EDITORIAL

Cured and starved: food for thought

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Food was key in the recommended treatment arsenal for tuberculosis (TB) in the pre-chemotherapy era. Good nutrition, rest, fresh air and sunlight were routinely prescribed in sanatoria and elsewhere. Things changed with the arrival of effective medicines to cure TB, and especially after a landmark study published in 1961 that demonstrated that ambulatory treatment at home can achieve as good treatment results as treatment in sanatoria, while it was mentioned that 'diet plays little, if any, part in the attainment of bacteriological quiescence'.¹ A secure drug supply and mechanisms to support adherence seemed sufficient, and the authors concluded that 'successful treatment of patients in their home in developing countries need not await an increase in the standard of living'.¹

This conclusion has not changed much since. A recent systematic review concluded that there is no good evidence that nutritional care and support can improve TB treatment outcomes, once proper chemotherapy is ensured.² With the lack of such evidence we may be comfortable with not recommending systematic scaled up nutritional care for TB patients. However, that would leave us with some uncomfortable facts about which Islam et al. remind us in their article in the current issue of *Public Health Action*.³

First, undernutrition is a risk factor for TB, and TB is a catabolic condition that leads to further weight loss; the prevalence of undernutrition is therefore often very high in people diagnosed with TB. While proper TB chemotherapy helps to resolve undernutrition, many are still underweight at the end of treatment. Islam et al. demonstrated that two thirds of TB patients in Bangladesh were underweight at the start of treatment and half remained so at the end of treatment. While the TB problem may be solved, the remaining nutritional deficiency leaves people at risk for other poor health outcomes.

Second, food is central to survival and at the core of daily life. If there is no food on the table, most other problems are of secondary importance. Food insecurity is rampant in those countries where TB is most preva-

lent. The daily struggle for survival can translate into neglecting to recognise TB symptoms, seek care or stay in care for TB. People who do manage to access proper care often face catastrophic costs, both direct and indirect.⁴ The choice to access TB treatment may not be obvious if the opportunity cost is aggravated starvation. Islam et al. highlight some of the social and cultural issues that govern attitudes around food and influence the allocation of household resources for food, and the allocation of food between family members.

The evidence that food support can improve access and adherence to TB treatment is inconclusive. Nevertheless, where food insecurity is an obvious treatment barrier it makes sense to include it in a package of enablers, especially when the risk of catastrophic costs related to TB treatment is high. However, the most compelling argument for nutritional support to TB patients is that nutritional rehabilitation is, in and of itself, essential to preserve health and well-being.

TB treatment is the first essential intervention for TB patients who are underweight, but nutritional care can both help nutritional rehabilitation and act as a social protection mechanism for food-insecure households. It should thus be part of good primary health care in general. The World Health Organization is developing guidelines on nutritional care for people with TB, to be published in 2013.

References

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