SOUTHERN AFRICA

TB AND HEALTH SYSTEMS SUPPORT (SATBHSS) PROJECT

WORLD BANK GROUP

NEPAD TRANSFORMING AFRICA

CDC

Southern Africa Tuberculosis and Health Systems Support Project

Project Summary 2016 - 2021

About Southern Africa Tuberculosis and Health Systems Support Project

The Southern Africa Tuberculosis and Health Systems Support Project is a World Bank (WB) funded regional project launched in 2016 with the aim of strengthening the health sector's response to Tuberculosis and occupational lung diseases. It is implemented in four (4) Southern African Development Community (SADC) Member States: Lesotho, Malawi, Mozambique and Zambia. In partnership with the WB and Member States, the NEPAD Agency and East, Central and Southern Africa Health Community (ECSA-HC) collaborate to provide technical support in project implementation in the participating countries.

Globally, Tuberculosis causes more deaths than HIV/AIDS annually and it is estimated that 1.5million people died of Tuberculosis in 2014 with Africa accounting for 450,000 deaths, the second highest in the world. The Southern Africa sub-region is the epicentre with the highest Tuberculosis case rates on the continent with elevated TB/HIV coinfection rates.

In addition, inadequate treatment of Tuberculosis creates resistance to first line drugs, leading to Multi-Drug Resistant (MDR) Tuberculosis which require much more expensive drugs to treat, with higher levels of toxicity, higher case fatality and increased treatment failure rates. This project is a response aimed at addressing some of the challenges of Tuberculosis in Africa by targeting the most affected areas and communities in low income countries." As a result, this project targets interventions in the mining communities, transport corridors and cross-border areas of the participating countries in the SADC region, as well as the neighbouring countries.

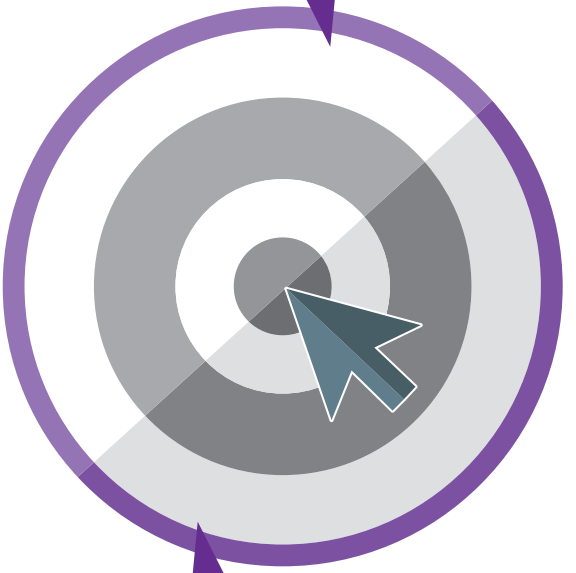
Due to high levels of inter-regional economic activity in Southern Africa, Tuberculosis easily spreads across national borders. This project represents a paradigm shift in the prevention and treatment of Tuberculosis at the sub-regional level by creating a multisectoral platform for regionally coordinated actions to deal with the spread of the disease across borders. The project contributes to regional, continental and global frameworks on Tuberculosis such as the SADC Strategic Framework for Control of Tuberculosis, the Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa by 2030, and the World Health Organization (WHO) End TB Strategy respectively, among others.

[1]TB Facts - Information About Tuberculosis: http://www.tbfacts.org/tb-statistics/

Project Development Objectives

The project is guided by two (2) project development objectives:

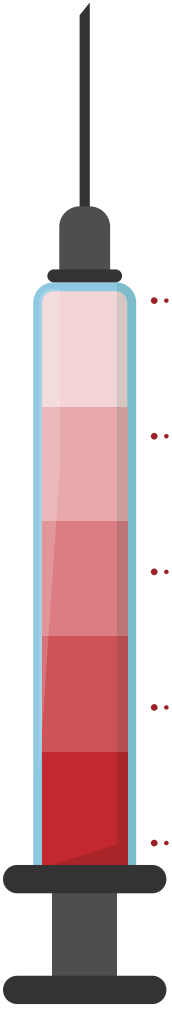
Improve coverage and quality of key TB control and occupational lung disease services in targeted geographic areas of the participating countries



Strengthen regional capacity to manage the burden of TB and occupational diseases.

Results Indicators

Progress on the mentioned Project Development Objectives will be monitored using a set of results outcome indicators as follows:



- TB Case notification in target geographic areas (number)
- TB treatment success rate in target geographic areas: (i) new and (ii) relapse TB cases (percentage)
- TB cases identified through active TB case finding (screening) among TB vulnerable populations in targeted geographic areas (number)
- Project-supported laboratories compliant with regionally harmonized standard operating procedures for surveillance of MDR-TB (number)
- Direct beneficiaries (number), and the share of females among them (percentage).

Project Component 1

Innovative Prevention, Detection, and Treatment of TB

The aim of this component is to improve the demand for and availability of high-quality TB, TB-HIV/AIDS, and occupational lung disease services in targeted geographic areas of the four participating countries. The aim will be achieved through the following interventions;

Subcomponent 1.1: Enhancing case detection and treatment success

Focuses on financing demand and supply-side interventions to enhance early case detection and improve treatment success rates through the rollout of a package of standardized TB prevention and treatment services across the four countries.

Subcomponent 1.2: Rolling out a standardized package of occupational health services and mining safety standards across the four countries

Focuses on (i) strengthening the capacity of public sector agencies responsible for mine safety to undertake inspection of mines with an emphasis on determining mine dust levels; (ii) expanding periodic screening and referral for occupational lung diseases and other diseases in line with standards set within the sub-region and international best practices; (iii) and developing/strengthening care programs for occupational lung diseases.

Project Component 2

Regional Capacity for Disease Surveillance, Diagnostics, and Management of TB and Occupational Lung Diseases

The aim of this component is to strengthen selective aspects of health systems to position the sub-region to better manage the TB epidemic and other infectious diseases. The aim will be achieved through the following interventions;

Subcomponent 2.1: Improving quality and availability of human resources in the targeted areas

Focuses on supporting the development of a skilled health workforce related to project activities based on a regionally defined curriculum, mentoring, and knowledge sharing in three critical areas: (i) case detection and management of TB; (ii) mine health regulation and occupational services; and (iii) disease surveillance.

Subcomponent 2.2: Strengthening diagnostic capacity and disease surveillance

Focuses on (i) strengthening regional diagnostic capacity and networking; (ii) enhancing access to diagnostics for TB and occupational health in the targeted intervention areas; (iii) and enables participating countries to strategically revamp surveillance systems.

Subcomponent 2.3: Strengthening mine health regulation

Focuses on supporting countries to update or draft occupational health and safety legislation; review and/or develop guidelines for mine health inspections, occupational health screening protocols, and compensation systems and guidelines; develop information technology (IT) systems for compliance monitoring and mine health surveillance; and provide equipment for mine health inspection.

Project Component 3

Regional Learning and Innovation, and Project Management

The main aim of this component is to fund technical support to strengthen regional capacity and promote regional innovation through sharing of knowledge and evidence from interventions implemented under Components 1 and 2. In addition, it supports advocacy for policy reforms and for greater accountability by mining companies on enforcement of occupational and mine health standards. This aim will be achieved through the following interventions;

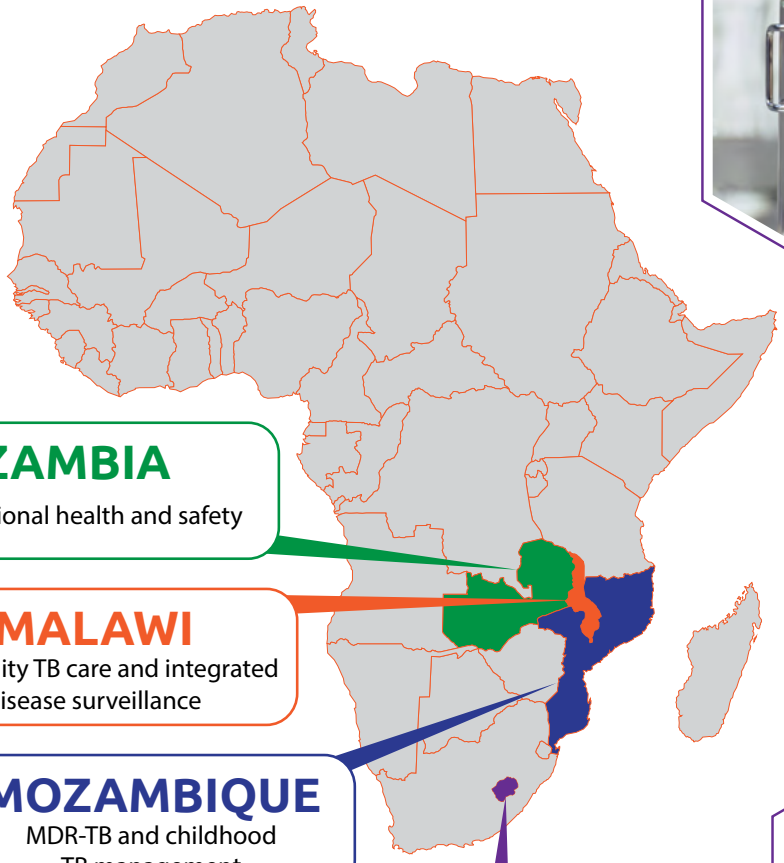
Subcomponent 3.1: Operational research and knowledge sharing

Focuses on including key baseline assessments with technical support of **CDC and IFC.** ECSA-HC will coordinate the major studies related to activities under the project.

Subcomponent 3.2: Centers of excellence in TB and occupational lung disease control

Focuses on ensuring that participating countries have a shared vision to innovate and learn in different technical areas. Each country will have a centre of excellence to provide regional leadership in key technical areas as follows: Lesotho - community-based management of MDR-TB; Malawi - community TB care and integrated disease surveillance; Mozambique - MDR-TB and childhood TB management; and Zambia - occupational health and safety.

National Centers of Excellence in TB and Occupational Lung Disease Control



ZAMBIA
occupational health and safety

MALAWI
community TB care and integrated disease surveillance

MOZAMBIQUE
MDR-TB and childhood TB management

LESOTHO
community-based management of MDR-TB

Project Component 3 - continued

Regional Learning and Innovation, and Project Management

Subcomponent 3.3: Regional coordination, policy advocacy, and harmonization

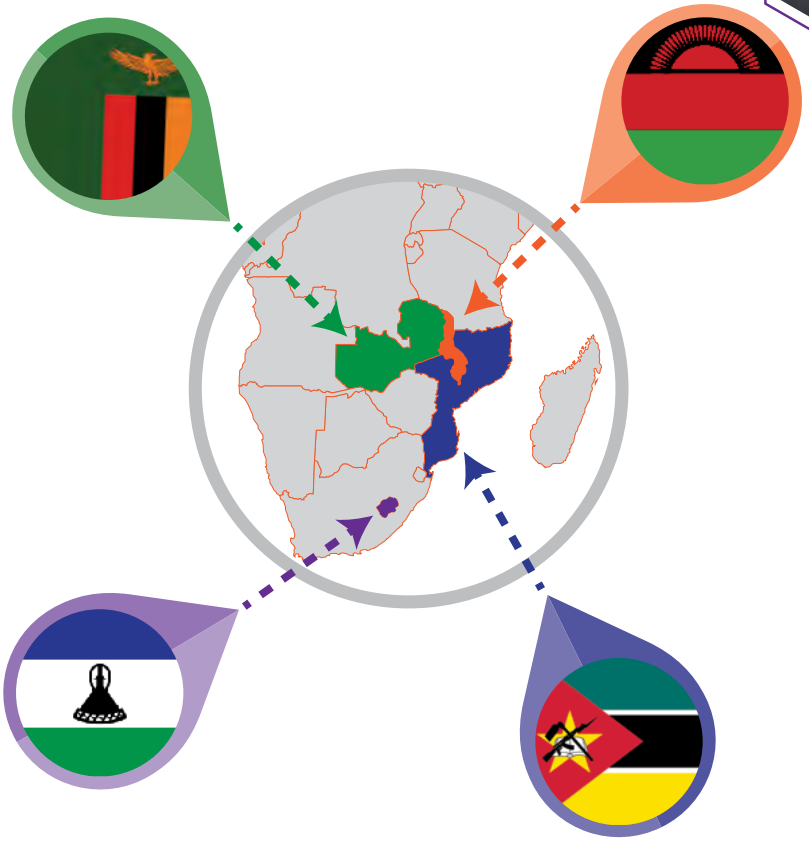
Focuses on supporting regional project activities that generate economies of scale and deepen learning and knowledge exchange. Existing platforms will be leveraged to promote South - South knowledge sharing.

Subcomponent 3.4: Project management

Focuses on supporting the work of the Project Implementation Units (PIUs), including financial management, procurement, risk-based auditing, and M&E. Meetings of inter-ministerial National Technical Committees and the Regional Advisory Committee will be held. Joint annual review meetings will be supported at national level and interim reviews in participating districts, as needed.

Project Beneficiaries

The primary beneficiaries are individuals and households in the Tuberculosis most affected and highest Tuberculosis burden areas. These include mining communities, peri-mining areas, transport corridors, and cross-border areas and labour sending communities of the four target countries: Lesotho, Malawi, Mozambique and Zambia. Miners, ex-miners, their families and health workers will also be direct beneficiaries. The project will directly benefit women, particularly in the small-scale mining sector.



Project Implementation and Institutional Arrangements

The project implementation and institutional arrangements are divided in to two: regional level and national level. This approach is informed by recommendations of the World Bank's independent evaluation of regional projects. Details of the project implementation and institutional arrangements are documented in the Project Implementation Manual.

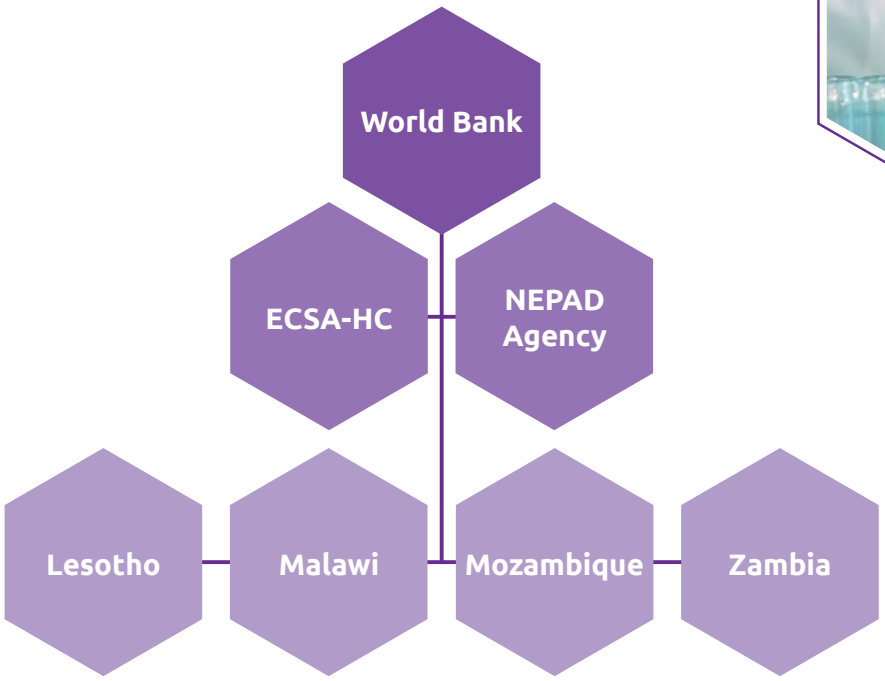
Project Implementation approach at Regional level

The project's multi-sectoral, multi-country approach will have greater impact on TB control programs and enhance prospects for sustainability. Previous initiatives to address TB in the region have not been effective in reducing the TB burden as they did not fully consider the multi-sectoral and multi-country dimensions in mining areas, peri-mining areas, and high-burden regions. A multi-country focus enables economies of scale, especially in: (i) expertise and resources for MDR-TB management; (ii) accreditation and development of laboratory capacity to manage TB and provide continued training in laboratory management; (iii) training of new and in-service health personnel to further strengthen knowledge and skills; and (iv) delivery of a standardized package of occupational health services and safety standards. The project will also take stock of opportunities for public–private partnerships in TB control. This approach is expected to boost chances of sustainability as ownership is enhanced, accountability improved, economies of scale achieved, and collaboration expanded.

Project Implementation approach at National Level:

The project will be implemented primarily through existing public sector structures such as national TB programs, and government financial and procurement systems in each country, enabling the participating-country governments to maintain activities with their current institutions and resource environment after the project closes.

Project Implementation Structure



The diagram above depicts the project implementation structure

Project Monitoring and Evaluation Framework

A community of practice on M&E - comprising M&E officers from the participating countries and the RCO - will be set up to strengthen skills and integrate a culture of data analysis and dissemination. Countries will lead M&E activities, but the RCO will be mandated to collect and aggregate project-monitoring data. This Project has a Results Framework and Monitoring strategy that applies best practices from the World Bank, Centers for Disease Control and Prevention (CDC), Stop TB Partnership, and World Health Organization (WHO) Monitoring and Evaluation (M&E) approaches.

Regional-level coordination of M&E

- At the regional level, ECSA-HC will establish a small team of experts to: provide technical oversight; monitor and support the lead implementing team at national level; and ensure coordinated and standardized execution of project activities.

- Annual review meetings, organized under the auspices of ECSA-HC and the New Partnership for African Development (NEPAD), will provide a forum for sharing implementation experiences, proposing recommendations on programmatic changes, and generating additional demands for information and analysis.

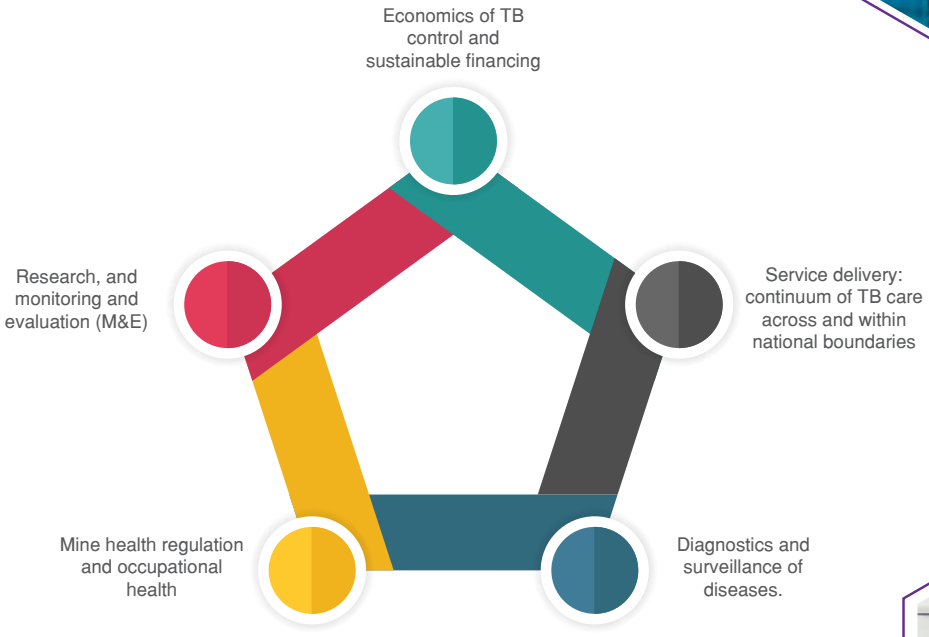
Country-level M&E Systems and Capacity-building Strategies

- Country level M&E shall rely on national structures of the participating countries, with targeted technical assistance, where appropriate. The capacity of these structures will be built to improve availability and quality of data, including surveillance systems in cross-border areas and laboratories to produce data that countries cannot generate at present.

- National Technical Committees (NTC) will be constituted to oversee project implementation. The NTC will be responsible for reviewing and approving consolidated annual work plans and budgets submitted by technical departments and providing technical guidance to implementing agencies.

Community of Practice (CoP)

The four (4) participating countries have agreed to function as a Community of Practice (COP) on TB and Occupational Lung Disease Control in order to foster cross-country knowledge generation, learning and sharing. The COP includes key themes and technical areas that present regional and cross-country challenges as represented in the diagram below:



LESOTHO TB FACT SHEET

Estimates of TB burden, a 2015	Number (thousands)	Rate (per 100 000 population)
Mortality (excludes HIV+TB)	1.2 (0.63–1.9)	55 (29–89)
Mortality (HIV+TB only)	4.8 (3–7)	223 (139–328)
Incidence (includes HIV+TB)	17 (11–24)	788 (510–1 125)
Incidence (HIV+TB only)	12 (7.7–18)	566 (359–820)
Incidence (MDR/RR-TB)b	1.1 (0.76–1.5)	52 (36–70)

Total cases notified -7 892

Total new and relapse -7 594

— % tested with rapid diagnostics at time of diagnosis 0%

— % with known HIV status 96%

— % pulmonary 86%

— % bacteriologically confirmed among pulmonary 49%

Estimated TB incidence by sex (thousands), a 2015

Females- *6.5 (2.9–10)*

Males- *10 (7.2–14)*

Total- ***17 (11–24)***

MALAWI TB FACT SHEET

Estimates of TB burden, a 2015	Number (thousands)	Rate (per 100 000 population)
Mortality (excludes HIV+TB)	2.3 (1.3–3.6)	13 (7.7–21)
Mortality (HIV+TB only)	6.6 (3.5–11)	38 (20–62)
Incidence (includes HIV+TB)	33 (18–53)	193 (104–310)
Incidence (HIV+TB only)	18 (9.4–29)	104 (55–168)
Incidence (MDR/RR-TB)b	0.44 (0.12–0.75)	2.6 (0.70–4.4)

Total cases notified -17, 104

Total new and relapse -15, 737

— % tested with rapid diagnostics at time of diagnosis 6%

— % with known HIV status 93%

— % pulmonary 75%

— % bacteriologically confirmed among pulmonary 58%

Estimated TB incidence by sex (thousands), a 2015

Females- ***13 (3.5 – 23)***

Males- ***20 (12 – 28)***

Total- ***33 (18 – 53)***

MOZAMBIQUE TB FACT SHEET

Estimates of TB burden, a 2015	**Number (thousands)**	**Rate (per 100 000 population)**
Mortality (excludes HIV+TB)	21 (12–32)	74 (43–115)
Mortality (HIV+TB only)	34 (21–50)	120 (73–178)
Incidence (includes HIV+TB)	154 (100–220)	551 (356–787)
Incidence (HIV+TB only)	79 (50–115)	284 (179–412)
Incidence (MDR/RR-TB)b	7.3 (4.1–10)	26 (15–36)

Total cases notified -61, 559

Total new and relapse -58, 344

— % tested with rapid diagnostics at time of diagnosis 7%

— % with known HIV status 99%

— % pulmonary 89%

— % bacteriologically confirmed among pulmonary 50%

Estimated TB incidence by sex (thousands), a 2015

Females- ***64 (30–98)***

Males- ***90 (62–119)***

Total- ***154 (100–220)***

ZAMBIA TB FACT SHEET

Estimates of TB burden, a 2015	Number (thousands)	Rate (per 100 000 population)
Mortality (excludes HIV+TB)	5 (2.9–7.7)	31 (18–47)
Mortality (HIV+TB only)	12 (6.9–20)	77 (42–121)
Incidence (includes HIV+TB)	63 (41–91)	391 (253–558)
Incidence (HIV+TB only)	38 (24–55)	235 (149–339)
Incidence (MDR/RR-TB)b	2.3 (1.4–3.2)	14 (8.6–20)

Total cases notified -41, 588

Total new and relapse -36, 741

— % tested with rapid diagnostics at time of diagnosis 100%

— % with known HIV status 95%

— % pulmonary 79%

— % bacteriologically confirmed among pulmonary 49%

Estimated TB incidence by sex (thousands), a 2015

Females- *24 (9.9–38)*

Males- *39 (27–52)*

Total- ***63 (41–91)***

Source: World Health Organization.

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