Addressing TB in the Mines: A Multi-Sector Approach in Practice

Regional Dialogue: Portability of Social Benefits for Mineworkers in Southern Africa

Tom Mogeni, World Bank, 27 March 2015
What do we know about mineworkers?
Mineworkers per Commodity (1000's)

GOLD: 120,000
PGM: 498,634
COAL: 80,000
CHROME: 20,000
MANGANESE: 10,000
OTHER: 10,000
DIAMONDS: 5,000
SAND, CLAY, STONE: 5,000
IRON: 5,000

Source: DMR 2013
Mineworker & Ex-Mineworker System

NEW ENTRANTS

Contractors
Employees

RE-EMPLOYED

Current Mineworkers
Living Ex-Mineworkers

498,384

CONTRACT END
RETRENCHED
RESIGNED

2,000,000

Unemployed
New Industry
Medically Unfit
Retired

Deceased
TB in Sub-Saharan Africa

- TB prevalence rates:
  - Global – 128/100,000
  - Sub-Saharan Africa – 350/100,000
  - South Africa – 948/100,000

- Africa is the only region not on track to achieve the MDG-related TB targets of reducing mortality by 50%.
What do we know about TB in the mines in Southern Africa?

- 498,634 mineworkers
- Estimated 2 million ex-mineworkers in four countries: Lesotho, Mozambique, South Africa and Swaziland
- Incidence rate of 2500 – 3000/per 100,000
  10 times the emergency threshold set by WHO
- Highest incidence of TB in any other working population in the world
- 9.6 million work days lost each year to TB

Source: World Bank Economic Analysis on TB in the mines
What are the Drivers of TB in the Mines?

- **HIV infection**—an HIV infected individual is more likely to develop TB
- **Silicosis** resulting from prolonged exposure to silica dust in mine shafts.
- **Poor access to routine health services**, particularly among contract workers.
- **Accommodation** in overcrowded hostels
- **Circular migration** between communities and mine locations which increases the risk of TB transmission, treatment interruption and treatment failure
Why is TB in the mining sector a complex problem?

Mining is private sector driven and requires industry involvement.

Managing a disease that cuts across borders and requires action and commitment from multiple governments.
What are we doing to get collective action?

- Galvanizing political commitment
- Mobilizing multiple stakeholders
Mobilizing multiple stakeholders

**Countries**
- Lesotho
- Mozambique
- South Africa
- Swaziland
- Other Southern African countries

**Sectors**
- Health
- Minerals/Mining
- Labor
- Finance

**Stakeholders**
- Mining Companies
- Mineworker Unions
- Ex-mineworker Association
- Development partners
- NGOs
- Academic Institutions
- Advocacy groups

Project Implementing Committee
What are we doing? (Sub-regional Initiative)

- Harmonized Treatment Protocols
- Mapping of miners, ex-miners and LSAs
- Establish tracking and referral system
- South-South Knowledge Exchange
- Compensation
- Innovation to improve TB treatment outcome (RBF, mHealth, etc)
- Advocacy and social mobilization
- Economic Impact & Social Welfare Analysis
- Resource mobilization
What are we doing? (Sub-regional Initiative)

Harmonized treatment Protocols
Mapping of mineworkers, ex-mineworkers and their families - First phase already commissioned
What are we doing? (Sub-regional Initiative)

Establish tracking and referral system
What are we doing? (Sub-regional Initiative)

South-South Knowledge Exchange
What are we doing? (Sub-regional Initiative)

Compensation: One Stop Service & streamlining policy framework
What are we doing? (Sub-regional Initiative)

Compensation: one stop service & streamlining policy framework

One Stop Facilities

[Images of one stop facilities, including buildings and equipment]
What are we doing? (Sub-regional Initiative)

- Innovation to improve TB treatment outcome (RBF, mHealth, etc)
- Advocacy and social mobilization
- Economic Impact & Social Welfare Analysis
Global Fund Concept Note Goal and Results

Supporting SADC Declaration of TB in the Mining Sector goal
“Zero new infections, zero stigma and discrimination and zero deaths resulting from TB, HIV and silicosis and other respiratory diseases”

Concept note expected results

(i) Increased number of TB case notification among the targeted key populations.
(ii) Improved treatment success rates among the key populations in the ten countries.
(iii) Increased number of TB patients put on ART during the period on TB treatment.
(iv) Increased access to information and education on TB prevention, care and treatment.
(v) Improved accountability of key institutions addressing TB, silicosis and HIV in the mining
TB in mining sector of Southern Africa: Concept note design

- Identify KAPs and service standards
- Database for referral of TB/HIV cases
- Innovation, learning & evidence

Demonstrate effective regional models to increase access to:
- TB/HIV services
- Occupational health
- Compensation

- Strengthen regional governance
- Improve national policies & legislation
- Remove human rights barriers

Improve national and local accountability through stronger:
- National policies
- Corporate response
- KAP empowerment

Increase TB case finding among key populations
Increase TB treatment completion in key populations
Increase the proportion of key populations with TB that are tested for HIV and enrolled for ART

Reduced burden of HIV/TB in mining communities
<table>
<thead>
<tr>
<th>Module</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: TB care and prevention</td>
<td>TB screening and active case finding</td>
</tr>
<tr>
<td></td>
<td>Improving TB prevention, care and treatment behavior</td>
</tr>
<tr>
<td></td>
<td>Prevention of TB in the Mines</td>
</tr>
<tr>
<td></td>
<td>Expansion of occupational health services delivery</td>
</tr>
<tr>
<td></td>
<td>Strengthening of continuity of TB care and treatment</td>
</tr>
<tr>
<td></td>
<td>Harmonization of the management of TB in the mining sector</td>
</tr>
<tr>
<td>2: Health information systems</td>
<td>Conducting surveys</td>
</tr>
<tr>
<td>and M&amp;E</td>
<td>Monitoring of delivery of TB services in the mining sector</td>
</tr>
<tr>
<td>3: Community systems strengthening</td>
<td>Improved provision of TB services at community level</td>
</tr>
<tr>
<td></td>
<td>Improved access to TB, silicosis and HIV services by the key populations</td>
</tr>
<tr>
<td>4: HSS-Policy and governance</td>
<td>Strengthen and sustain coordination and partnerships</td>
</tr>
<tr>
<td>5: Programme management</td>
<td>Establish and operationalize grant management structures and systems</td>
</tr>
<tr>
<td>Module</td>
<td>Scenario 1</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>1: TB care and prevention</td>
<td>31,498,290</td>
</tr>
<tr>
<td>2: Health information systems and M&amp;E</td>
<td>4,187,797</td>
</tr>
<tr>
<td>3: Community systems strengthening</td>
<td>3,100,000</td>
</tr>
<tr>
<td>4: HSS-Policy and governance</td>
<td>6,801,310</td>
</tr>
<tr>
<td>5: Programme management</td>
<td>14,500,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60,087,397</strong></td>
</tr>
</tbody>
</table>
Oversight and Implementation

Regional Coordination Mechanism – Oversight of the grant
Wits Health Consortium – Principal Recipient
Sub-recipients – to be selected to implement the grant across countries

Implementation partners, systems and processes
• Ministries of Health
• Ministries of Mining
• Ministries of Labor
• Mining companies
• Key affected populations – mineworker associations; labour unions etc
• Civil society – service delivery and advocacy

Partnerships
• Development partners
• Other government initiatives

SADC - Policy and governance
• Political and policy level support/commitment
• Mobilizing inter-ministerial coordination through SADC structures
• Linking RCM to SADC governance structure for overall oversight, ownership and support
• Collaboration:
  – Comparative advantage based on sector expertise
  – Work towards a shared vision
  – Mobilize resources: government, private sector, GF up to $60m, World Bank up to $100m, DFiD $3.5M
Thank You