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# Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 13-Apr-2020 | Report No: PIDISDSA28617



**BASIC INFORMATION**

**A. Basic Project Data**

Country Africa	Project ID P173228	Project Name Southern Africa Tuberculosis and Health Systems Support Project Additional Financing	Parent Project ID (if any) P155658
Parent Project Name AFR RI-Southern Africa Tuberculosis and Health Systems Support Project	Region AFRICA	Estimated Appraisal Date 05-May-2020	Estimated Board Date 11-Jun-2020
Practice Area (Lead) Health, Nutrition & Population	Financing Instrument Investment Project Financing	Borrower(s) Republic of Mozambique, Kingdom of Lesotho, Republic of Zambia, Republic of Malawi, Ministry of Finance, Ministry of Finance	Implementing Agency Ministry of Health, Ministry of Health, Ministry of Health, Ministry of Health

Proposed Development Objective(s) Parent

A. Proposed Development Objective(s)

The overall objectives of the project are to: (i) improve coverage and quality of TB control and occupational lung disease services in targeted geographic areas of the participating countries; and (ii) strengthen regional capacity to manage the burden of TB and occupational diseases.

Components

Innovative Prevention, Detection and Treatment of TB  
Regional Capacity for Disease Surveillance, and Diagnostics and Management of TB and Occupational Lung Diseases  
Regional Learning and Innovation, and Project Management

**PROJECT FINANCING DATA (US\$, Millions)**

**SUMMARY**

<b>Total Project Cost</b>	59.00
<b>Total Financing</b>	59.00
<b>of which IBRD/IDA</b>	59.00



<b>Financing Gap</b>	0.00
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**DETAILS**

**World Bank Group Financing**

International Development Association (IDA)	59.00
IDA Credit	51.00
IDA Grant	8.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

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Other Decision (as needed)

**B. Introduction and Context**

1. Globally, tuberculosis (TB) is the ninth leading cause of death and the leading cause of death from a single infectious agent, ranking above HIV/AIDS. TB is the main cause of death among people living with HIV, causing one in three of all AIDS-related deaths worldwide, and Southern Africa is considered the epicenter of the co-epidemic. The sub-region is off track to achieve the World Health Organization (WHO) End TB Strategy targets to reduce TB incidence and mortality by 90% and 95% respectively by 2035. Treatment coverage in the four Southern Africa Tuberculosis and Health Systems Support (SATBHSS) project countries ranges from 48 percent in Lesotho to 68 percent in Malawi, meaning that many TB cases are not diagnosed, and treatment outcomes are well below expectations. Southern Africa has the highest per capita burden of TB and a persistently high death rate per capita from TB. The region’s high TB burden is closely associated with poverty, persistently high HIV prevalence among the general population (15-20% in most Southern African Development Community [SADC] countries), and even higher HIV prevalence among vulnerable populations such as miners, ex-miners, their families, and surrounding communities. Among miners and ex-miners, a chief co-factor in the causality of TB infection is the high frequency of occupational lung disease (OLD) due to silica dust exposure in the underground mines. The incidence rate of TB among miners and ex-miners is estimated to be seven-fold that of the general population (reported at 3,000–7,000 per 100,000 miners per year in some areas).

2. The mining industry is intrinsically linked to the spread of disease in Southern Africa—particularly between labor-sending countries and South Africa. Approximately 500,000 miners currently work in South Africa’s mines—including those from within South Africa—and there are an estimated 3 million ex-miners, though there is little available data to confirm this number. The historical and ongoing circular migration from South Africa’s neighboring countries to mining



areas in South Africa poses considerable challenges as miners move between their communities and the mines, often carrying infections such as TB and HIV which can be transmitted to their communities, as well as OLD. While this migration pattern creates economic opportunities for miners (who are often from poor backgrounds), it also facilitates the spread of communicable diseases such as TB and HIV to miners' households, neighbors, and peri-mining communities—and perpetuates a vicious cycle of poverty and disease. The WHO estimates that one person with active TB can potentially infect 10-15 persons in a year. Many miners return to their homes with advanced TB. Although TB is completely curable, because of the lack of both a strong referral system and continuum of care across borders, miners with TB are lost to follow-up, fail to complete treatment in a timely manner, and transmit TB within their homes. This stymies public health efforts towards effective TB control. There is direct link between TB morbidity and mortality and human capital formation/accumulation. The economic burden of TB and other communicable diseases cannot be overemphasized, as TB affects mostly people in the prime of their economic productivity. The direct effects of TB and HIV on productivity stem from the physical incapacity associated with the untreated or inadequately treated diseases and the resulting loss of income. Conversely, investing in finding and treating TB has high economic returns, estimated at US\$30 for every dollar invested. Health systems in most countries of the sub-region are weakened by the burden of the co-epidemic and a lack of readiness (e.g., staffing, finance, supply chain, information systems and technology) to effectively prevent, diagnose, and treat TB and HIV compounds the significant burden of these infections.

3. Silica dust produced by gold mining in particular is a facilitator of the TB bacillus and enhances the ability of the bacillus to establish infection and disease in the lungs even without fully developed silicosis. This is a dose-response relationship, as silica interferes with immune system defense mechanisms, preventing them from attacking the TB bacillus. Attempts to quantify dust exposure by occupational category within the mining industry documented that drillers and winchers had statistically significantly higher rates of TB than other miners. Control of silica dust levels would contribute to decreased TB incidence. Silicosis, past or current pulmonary tuberculosis, and respirable dust are all independently associated with lung function loss.

4. The gold mining industry has a poor record of compliance with health and safety standards relating to the prevention of exposure to silica dust. Making matters worse, the current legal levels of silica dust in mines (0.1mg/m<sup>3</sup>) are outdated and derived from ineffective recommendations that do not prevent the development of the disease. The American Conference of Governmental Industrial Hygienists (ACGIH), for example, recommends that silica dust levels in mines be reduced to 0.025mg/m<sup>3</sup> as a way of preventing over-exposure. There are several ways to accomplish this reduction, including exhaust ventilation and diluting contaminated air with uncontaminated air. Given the significantly increased risk of contracting TB once one has developed actual silicosis, reducing silica dust levels would reduce silicosis and thereby cut TB even further.

5. The magnitude and severity of the TB and HIV epidemics require sustained efforts for longer periods. Going forward, it is critical to scale up detection of missing cases of DS-TB and DR-TB; improve TB screening of vulnerable groups, particularly people living with HIV, miners and ex-miners, health care workers (HCWs), prisoners, the poor, and otherwise marginalized populations; and ensure treatment completion and success.

6. Only a concerted regional and multisectoral effort to improve prevention, treatment, and control of TB, TB/HIV, and OLD can change the trajectory of the sub-region's dual epidemic—and reduce the emergence of drug resistant TB (DR-TB). DR-TB, which is more difficult and costly to treat, and is NOT always curable, strains health systems and is a serious threat to TB control and to public health at large. Improved treatment success and reduction of DR-TB depends upon harmonized diagnostic and treatment protocols, including a continuum of clinical care across borders to ensure adherence to treatment and scale-up of innovative approaches to track patients, ensure effective referrals mechanisms, and share lessons within and beyond the sub-region. For these reasons, and notwithstanding global and regional progress



in detecting and treating drug sensitive TB (DS-TB) and DR-TB and rolling out Anti-Retroviral Treatment (ART), Southern Africa's TB, TB/HIV, and OLD agenda is unfinished.

### C. Proposed Development Objective(s)

**Note to Task Teams:** The PDO has been pre-populated from the datasheet for the first time for your convenience. Please keep it up to date whenever it is changed in the datasheet. *Please delete this note when finalizing the document.*

#### Original PDO

##### A. Proposed Development Objective(s)

The overall objectives of the project are to: (i) improve coverage and quality of TB control and occupational lung disease services in targeted geographic areas of the participating countries; and (ii) strengthen regional capacity to manage the burden of TB and occupational diseases.

#### Current PDO

##### A. Proposed Development Objective(s)

The overall objectives of the project are to: (i) improve coverage and quality of TB control and occupational lung disease services in targeted geographic areas of the participating countries; and (ii) strengthen regional capacity to manage the burden of TB and occupational diseases.

### D. Project Description

7. The proposed Additional Financing (AF) will deepen SATBHSS achievements to date in both TB and OLD control and enhance country-level and cross-border preparedness and response to disease outbreaks. The AF will:

- (i) Close the financing gap for Malawi and Lesotho to meet their project end targets ;
- (ii) Enhance and scale up high impact interventions, particularly the use of more sensitive diagnostic technologies to increase TB case finding and identification of DR-TB;
- (iii) Fully operationalize Communities of Practice (COEs) to enhance and consolidate innovation, learning, and exchange, which benefits broader sub-regional, regional, and global TB control efforts;
- (iv) Support establishment and enforcement of legislation and regulatory frameworks for best practices in occupational health and safety (OHS) and in primary prevention of OLD, and for strengthening mechanisms to ensure that miners eligible for OLD compensation receive it;
- (v) Bolster emergency and disease outbreak preparedness and response, including consolidating cross-border collaboration between participating countries and beyond. This will complement the Africa CDC mandate to improve regional-level epidemic and pandemic preparedness and response at the regional level.

8. AF development objectives remain unchanged from the recently approved project restructuring. As such, the AF PDOs are to: (i) improve coverage and quality of TB control and OLD services in targeted geographic areas of the



participating countries; (ii) strengthen regional capacity to manage the burden of TB and OLD; and (iii) strengthen country-level and cross-border preparedness and response to disease outbreaks.

9. The AF components also remain unchanged from the original project components. The additional funds allocated to each component are as follows: Component 1: Innovative Prevention, Detection, and Treatment of TB (US\$27.97 million in Additional Financing); Component 2: Regional Capacity for Disease Surveillance, Diagnostics, and Management of TB and Occupational Lung Diseases (US\$26.55 million in Additional Financing); and Component 3: Regional Learning and Innovation, and Project Management (US\$20.48 million in Additional Financing).

## **E. Implementation**

10. The Institutional and Implementation arrangements will remain essentially unchanged. At national level, the institutional framework for implementation will be based on each country's national systems and procedures with the necessary adaptation and technical assistance to implement Bank-funded project. Generally, Ministries of Health will be the key implementing agencies, with Ministries of Labor and Mines being active participants. Within the Ministries of Health and in accordance with each country's organizational structure, the units in charge of project implementation will manage day-to-day operations while the National TB Control Programs (NTPs) will provide technical leadership during implementation. NTPs will be responsible for the technical oversight, analysis of progress, reporting on results based on the project indicators, and other analysis and evaluations. The Ministries of Health will work collaboratively with the Ministries of Labor and Mines to advance project activities, especially in the area of OHS.

11. 11. As in the original project the National Technical Committees (NTCs) will continue providing oversight and policy support to the project, including approving annual work plans.

12. In each country the existing institutional arrangement for implementation will be maintained. In Lesotho and Malawi, the respective PIUs may need to be strengthened because they manage more than one Bank-funded operation simultaneously, including the COVID-19 Emergency Response Projects

13. At regional level, ECSA-HC will continue playing its role of Regional Coordinating Organization (RCO) and will provide technical support and facilitate regional coordination. Activities that ECSA-HC will implement include organizing the Regional Advisory Committee (RAC) meetings, providing technical assistance in laboratory strengthening, disease surveillance, M&E and TB control, and advocacy. ECSA-HC will also support implementation support missions in countries as required. The Africa Union Development Agency – New Partnership for Africa Development (AUDA-NEPAD) will continue supporting occupational health interventions focusing more on primary prevention of OLD.

14. The RAC will continue to serve as the project's technical advisory body to countries and a forum for exchange of experiences and learning on TB control and OLD. The RAC provides the space for discussion between high-level decision-makers, such as Permanent Secretaries of Ministries of Health, Mines, Labor, and Finance. In addition, TB program managers also attend and exchange ideas on TB control efforts in their respective countries. The RAC plays a critical regional coordinating role, ensuring harmony in M&E of TB control efforts, networking support toward regional collaboration, sharing of lessons and innovations, and integrated approaches. Moving forward the RAC membership may be expanded to include technical partners in disease surveillance, and outbreak preparedness and response in line with the PDO and enforced support under component 2.

15. Country-level NTCs will continue to be responsible for program oversight. The NTCs review and approve consolidated annual work plans and budgets submitted by the technical departments and provide technical guidance to



implementing agencies.

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**F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)**

The parent project includes Lesotho, Malawi, Mozambique, and Zambia. Activities to be financed under the AF are only in Lesotho and Malawi.

**G. Environmental and Social Safeguards Specialists on the Team**

- Ruma Tavorath, Environmental Specialist
- Bruno Alberto Nhancale, Environmental Specialist
- Paulo Jorge Temba Sithoe, Environmental Specialist
- Eden Gabriel Vieira Dava, Social Specialist
- Violette Mwikali Wambua, Social Specialist
- Njavwa Namposya Chilufya, Social Specialist
- Mantsebo Moipone Amelia Ndlovu, Social Specialist

**SAFEGUARD POLICIES THAT MIGHT APPLY**

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	No	



Involuntary Resettlement OP/BP 4.12	No
Safety of Dams OP/BP 4.37	No
Projects on International Waterways OP/BP 7.50	No
Projects in Disputed Areas OP/BP 7.60	No

## KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

### A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The AF is being processed to bridge the financing gap in participating countries; and will support (i) improvements in identification of TB cases and OLD among miners, ex-miners, and their families; (ii) scale-up of more sensitive, rapid, and efficient diagnostic tools to increase capacity to test and detect TB, MDR-TB, and silicosis and other types of pneumoconiosis; (iii) bolster the current use of innovative technological approaches to TB control at community and facility levels, by supporting COEs and (iv) consolidate the project’s interventions in disease surveillance and response broadly, and in so doing strengthen sub-regional capacity, as part of the broader continental shift towards enhanced health security.

The AF will not finance any new construction or renovation of laboratories. In this regard, the AF will not result in any additional risks and potential impacts, apart from those identified in the parent project, which included waste management and Occupational health and safety, including environmental health; Infectious waste management and possible exclusion of vulnerable and disadvantaged groups such as People Living with HIV and AIDS (PLWHA) some of whom may have TB rates that are likely to be higher than the general population.

The provision of community health services and other proposed interventions should be better tailored to the circumstances imposed by the COVID-19 measures such as social distancing in its various degrees to ensure that critical TB services are provided to vulnerable populations including miner, ex-miners and their surrounding communities.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area: Project activities are not expected to have long-term or significant impacts, both in terms of public health risks and in terms of its environmental and social footprint, once the mitigation measures are adequately and accurately undertaken.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts. There are no specific alternatives considered by the project, since the activities will mostly be on existing sites and within defined boundaries of provision of healthcare services.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described. Under the parent project, all countries have prepared Environmental and Social Management Frameworks (ESMFs),





which define key issues and mitigation measures required to manage construction related environment and social risks and impacts. The countries have also prepared Infection Control and Waste Management Plans (ICWMPs) which detail occupational safety measures and good practices required for dealing with infectious waste. Since the AF is not financing any new activities, the existing safeguards instruments are deemed to be sufficient. They have been, however, redisclosed in the 2 countries which have the AF -Malawi on April 16 and Lesotho on April 14, 2020 and on Infoshop on April 29, 2020

All participating countries have health programs funded by the World Bank. They are therefore familiar with World Bank Operational Policies and due diligence requirements for environment and social safeguards; But there is need for ongoing capacity building and institutional strengthening measures to improve implementation and monitoring of the ICWM Plans.

In the case of Mozambique, there are several and dispersed sub-projects and there is a need to hire a dedicated PIU environmental safeguard specialist to support the MOH with occupational health and safety and infectious waste management issues. In Lesotho, the same PIU is also involved in the preparation of 2 Bank projects - Lesotho Nutrition and Health System Strengthening Project and the Lesotho COVID 19 Emergency Response Project. Given the expanded role of the PIU, there will be need for additional capacity building at the PIU to oversee implementation and monitoring of E&S issues under the AF.

In Malawi, the PIU has adequate capacity to manage environment and social due diligence for the parent project. However, the same PIU is expected to manage the proposed Malawi COVID-19 Emergency Response and Health Systems Preparedness Project, and therefore there will be need for additional capacity medical waste management and health and safety expertise.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

Primary stakeholders will be the beneficiaries which are TB-affected individuals and households some of whom are vulnerable such as people living with HIV, mining communities, mine workers, ex-mine workers, their families, labor-sending areas, and health workers. Additional stakeholders are Ministries of Health, Labor and Mines of the respective countries, research organizations and private sector mining organizations and selected and strategic public, private and civil society stakeholders.

The ESMFs and the ICWMPs define the mechanism for consultation and disclosure prior to and/or during implementation of project activities. With regard to GRMs, substantial efforts have been made under the Parent Project. However, additional work is needed to develop Grievance Redress Committees as well as other appropriate grievance uptake channels and ensure the GRM is adequately rolled out to the public for it to be fully operational. It will be important that independent GRCs are established, capacity is built among committee members and a program for raising awareness to make sure communities are aware of the GRM and how they can access and make use of it. Through the AF the project will ensure that that the GRM does not only concentrate on the health sector in all 4 countries but makes particular effort to reach out to active miners, ex-miners and others in the mining-related communities.



**B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)**

**Environmental Assessment/Audit/Management Plan/Other**

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
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**"In country" Disclosure**

**C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)**

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**APPROVAL**

Task Team Leader(s):	Humberto Albino Cossa
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**Approved By**

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Country Director:	Claire Kfoury	05-May-2020

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