary objective of generating employment and incomes to the persons concerned. Such units are unincorporated enterprises not constituted as separate entities independently of their owners (2). Typically, they operate at a low level of organization, on a small scale and with little or no division of labour and capital as factors of production. Therefore, many micro and small enterprises (MSEs), including those operating in the rural economy, are in the informal sector. In some countries, such MSEs are not or are only partially included in the scope of labour and social protection legislation. Similarly, they often face practical difficulties complying with tax, labour and social security legislations due to their limited administrative and financial capacities. In many cases, neither the employers nor the workers in MSEs are covered by social protection systems.

² Strictly speaking, this term would encompass all social transfers provided in cash, including fully or partially contributory transfers, yet it is usually understood as limited to non-contributory transfers.

The term “**informal employment**” is defined in terms of the employment relationship and protections associated with the job of the worker (3). It refers to working arrangements that are de facto or de jure not subject to national labour legislation, income taxation or entitlement to social protection or certain other employment benefits (such as advance notice of dismissal, severance pay, or paid annual or sick leave). Workers in informal employment are defined as those who work in informal jobs, whether carried out in formal sector enterprises, informal sector enterprises, or households. It can encompass diverse realities when it comes to status in employment (such as employees holding informal jobs, employers and own-account workers employed in their own informal sector enterprises, members of informal producers’ cooperatives, contributing family workers in formal or informal sector enterprises and own-account workers engaged in the production of goods for own end use by their household (4). Although not everyone in the informal economy is poor, a significant proportion of the poor are in the informal economy (2).

Multidrug-resistant tuberculosis (MDR-TB): TB that does not respond to at least isoniazid and rifampicin, the two most powerful anti-TB drugs.

National Tuberculosis Programme (NTP): the national entity in charge of the response against TB in the country. Typically, the NTP is part of the local ministry of health and provides technical and managerial leadership to achieve the global targets set by the WHO *End TB Strategy* (5).

Non-contributory social protection programmes: programmes that require no direct contribution from beneficiaries or their employers as a condition of entitlement to receive relevant benefits. The term covers a broad range of programmes, for example:

- **universal** non-contributory services for all residents (such as national health services);
- **categorical** programmes for certain broad groups of the population (such as universal pensions for all older people above a certain age, or universal child benefits for all children below a certain age);
- **means-tested** programmes in which only persons below a certain income level are eligible for the benefit (such as family benefits targeted only at poor families); and
- **benefit-tested** programmes in which only persons who are not already receiving benefits from another programme are eligible (for example social pensions for older persons not already receiving a pension from a social insurance programme because they were not able to meet the minimum contributory requirements over their working life).

Percentage of TB patients and their households facing catastrophic total costs due to TB: an indicator that examines total costs borne by patients receiving TB treatment that exceed 20% of the household’s annual pre-TB disease income or expenditure. The measure seeks to determine whether the sum of direct medical expenditures, direct nonmedical expenditures and indirect costs (for example, income losses) exceeds a certain threshold (> 20%) compared with the household’s economic resources available to pay for basic subsistence needs (6).

Public employment programme: a government programme offering employment opportunities to certain categories of persons who are unable to find other employment. Public employment programmes include employment guarantee schemes and “cash for work” and “food for work” programmes.

Social assistance: a programme that provides benefits to vulnerable groups of the population, especially households living in poverty. Most social assistance programmes are means-tested. Some are targeted based on categories of vulnerability, while others are targeted to low-income households. They can take several forms, for example non-contributory social pensions, fee waivers and exemptions for health care, schooling or utilities. Conditional cash transfers, for example, are programmes that provide cash to families if they fulfil specific behavioural requirements. Beneficiaries may be required to ensure that their children attend school regularly, or



use basic preventive nutrition and healthcare services. Almost all countries at all income levels have at least one form of social assistance programme.

Social determinants of health (SDH): the social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality.

Social health protection: a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earnings, or the cost of necessary treatment that can result from ill health (7).

Social insurance: contributory social protection programme that guarantees protection through an insurance mechanism, based on: (1) the payment of contributions before the occurrence of the contingency; (2) the sharing or “pooling” of risk; and (3) the notion of a guarantee. The contributions paid by (or for) insured people are pooled together, and the resulting fund is used to cover the expenses incurred exclusively by those individuals affected by the occurrence of the contingency. In contrast to commercial insurance, risk-pooling in social insurance is based on the principle of solidarity, with contributions typically related to people’s capacity to pay (that is, proportional to earnings) as opposed to premiums that reflect individual risks. For example, social health insurance is typically a health insurance programmes with public stewardship and at least some insurance contributions from and/or on the behalf of the protected persons or some categories of protected persons.

Social protection: also referred to as social security, social protection is a human right and is defined as the set of policies and programmes designed to reduce and prevent poverty, vulnerability and social exclusion throughout the life cycle. Social protection includes nine main areas: child and family benefits, maternity protection, unemployment support, employment injury benefits, sickness benefits, health protection (medical care), old-age benefits, invalidity/disability benefits, and survivors’ benefits. Social protection systems address all these policy areas via a mix of contributory schemes (social insurance) and non-contributory tax-financed benefits (including social assistance). “Social protection” is also currently used to refer to the human right to “social security” and the two terms are often used interchangeably. It must be noted that sometimes the term “social protection” is used with a wider variety of meanings than “social security”, including protection provided between members of the family or members of a local community; on other occasions it is also used with a narrower meaning, understood as comprising only measures addressed to the poorest, most vulnerable or excluded members of society. The ILO and in general UN institutions use both terms in discourse with their constituents and in the provision of relevant advice to them.

Social protection floor (SPF): ILO Recommendation No. 202 (8) sets out that member States should establish and maintain national social protection floors as a nationally defined set of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion (8). These guarantees should ensure at a minimum that over the life cycle, all in need have access to at least essential health care and basic income security. These together ensure effective access to essential goods and services defined as necessary at the national level. More specifically, national social protection floors should comprise at least the following four social security guarantees, as defined at the national level:

- A. access to essential health care, including maternity care;
- B. basic income security for children;
- C. basic income security for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability; and
- D. basic income security for older persons (8).

Such guarantees should be provided to all residents and all children, as defined in national laws and regulations, and subject to existing international obligations.

Recommendation No. 202 also states that basic social security guarantees should be established by law (8). National laws and regulations should specify the range, qualifying conditions and levels of the benefits giving effect to these guarantees and provide for effective and accessible complaint and appeal procedures. Social protection floors correspond in many ways to the existing notion of “core obligations”, to ensure the realization of, at the very least, minimum essential levels of rights embodied in human rights treaties (8,9). Recommendation No. 202 (8) sets out that higher levels of protection should be progressively achieved by national social security systems in line with Convention No. 102 (10) and other ILO instruments.

Social protection programme: a distinct framework of rules to provide social protection benefits to entitled beneficiaries. Such rules would specify the geographical and personal scope of the programme (target group), entitlement conditions, the type of benefits, benefit amounts (cash transfers), periodicity and other benefit characteristics, as well as the financing (contributions, general taxation, other sources), governance and administration of the programme. Social protection programmes are often referred to as “social protection schemes”. A social protection programme/scheme can be supported by one or more social security institutions governing the provision of benefits and their financing.

Social protection system: Totality of social protection schemes and programmes in a country. All the social protection schemes and institutions in a country are inevitably interlinked and complementary in their objectives, functions and financing, and thus form a national system. For reasons of effectiveness and efficiency, it is essential that there is close coordination within the system, and that financing of the schemes comprising the system is planned in an integrated way.

Social security: The fundamental right to social security is set out in the Universal Declaration on Human Rights (1948) (11), the International Covenant on Economic, Social and Cultural Rights (1966) (12), and in other major UN human rights instruments. States have the legal obligation to protect and promote human rights, including the right to social protection, or social security, and to ensure that people can realize their rights without discrimination. The overall responsibility of the State includes ensuring the due provision of benefits according to clear and transparent eligibility criteria and entitlements, and the proper administration of the institutions and services. Where benefits and services are not provided directly by public institutions, the effective enforcement of the legislative frameworks is particularly important for the provision of benefits and services (13). The notion of social security covers all measures providing benefits, whether in cash or in kind, to secure protection, inter alia, from:



- lack of work-related income (or insufficient income) caused by sickness, disability, maternity, employment injury, unemployment, old age, or death of a family member;
- lack of (affordable) access to health care;
- insufficient family support, particularly for children and adult dependants; and
- general poverty and social exclusion.

Social security thus has two main (functional) dimensions, namely “income security” and “availability of medical care”.³ Access to social security is essentially a public responsibility, and is typically provided through public institutions, financed from either contributions or taxes or both. However, the delivery of social security can be and often is mandated to private entities. Two main features distinguish social security from other social arrangements. First, benefits are provided to beneficiaries without any simultaneous reciprocal obligation (thus it does not, for example, represent remuneration for work or other services delivered). Second, it is not based on an individual agreement between the protected person and the provider (as is, for example, a life insurance contract); the agreement applies to a wider group of people and so has a collective character.

Social transfer. All social protection benefits comprise transfers either in cash or in kind, that is, they represent a transfer of income, goods or services (for example, healthcare services). This transfer may be from the active to the old, the healthy to the sick, or the affluent to the poor, among others. The recipients of such transfers may be in a position to receive them from a specific scheme because they have contributed to such a scheme (contributory scheme), or because they are residents (universal schemes for all residents), or because they fulfil specific age criteria (categorical schemes), or specific resource conditions (social assistance schemes), or because they fulfil several of these conditions at the same time. In addition, it is a requirement in some schemes (employment guarantee schemes, public employment programmes) that beneficiaries accomplish specific tasks or adopt specific behaviours (conditional cash transfer programmes). In any given country, several schemes of different types generally coexist and may provide benefits for similar contingencies to different population groups.

Tuberculosis (TB): TB is caused by bacteria (*Mycobacterium tuberculosis*), and it most often affects the lungs. TB is spread through the air when people with lung TB cough, sneeze or spit. A person needs to inhale only a few germs to become infected. Every year, 10 million people fall ill with TB. Despite being a preventable and curable disease, 1.5 million people die from TB each year – making it the world’s top infectious killer. TB is the leading cause of death of people with HIV and is also a major contributor to antimicrobial resistance. Most of the people who fall ill with TB live in low- and middle-income countries, but TB is present all over the world. About half of all people with TB can be found in eight countries: Bangladesh, China, India, Indonesia, Nigeria, Pakistan, the Philippines and South Africa. About a quarter of the global population is estimated to have been infected with TB bacteria, but most people will not go on to develop TB disease and some will clear the infection. Those who are infected but not (yet) ill with the disease cannot transmit it. People infected with TB bacteria have a 5–10% lifetime risk of falling ill with TB. Those with compromised immune systems, such as people living with HIV, malnutrition or diabetes, or people who use tobacco, have a higher risk of falling ill.

TB-specific social protection: programmes focused on people with TB and their households with the specific aim to improve TB prevention, care and support.

³ These two main dimensions are also identified in the ILO Income Security Recommendation, 1944 (No. 67), and the Medical Care Recommendation, 1944 (No. 69), respectively, as “essential element[s] of social security”. These Recommendations envisage that, first, “income security schemes should relieve want and prevent destitution by restoring, up to a reasonable level, income which is lost by reason of inability to work (including old age) or to obtain remunerative work or by reason of the death of a breadwinner” (Recommendation No. 67, Guiding principles, Para. 1); and second, that “a medical care service should meet the need of the individual for care by members of the medical and allied professions” and “the medical care service should cover all members of the community” (Recommendation No. 69, Paras 1 and 8). Recommendation No. 202 also reflects these two elements in the basic social protection guarantees that should form part of national social protection floors.

TB-sensitive social protection: programmes that are not limited to household and individuals affected by TB but that can potentially affect the TB epidemic by covering people with TB, at risk of TB, and/or affected by the consequences of TB.

Universal health coverage: access for all to necessary health services (including promotion, prevention, treatment, rehabilitation and palliation) without financial hardship.

WHO End TB Strategy: the vision articulated in the *End TB Strategy (5)* is “a world free of TB”, also expressed as “zero deaths, disease and suffering due to TB”. All countries could use this vision in national strategies and plans. The WHO *End TB Strategy* has set the following global targets:

- 80% reduction in TB incidence by 2030, compared with 2015–2020 milestone, 20% reduction;
- 90% reduction in the number of TB deaths by 2030, compared with 2015–2020 milestone, 35% reduction; and
- no TB-affected households face catastrophic costs by 2020.

Key elements contributing towards reaching these targets include optimum use of existing interventions, achievement of universal health coverage for essential prevention, treatment and care interventions as well as efforts to address the social determinants and consequences of TB and consequences of TB, including TB-associated impairments and disabilities. The three high-level indicators of the *End TB Strategy* – reductions in TB deaths, reductions in the TB incidence rate and elimination of catastrophic costs – are relevant to all countries. However, targets and milestones for these indicators can be adapted by countries to reflect such factors as different starting points, the main drivers of local epidemics, national policy and strategy related to universal health coverage and social protection and planned programmes. Countries need to set their own national targets guided by the global level of ambition but taking into account national circumstances (14).



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