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▶ ILO-WHO Joint Workshop

Epidemics and pandemic prevention,
preparedness and response: How to maximize
the health impact of social protection systems?

Session 2

Date: 04-05 / October / 2023





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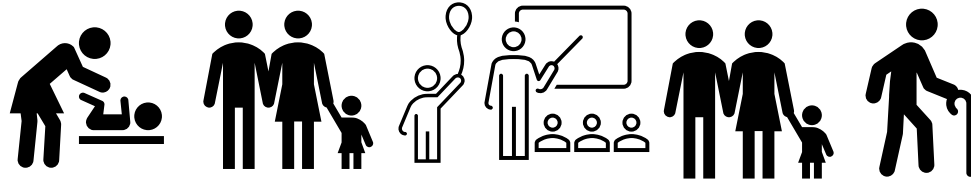
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► Social protection, the social determinants of health and PPR

Ramona Ludolph, WHO

Health maintenance needs across the life course and across major life events



Seeking/decision for care

Contacts/utilization/interaction

Coverage and adherence






Health outcomes, disability, chronic health status

Inequity in exposure and sensitivity to pandemic and epidemics

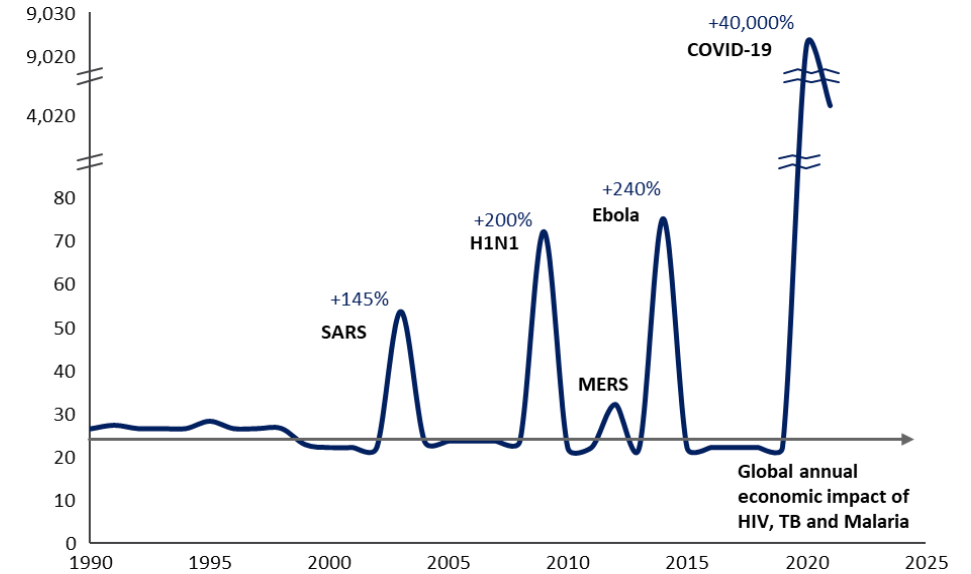
Important health impacts from social protection

- ❖ Alleviate hunger and improve nutrition reducing susceptibility to infection and NCDs
- ❖ Improve housing and community settings to reduce exposures to health risks, vector-borne disease and infection transmission
- ❖ Improve employment opportunities and related benefits of employment for health
- ❖ Reduce acute and chronic stress (from income insecurity), improving interpersonal relations, reduce interpersonal violence, improving biological and psychosocial resilience
- ❖ Improve health seeking and care decisions, access to services, adherence, healthy behaviours
- ❖ Facilitate recovery from episodes of illness, rehabilitation and recovery from pregnancy
- ❖ Reduce intergenerational transmission
- ❖ Improve gender equality, reduce stigma and discrimination, reducing negative impacts on mental health, and health care seeking
- ❖ Improve early years development, and protection against infection in adulthood
- ❖ Improve feeling of belonging to social networks, worth, social capital and trust.

Devastating effect of COVID-19 & other emergencies

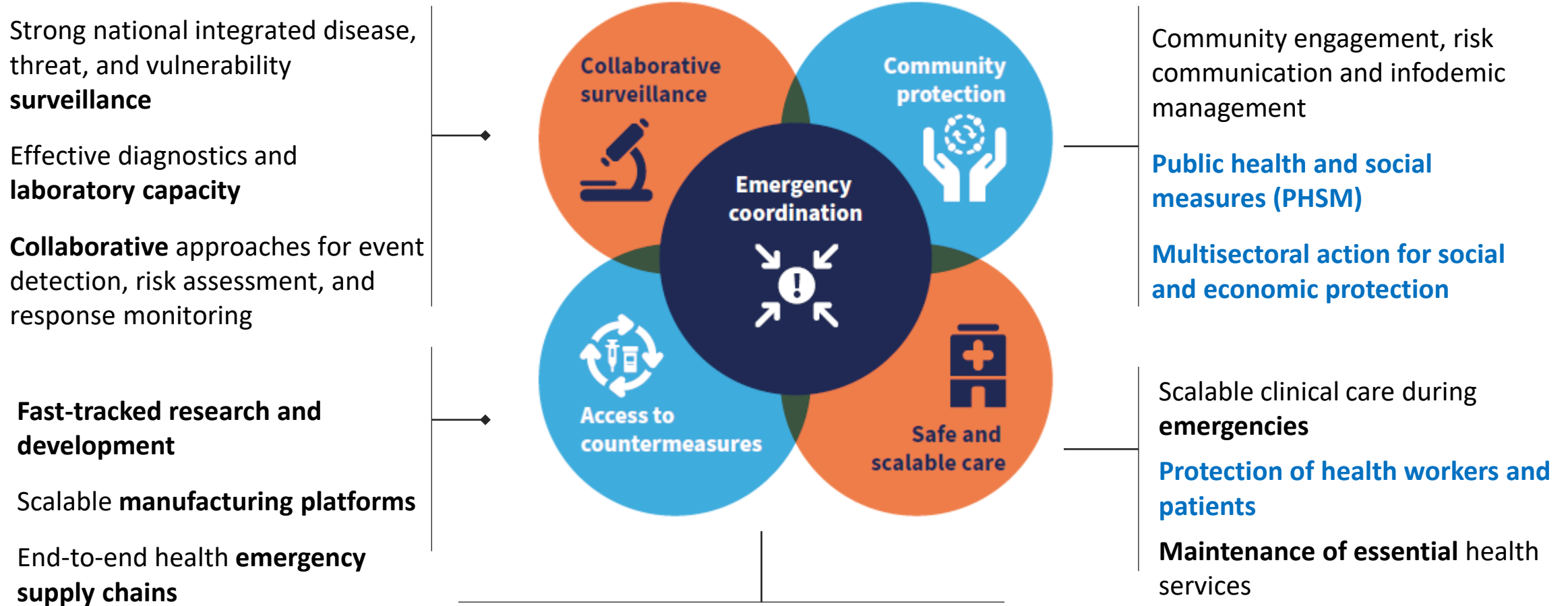
Health		+8M	estimated deaths ¹
Economy		\$16T	estimated revenue losses in international sectors ²
Education		1.6B	students out of school ³
Climate		-30%	investment in clean energy transition ⁴
Poverty		+135M	people pushed into poverty by 2030 ⁵

Pandemics are increasing in frequency & impact



1. Recorded deaths, excess mortality estimates over 12 million; 2. Midpoint of estimates by David M. Cutler, PhD, Department of Economics, Harvard University; IMF; McKinsey; and Congressional Research Service, 3 World bank; 4 Market intelligence ; 5 Effect of covid-19 only, UN

Global architecture for health emergency prevention, preparedness, response and resilience



Strengthened **workforce capacity for health emergencies**

Health emergency **preparedness, readiness, and resilience**

Health **emergency alert and response coordination**



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▶ Lessons learned

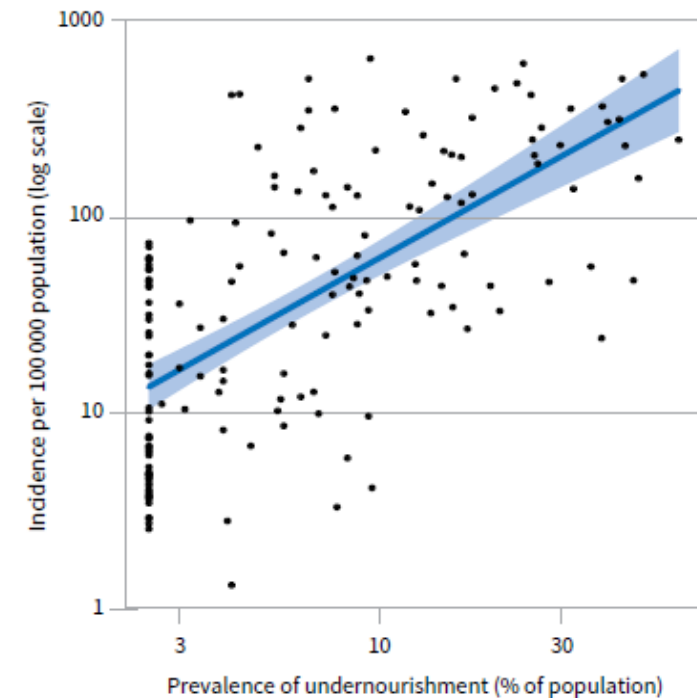
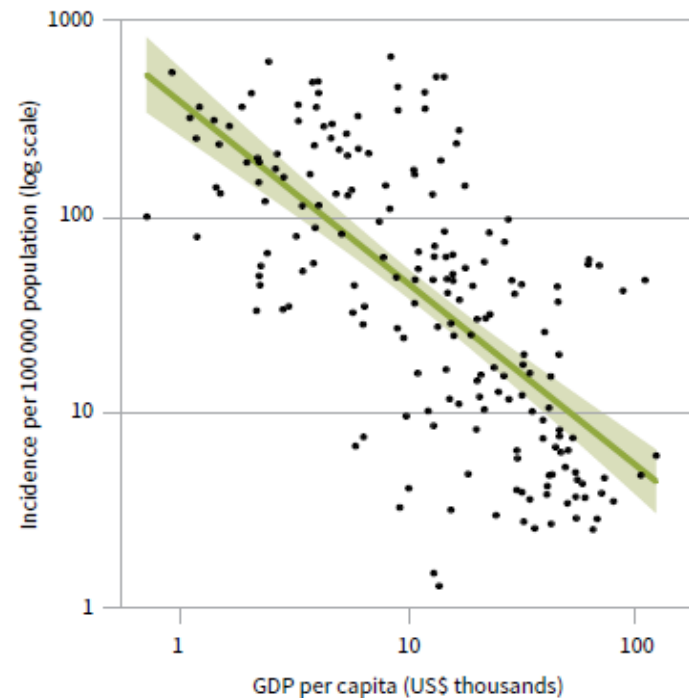
Evidence, approach and
intervention model from the fight
against Tuberculosis

Ernesto Jaramillo, WHO

TB is strongly influenced by social and economic development

- Fastest declines in TB incidence and mortality in western Europe occurred in the 1950s and 1960s, **with expanding UHC, rapid socioeconomic development**, and availability of effective treatments.
- Studies of vulnerable populations, e.g., in prison settings, homeless individuals or (some) ethnic minorities, demonstrate a **strong association between social deprivation and risk of TB**

TB incidence per 100,000 vs (i) GDP per capita and (ii) prevalence of undernourishment, 2021



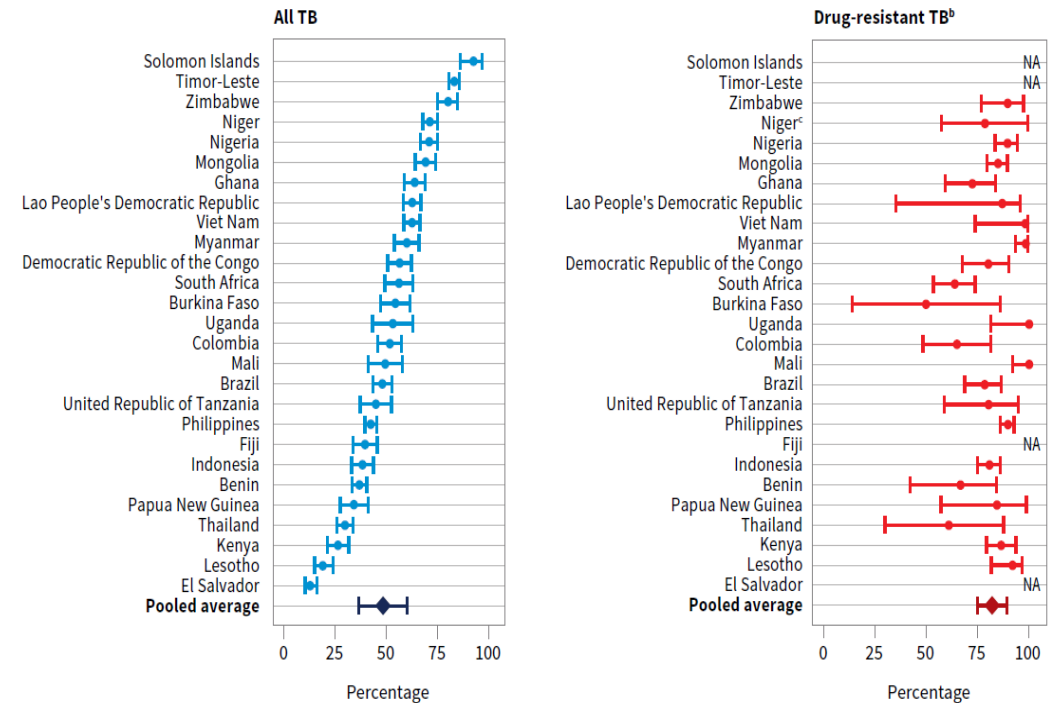
* The year of data used for GDP per capita and undernourishment is the latest year for which data are available in the World Bank (<https://data.worldbank.org/>) and SDG (<https://unstats.un.org/sdgs/dataportal>) databases, respectively.



Poverty increases TB risk, TB exacerbates poverty

- Since 2015, 27 countries have completed and reported results of TB patient cost surveys (including 15 TB HBCs).
- ~48% of people with TB and their households face TB-related catastrophic total costs
- The proportion incurring catastrophic total costs was much higher (82%) for people with DR-TB

Estimates of the percentage of TB patients and their households facing catastrophic costs,^a national surveys completed 2016–2022



Association between spending on social protection and tuberculosis burden: a global analysis



Andrew Siroka, Ninez A Ponce, Knut Lönnroth

Summary

Background The End TB Strategy places great emphasis on increasing social protection and poverty alleviation programmes. However, the role of social protection on controlling tuberculosis has not been examined fully. We analysed the association between social protection spending and tuberculosis prevalence, incidence, and mortality globally.

Lancet Infect Dis 2016;
16: 473-79

Methods We used publicly available data from WHO's Global Tuberculosis Programme for tuberculosis burden in terms of yearly incidence, prevalence, and mortality per 100 000 people, and social protection data from the International Labour Organization (ILO), expressed as the percentage of national gross domestic product (GDP) spent on social protection programmes (excluding health). Data from ILO were from 146 countries covering the years between 2000 and 2012. We used descriptive assessments to examine levels of social protection and tuberculosis burden for each country, then used these assessments to inform our fully adjusted multivariate regression models. Our models controlled for economic output, adult HIV prevalence, health expenditure, population density, the percentage of foreign-born residents, and the strength of the national tuberculosis treatment programme, and also incorporated a country-level fixed effect to adjust for clustering of datapoints within countries.

Findings Overall, social protection spending levels were inversely associated with tuberculosis prevalence, incidence, and mortality. For a country spending 0% of their GDP on social protection, moving to spending 1% of their GDP was associated with a change of -18.33 per 100 000 people (95% CI -32.10 to -4.60 ; $p=0.009$) in prevalence, -8.16 per 100 000 people (-16.00 to -0.27 ; $p=0.043$) in incidence, and -5.48 per 100 000 people (-9.34 to -1.62 ; $p=0.006$) in mortality. This association was mitigated at higher levels of social protection spending, and lost significance when more than 11% of GDP was spent.

Interpretation Our findings suggest that investments in social protection could contribute to a reduced tuberculosis burden, especially in countries that are investing a small proportion of their GDP in this area. However, further research is needed to support these ecological associations.

Funding National Institutes of Health National Center for Advancing Translational Science (University of California, Los Angeles [CA, USA] Clinical and Translational Science Institute)

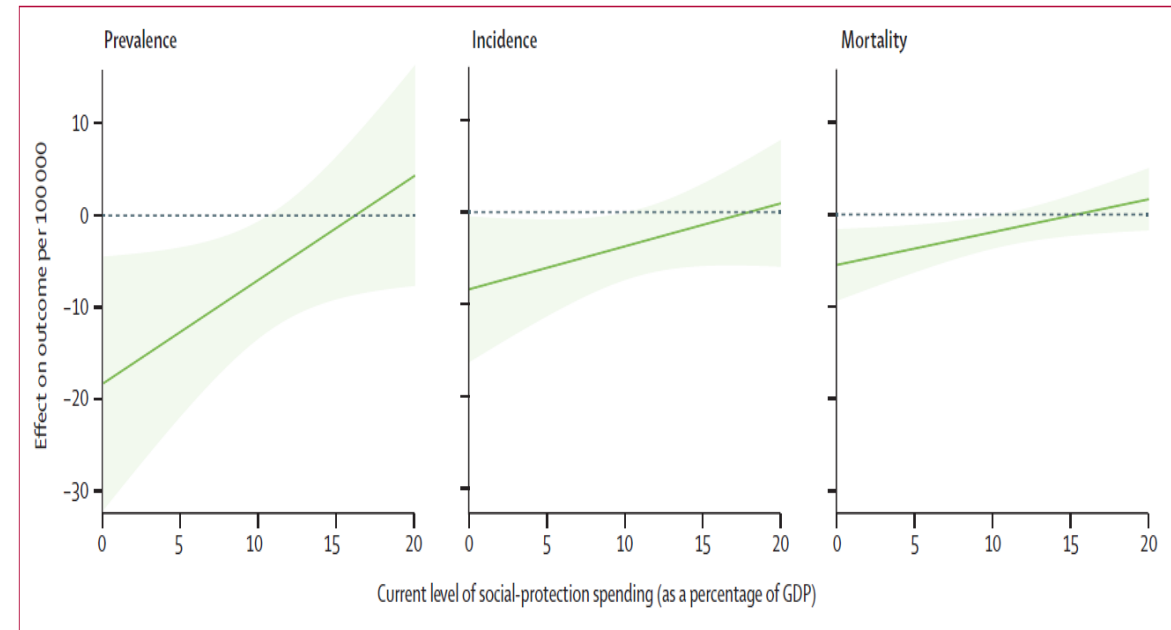


Figure 3. Estimated effect of an increase of one percentage point of GDP in social protection spending on tuberculosis prevalence, incidence, and mortality at different levels

Estimates are changes after an increase in social protection spending of 1% of GDP (95% CI bands); $n=664$ country-years. Models adjusted for GDP per person, levels of health expenditure, adult HIV prevalence, percentage foreign-born, population density, tuberculosis treatment success, and country-level fixed GDP effects. GDP=gross domestic product.



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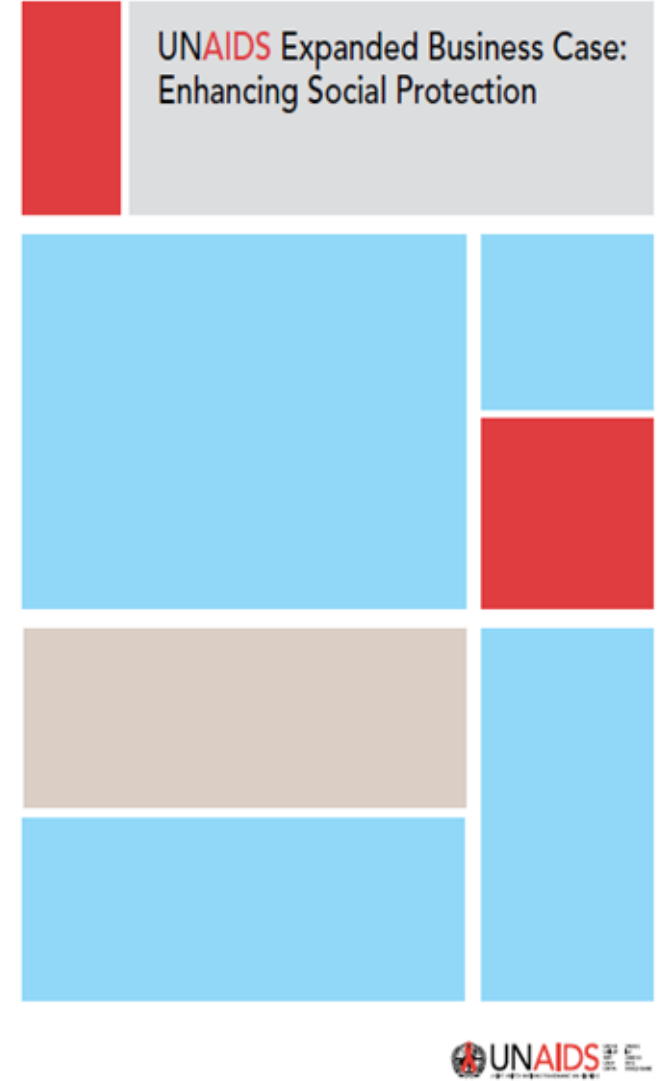
▶ Lessons learned

Evidence, approach and
intervention model from the fight
against HIV/AIDS

Lazarus Muchabaiwa, UNAIDS

Increased vulnerability PLWHIV & KPs

- Informal economy disruptions, KPs subsistence, livelihoods, stigma, violence and alienation even at POC.
- Lack of prevention, treatment and rehabilitation services (PWUD).
- School closures, children and YP vulnerability.
- Migrants, refugees and asylum seekers exclusion from national social protection.
- Vulnerability, food insecurity, people in humanitarian settings.
- PWDs employment gap 24%, higher HIV risk 1.18-2.26%.
- At least 3,856 Social protection & Labour measures
- PLWHIV and TB patients' higher excess deaths.
- Countries with high inequality = higher HIV incidence and Higher Mortality.



Evidence

- ❖ Combination CCT+ reduce vulnerabilities and HIV infection among AGYW
- ❖ CCT+ food for malnutrition among PLWHIV, TB patients, KPs vulnerabilities
- ❖ PLWHIV + KPs face communication challenges to access SP
- ❖ Social protection has significant economic, social and health multiplier effects
- ❖ The size of the transfers in social protection has a vital role in increasing its impact,
- ❖ A higher national coverage rate of social protection is vital for access to social protection benefits by people living with, at risk of, or affected by HIV.

UNAIDS position from pandemic experience

- significant economic, social and health benefits
- Investment, multiplier effects, size
- Leave no-one behind, strengthen SP systems + minimum standards/floors
- Expanded (3800)- leverage, integration, strengthening, expansion
- Universal SP and health, decent work & pay
- evidence-based decision making and resource allocation.
- Stakeholder coordination; harmony and efforts alignment



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▶ Lessons learned from COVID-19

Preliminary and confidential findings of a scoping review commissioned by WHO

Salla Atkins and Janet Tapkigen

For Ramona Ludolph, Nicole Valentine, Lou Tessier, Meri Koivusalo, Lauri Kokkinen, Lieve Vanleeuw, Johanna Pajula, Elina Kervinen

Date: 04-05 / October / 2023

RQ 1: What social protection policies and programmes were used to mitigate unintended negative socio-economic consequences of PHSM on the social determinants of health during the Covid-19 pandemic?

- 1074 different social protection policies and programmes captured by 322 studies in 124 countries

RQ 2: Where have they been implemented?

- Of 1074 programmes indicating a country:
 - 55 in low-income countries,
 - 202 in lower-middle-income countries,
 - 358 in upper-middle-income countries, and
 - 430 in high-income countries
 - 29 from several countries that were classified into different income categories

<i>Type of benefit</i>		<i>Low income</i>	<i>Lower middle income</i>	<i>Upper middle income</i>	<i>High income</i>	<i>Multi-country</i>	<i>Total</i>
In cash benefits							
	In cash (Family maintenance)	26	96	177	112	13	424
	In cash (Unemployment)	3	17	38	112	2	172
	In cash (Sickness & Healthcare)	2	6	8	57	3	76
	In cash (Old age pension)		7	17	3	2	29
	In cash (Disability)		1	10	6		17
	In cash (Other)			1	7		8
	In cash (Maternity/paternity/parental)			3	4		7
	In cash (Education)			3			3
	In cash (Housing)				2		2
In-kind benefits							
	In-kind (goods)	16	38	47	31	1	133
	In-kind (services)	1	11	19	37	5	73
	In-kind (vouchers)	0	2	10	10	1	23
General labour and fiscal measure		1	3	8	11		23
Moratorium on evictions/rent		0	2	2	15	1	20
Utility / financial fee waiver		6	18	15	23	1	63
Other			1				1
Total		55	202	358	430	29	1074

RQ3: How well did social protection policies and programmes mitigate negative socioeconomic consequences linked to PHSM and inequities and what are their reported effects?

- **Social assistance and benefits in cash (n=44)**

- **Reduction in food insecurity**, mixed evidence on financial distress (n=18) and employment difficulties; **increased utilization and reduced delay in accessing healthcare mainly in non-HIC countries**

- Only 3 studies focused on SARS-Cov-2 infection or adherence to PHSM – of these 2 were one-time cash transfers. All 3 studies showed **no association with changes in PHSM adherence**. The cash-transfer scheme study showed **an association with reduced SARS-Cov-2 infection**. The other two one-off payments did not.

- **Social assistance – benefits in kind (n=22)**

- Food transfers in mainly LMIC helped **continue agricultural efforts**, elsewhere mixed effects; **decreases in food insecurity** mainly in LMIC;
- **No evidence of reduced stress**, but expanded health insurance **reduced delays in health seeking**.

RQ 3 continued

- **Social insurance (n=13)**

- Evidence of unemployment benefits **increasing housing security, increasing food security, reducing symptoms of poor mental health** and **reducing health seeking delays**; other insurances (e.g. pensions) had mixed effects

- **Other measures (n=19)**

- Tax credits associated with **reduced financial distress and food insecurity**, no evidence of better health
- Public works programmes associated with **reduced financial distress**
- Minimum wage, paid sick leave and public employment were associated **with lower food insecurity.**
- Moratoria on evictions were generally **associated with reduced symptoms of poor mental health, lower food insecurity.**
- Utility shut off freezes were shown to **positively impact mental health**

Conclusions

- Studies of access to health services and COVID-19 outcomes were fewer than anticipated possibly because of the lack of focus on examining the effects of social protection on health care access, behaviours and adherence. The few studies included showed positive impacts.
- Methodological weaknesses and designs of included studies limit the robustness of conclusions that can be drawn, and underlying vulnerability and benefit value may influence the associations. Nonetheless, a number of experimental or quasi-experimental studies which made genuine efforts to establish causation were accessible from diverse contexts.
- Results point to a need for assessing the value of the transfers given within the programmes and considering the ways in which outcomes are measured.
- **Review shows that SP measures contributed to alleviation of the socioeconomic consequences for households during the Covid-19 pandemic.** Findings will be used to support decision-making on PHSM during future health emergencies.
- **SP measures are crucial instrument to mitigate the unintended negative consequences of PHSM and need to be systematically integrated in pandemic preparedness, prevention and response**



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► Evidence gaps

Filling the knowledge gap: What don't we know and must to understand better?

General global data gaps in coverage and adequacy

- ▶ Existing coverage data:
 - ▶ Limited longitudinal data for effective coverage.
 - ▶ Limited gender disaggregation.
- ▶ No systematic data collection on non-statutory provision (mainly a logistical challenge).

Adequacy data:

- ▶ No systematic/comparative picture of the adequacy of many SP benefits

- ▶ Many studies on the needs and barriers faced by PLHIV or affected by TB and HIV have been conducted.

But limited evidence for:

- ▶ **Statistics on SP coverage** of key and vulnerable populations are limited (not included for good reasons in administrative data, but alternative sources under-explored) —this makes it difficult to gauge the inclusiveness of existing SP schemes.
- ▶ **Monitoring of the health impact of social protection programmes** – the M&E systems of social protection schemes and systems is often limited to economic dimensions and overlooks impacts on health and wellbeing, reinforcing the lack of longitudinal evidence
- ▶ **Effective practice to improve access to SP from an institutional perspective**, e.g. how do we sensitise policymakers and administrators to needs
- ▶ These data gaps limit the guidance available to policymakers