



East, Central & Southern Africa Health Community

Strategic Framework for Cross-Border and Regional Programming in Tuberculosis (TB) Prevention and Control for East, Central and Southern Africa Health Community (ECSA-HC) Region



TB CARE I

Table of contents

Table of contents	ii
List of Tables	iii
Acronyms and Abbreviations.....	iv
Acknowledgements.....	vi
Executive Summary.....	viii
CHAPTER 1.0: INTRODUCTION	1
1.1. Background	1
1.2. Health risks associated with cross-border population movements	1
1.3. National and Regional Responses to cross-border TB threat	2
1.4. ECSA-HC Strengths, Weaknesses, Opportunities and Threats for a regional cross-border TB control program	3
1.5. Relevance of a regional strategic framework for cross-border and regional programming in TB prevention and control	4
CHAPTER 2.0: VISION, MISSION AND VALUES.....	6
2.1. Vision.....	6
2.2. Mission.....	6
2.3. Values.....	6
2.4. Policy and regulatory environment for cross-border TB control.....	6
2.5. Guiding principles for this framework	7
CHAPTER 3.0: PRIORITY ACTIVITIES, CONSIDERATIONS AND JUSTIFICATION FOR A REGIONAL STRATEGIC FRAMEWORK	8
3.1. Priority Cross-border TB control activities in the region	8
3.2. Considerations and justification for a strategic framework for cross-border and regional TB programming	10
CHAPTER 4.0: GOAL, OBJECTIVES AND STRATEGIES	12

4.1 Overall goal	12
4.2. Specific objectives	12
4.3. Broad strategies	12
CHAPTER 5.0: IMPLEMENTATION FRAMEWORK.....	19
5.1. ECSA-HC Secretariat.....	19
5.2. TB Program Expert Committee	19
5.3. National TB Programs	19
CHAPTER 6.0: MONITORING AND EVALUATION FRAMEWORK.....	20
CHAPTER 7.0: PARTNERSHIPS AND COLLABORATION	23
7.1 ECSA-HC Secretariat.....	23
7.2 Regional intergovernmental organizations.....	23
7.3 Regional and international technical agencies	23
7.4.1 Development partners.....	23
7.5 National TB Programs (NTPs).....	24
References.....	25

List of Tables

Table 1: Status of Global TB Control targets in ECSA member states (Data source: Global TB Report 2013)	8
Table 2: TB control indicators in ECSA-HC and neighboring countries (Source: Global TB Report 2013)	9
Table 3: Regional cross-border TB control monitoring and evaluation framework .	20

Acronyms and Abbreviations

COMESA	Common Market for Eastern and Southern Africa
CSO	Civil Society Organization
DTLC	District Leprosy and TB Coordinator
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment Short Course
DRS	Drug Resistance Survey
DST	Drug Susceptibility Testing
EAC	East African Community
ECSA	East, Central and Southern Africa
ECSA-HC	East, Central and Southern Africa Health Community (Kenya, Lesotho, Malawi, Mauritius, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe)
GFTAM	Global Fund for Tuberculosis, AIDS and Malaria
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IGAD	Intergovernmental Authority on Development
IOM	International Organization for Migration
MDGs	Millennium Development Goals
MDR-TB	Multi-Drug Resistant TB
Migrants	(synonym – “mobile populations” and “cross-border Populations”): Persons moving to another country or region to better their material or social conditions and improve the prospects for themselves or their families
NGO	Non-Governmental Organization
NTP	National TB Program
OOP	Out of pocket
PLWHA	Persons Living with HIV/AIDS
PMDT	Programmatic Management of Drug resistant TB
RCQHC	Regional Center for Quality of Health Care
SADC	Southern African Development Community
STOP TB Strategy	A Global strategy for the control of TB
TB	Tuberculosis
THE	Total Health Expenditure
UN	United Nations

UNHCR: United Nations High Commission of Refugees
USAID-EA: United States Agency for International Development (East Africa)
WHO: World Health Organization
XDR-TB: Extensively Drug-resistant TB

Acknowledgements

The Family Health & Infectious Diseases Program wishes to sincerely express its gratitude to the Principal Secretaries of the Ministries of Health (MoH) of the ECSA Member States, for granting approval to ECSA-HC to liaise with the NTPS to develop this strategy

Special gratitude goes to all the TB experts for their valuable input to the draft strategy during the TB Experts Committee Meeting. They provided valuable input.

This work would not have been possible without the special effort of the consultant, Dr. Peter Kimuu. We are grateful for his dedication and commitment.

Finally, ECSA-HC acknowledges the valuable contributions from its collaborating Partners, the World Health Organization, KNCV Tuberculosis Foundation through the United States Agency for International Development (USAID) funded TB CARE I project for providing both technical and financial support that made it possible for the strategy to be developed.

A handwritten signature in black ink, appearing to read 'Stephen Muleshe', with a date '1/11' written below it.

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The Global Health Bureau, Office of Health, Infectious Disease and Nutrition (HIDN), US Agency for International Development, financially supports this publication through TB CARE I under the terms of Agreement No. AID-OAA-A-10-00020. This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of TB CARE I and do not necessarily reflect the views of USAID or the United States Government.

Foreword

The ECSA region is not unique when it comes to issues of TB across the borders. Cross Border TB programming has been a topic of discussion for a long time now. Regional TB programming, in practical terms, has not been a priority and has attracted less regional attention. However, there is need for a regional approach to address certain components of TB control that in an era of economic development, free trade and with the advent of MDR-TB can never be achieved solely by a good country program. There have been some regional initiatives to fight TB in Eastern and other parts of Africa, but no one organization can bring about the desired regional impact in TB control, organizations must work together.

Until recently TB programming has been country specific and it has been up to National TB Programs (NTPs) to address TB within the boundary of their individual country. But infectious diseases like TB do not respect boundaries and cross border movement has significantly increased following economic growth, trade linkages and business opportunities in the region of East Africa and Africa in general. It follows that TB patients and infected individuals are also travelling across the boundaries of the individual countries so TB is finding new avenues to infect and grow. There is need therefore to relook at TB programming in a broader context and beyond the borders. There are various facets of TB control that have to be taken into consideration within a regional approach to complement the national programs, link program and diagnostics and influence regional intergovernmental/technical/other establishments to bring about desired policies to address the issues of TB patients. The 34th and 58th ECSA-HC Health Ministers' Conferences noted with concern the risk of cross border spread of diseases and the vulnerability of the ECSA region, it directed ECSA-HC to "*explore the possibility of developing a regional strategy on cross border prevention and control of infectious diseases*".

In view of the above and as part of ECSA's mandate, the Family Health & Infectious Diseases Program has developed this strategy on Cross Border & Regional Programming in TB prevention and control for the ECSA region. This strategy will provide policy guidance for ECSA Member States to mitigate the impact of Cross border TB.



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Director General

Executive Summary

Tuberculosis (TB) remains a major public health problem in Sub-Saharan Africa with nine of the 22 high burden countries, namely the Democratic Republic of Congo, Ethiopia, Kenya, Mozambique, Nigeria, South Africa, Uganda, Tanzania and Zimbabwe being in the region. Four of these countries are East, Central and Southern Africa - Health Community (ECSA-HC) member states.

As an airborne disease, the transmission and spread of TB does not respect international borders, meaning that the movements of people across national borders pose real risks that lead to the increased transmission and spread of the disease. The link between increased cross-border movements and the spread of TB is well documented. Poor working conditions, social exclusion and poverty, and limitations to accessing health services among other things, are some of the key risk factors associated with the migration process that render mobile populations more vulnerable to the risks of ill health and disease in general, and communicable diseases such as TB in particular.

Cross-border movements within, as well as to and from the East and Horn of Africa region are a common occurrence. The major regional economic blocs comprised of the Common Market for Eastern and Southern Africa (COMESA), the Southern African Development Community (SADC), the East African Community (EAC) and the Intergovernmental Authority on Development (IGAD) with legally binding protocols that include free trade and the movement of people across international borders, are expanding rapidly. Further to the legal cross-border movements for trading purposes, both legal and illegal migration associated with economic uncertainties and political conflicts is ongoing.

Cross-border population movement is therefore a major social determinant of health associated with the transmission of TB, including multi-drug resistant TB (MDR-TB) and extensively drug resistant TB (XDR-TB) in the ECSA-HC region.

The risk mitigation measures available in the region are largely inadequate and individual member states are ill-prepared to handle disease control issues beyond national borders in all aspects of policy, legal environments and health service delivery systems. A clear strategy and institutional framework for cross-border and regional programming in TB control in the region is lacking.

This strategic framework forms the foundation for a regional program in support of cross-border TB control.

Chapter 1 of the framework provides background information on ECSA-HC, describes the health risks associated with cross-border population movements and reviews the status of the current National and Regional Responses to cross-border TB threat. The chapter also examines ECSA-HC Strengths, Weaknesses, Opportunities and Threats for a regional cross-border TB control program and provides a justification for a regional program.

Chapter 2 identifies the vision, mission and values in the context of a regional cross-border TB control program in contribution to the wider ECSA-HC mandate. The chapter also provides an analysis of policy and regulatory environment for cross-border TB control and outlines some of guiding principles for this framework.

Chapter 3 provides information on the current status of cross-border and regional programming in TB control and highlights on the key challenges and gaps which include inadequate policy and regulatory environment, lack of a coordinated regional approach, low funding for NTPs, non-inclusive TB information and surveillance data, limitations to accessing quality and affordable TB diagnosis and treatment and weak cross-country patient transfer and referral systems.

Chapter 4 covers the goals, objectives and strategies, and clearly identifies time-bound expected results of the regional program.

Chapter 5 is an outline of the implementation framework and assigns functions to identified implementing parties.

Chapter 6 is a results framework that forms the basis of program monitoring and evaluation. The framework defines indicators, baseline and targets for each of the five program result areas.

Chapter 7 provides an outline of a partnership structure required for the program.

The operationalization of this strategy will effectively address the general health needs, and TB care services in particular for mobile populations in the region.

CHAPTER 1.0: INTRODUCTION

1.1. Background

The East, Central and Southern Africa Health Community (ECSA-HC) is a regional intergovernmental health organization that was set up in 1974 to foster cooperation that will lead to the strengthening of health care programs in the region, and promote attainment of the highest possible standards of health among member states. In recognition of the similarities in disease burden, and the potential for joint action on common health challenges in the region, the ECSA-HC works both in member states as well as extending its reach to other countries in terms of the implementation of activities.

Membership to the ECSA-HC is open to all countries in the East, Central and Southern African region. The current Member States are Lesotho, Kenya, Malawi, Mauritius, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

Programs and activities of the community are coordinated by the ECSA-HC Secretariat whose operations are administratively overseen by an Advisory committee that comprises of Permanent Secretaries of the Ministries of Health of Member states. The mandate of the Secretariat is derived from the ECSA-HC Conference of Health Ministers, which is the top governing body responsible for policy guidance, regional health strategies and priorities.

1.2. Health risks associated with cross-border population movements

Movement of persons across international borders has increased over time. With globalization, ever-growing international trade, political conflict situations and climate change, the magnitude of such movements continues to increase. Recent data from the International Organization for Migration estimates that there are approximately 214 million international migrants worldwide. However, this figure is an underestimation of the actual magnitude of cross-border movements since it leaves out irregular (illegal) as well as casual cross-border migration.

The factors that pull and push populations out of countries are a common feature in ECSA-HC member states. Huge populations, mainly from Mozambique, Swaziland and Lesotho have migrated to South Africa in search of job opportunities in the mining industry where migrants account for 34%

of miners. In addition, nationals from other member states also migrate to South Africa in search of employment and education opportunities.

On the other hand, massive cross-border movements involving member states in the Horn of Africa are attributed to the huge number of asylum seekers and refugees moving out from countries in political turmoil and conflicts, as well as spontaneous returns of such populations and resettlements. According to the UNHCR Somalia generated the third highest number of refugees in the world. In May 2013, there were 1,023,722 Somali refugees in the region (mainly in Kenya, Ethiopia, Djibouti, Tanzania and Uganda). Further movements of such refugee populations are through large scale resettlement programs implemented by the International Organization for Migration (IOM). In such programs, many refugees end up in destinations both inside and outside the region.

Casual and unofficial cross-border movement of communities living along national borders in search of services and other social events, including health services, are also common.

Among pastoralist communities, cross-border movements have also been attributed to drought and climate change, and its effects on livelihoods. In an assessment carried out in July 2011, IOM Kenya reported this to be a common practice with most pastoralists expressing their wish to be allowed to move into the neighboring countries during future droughts.

Poor working conditions, social exclusion, poverty and limitations to accessing health services, are some of the key risk factors associated with the migration process that render mobile populations more vulnerable to risks of ill health and disease in general, and communicable diseases such as TB including multi-drug resistant TB (MDR-TB) and extensively drug resistant TB (XDR) in particular. Migration is therefore among the major social determinants of health associated with the transmission of TB in the ECSA-HC region.

1.3. National and Regional Responses to cross-border TB threat

Despite migration posing a real threat to the control of TB in the region, the risk mitigation measures are largely inadequate. Individual member states are ill-prepared to handle disease control issues beyond their national borders in all aspects of policy, legal environments and health service

delivery systems. Regionally, a clear strategy and institutional framework for cross-border and regional programming in TB control is lacking.

1.4. ECSA-HC Strengths, Weaknesses, Opportunities and Threats for a regional cross-border TB control program

Strengths and Weaknesses: As an intergovernmental health organization, ECSA-HC is in a unique position and has a comparative advantage to other regional health Communities in convening, facilitation and coordination of disease control programs for mobile populations crossing national borders in the region. The regional TB experts' committee provides a perfect platform for accessing the national TB programs activities and influencing regional cross border interventions.

As a leader in health, ECSA-HC is contributing towards the attainment of the highest standard of physical, mental and social well-being of the people in the region. The organization recognizes health as a fundamental human right and its mission is to promote "the highest standards of health for the individuals, families and communities through advocacy, capacity building, brokerage, coordination, inter-sectoral collaboration and harmonization of health policies and programs."

The vision and mission are actualized by implementing successive medium term strategies and plans, the current being the Organization's Strategic Plan 2013 – 2018 and the closely linked HIV/AIDS, TB and Other Infectious Diseases Strategic Plan 2013 – 2018. However, the strategies outlined in the two plans do not cover cross-border and regional TB control programming.

Opportunities and Threats: The region is home to other intergovernmental organizations that focus mainly on regional trade and development; namely the Common Market for Eastern and Southern Africa (COMESA), the East African Community (EAC), the Intergovernmental Authority on Development (IGAD) and the Southern African Development Community (SADC). The presence of these organizations bring opportunities for coordinated responses and resource mobilization for an ECSA-HC led inter-organizational regional TB control response. The current advances in information and communication technologies (ICT), including mobile phone technology, are useful for facilitating any future inter-country programs.

However, the weak regional economies, inadequate regional integration and persistent potential for political conflicts pose threats to long term regional programming for TB control.

1.5. Relevance of a regional strategic framework for cross-border and regional programming in TB prevention and control

TB is an airborne infectious disease that infects almost one-third of the world's population; and commonly manifests as an infection of the lungs, usually with symptoms of coughing, weight loss and other constitutional symptoms. The economic impact attributable to the disease is high owing to the size of the problem and the fact that, in the poorest countries, the majority of those affected are economically active.

As an airborne disease, TB does not respect international borders, and the movements of people across such national borders pose risks that lead to its spread. The association between increased cross-border movements and the spread of TB is well documented.

With the monumental growth in both regional and international trade since 1990's, as well as existence of conflict situations that have triggered displacement of persons, masses of people are crossing international borders each day. The World Health Organization (WHO) estimates that global trade has increased six-fold, and the number of people travelling by air has increased seventeen-fold since 1990. Today, more than two million people are crossing international borders each day and in nearly all such movements, travel times are shorter than the incubation periods of many communicable diseases.

In addition, unrestricted and undocumented movement among communities living along national borders in search of socio-economic opportunities and social services is a common practice.

Cross-border movements within, as well as to and from the ECSA-HC region are common. A rapid expansion of major regional economic blocs (COMESA, SADC, EAC and IGAD) that have legally binding protocols that include free trade and the movement of people across international borders, has been witnessed. Besides this legal migration, both legal and illegal migration associated with economic uncertainties and political conflicts is also common in the region.

This strategic framework enables the ECSA-HC to facilitate and coordinate the implementation of a regional response in support of TB control efforts. This approach will ensure comprehensive support to member states, effective engagement of stakeholders including non-member states and the coordination of regional efforts to reduce the risk of TB exposure, infection and disease associated with population movements across international borders.

CHAPTER 2.0: VISION, MISSION AND VALUES

The strategy fits well within the overall mandate, structure and vision of ECSA-HC as an organization. However, this strategy proposes a specific vision, mission and values that will contribute to the broader vision and mission of the organization.

2.1. Vision

A TB-Free Region

2.2. Mission

To facilitate and coordinate the implementation of a cross-border TB control program for the ECSA-HC region.

2.3. Values

In the operationalization of this strategic framework, the ECSA-HC will be driven by the following values:

1. Need for leadership: assume leadership position in regional health interventions.
2. Equality: promote the equal treatment of mobile persons and host country nationals.
3. Recognition of non-discriminatory practices: discourage discriminatory practices in access to health care on the basis of nationality in host countries
4. Strong partnership: enhanced collaboration with member states and other stakeholders.

2.4. Policy and regulatory environment for cross-border TB control

There is no specific policy or regulatory framework for cross-border TB control in the region. However, national laws (migration, labour and public security) and health policies and regulations in member states are applicable in member states. From time to time, and in special circumstances, the WHO and other United Nations (UN) agencies have issued technical guidelines including guidance in form of treaties and resolutions that have been used either as standalone guidelines or incorporated into national laws, policies and manuals.

While the treaties establishing the major regional trade blocs (SADC, EAC, COMESA and IGAD) promote the free movement of people across

international borders for purpose of trade, they are largely silent on cross-border TB control.

2.5. Guiding principles for this framework

As established, ECSA-HC has a technical advisory mandate on health matters for member states. This mandate is discharged through binding resolutions that are passed at various intervals, as well as the coordination of regional initiatives, programs and projects, and direct technical support to member states.

This unique strategic framework has isolated TB control issues and challenges that are beyond the country-specific NTPs and require a regional approach to coordination and implementation.

To effectively implement this strategy, ECSA-HC endeavors to rally support and collaboration from the member states.

CHAPTER 3.0: PRIORITY ACTIVITIES, CONSIDERATIONS AND JUSTIFICATION FOR A REGIONAL STRATEGIC FRAMEWORK

3.1. Priority Cross-border TB control activities in the region

Remarkable progress towards the elimination of TB has been made globally. According to WHO, the Millennium Development Goal (MDG 6) target to halt and start reversing TB epidemic by 2015 has already been achieved as demonstrated by the falling number of new cases notified (falling 2% between 2010 and 2011) and the reduced TB death rate now at 45% of the 1990 rate. This trend has been observed across all the six WHO regions as well as in most of the twenty two high burden countries (countries that account for more than 80% of the global incident TB cases).

NTPs within ECSA member states have recorded impressive achievements in in-country TB control efforts. The Global TB Report 2013 shows that three member states (Tanzania, Kenya and Malawi) have already achieved the global 70% case detection rate and 85% treatment success rate targets for TB control. Lesotho has achieved the 70% target for case detection rate but not the 85% target for treatment success rate, Mauritius and Zambia have achieved the 85% target for treatment success rate but not the target for case detection rate and Swaziland, Uganda and Zimbabwe are yet to achieve either of the targets (Table 1).

Table 1: Status of Global TB Control targets in ECSA member states (Data source: Global TB Report 2013)

Source : WHO data		85% Treatment Success Rate (2011)	
		Reached	Not Reached
70% Case Detection Rate (2012)	Reached	Kenya ^{hbc*} Malawi Tanzania ^{hbc}	Lesotho Angola Botswana
	Not Reached	Mauritius Zambia Ethiopia ^{hbc} Mozambique ^{hbc} DRC Congo ^{hbc}	Swaziland Uganda ^{hbc} Zimbabwe ^{hbc} South Africa ^{hbc} Namibia

*hbc = high burden country

Table 2 below further summarizes other program performance indicators in ECSA member states as well as other countries in Sub-Saharan Africa.

The monumental increase in case notification rates between 1992 – 2012 shows that an increasing number of people have benefitted from TB treatment in the region.

Table 2: TB control indicators in ECSA-HC and neighboring countries (Source: Global TB Report 2013)

	Member State	CNR 2012 and 1992* (All forms) per 100000	TB/HIV Co-infection 2012 (%)	CDR (new and relapses) 2012 (%)	TSR (new ssm+) 2011 cohort (%)	CR (new ssm+) 2011 cohort (%)	MDR-TB rate (new cases 2012) (%)
1	Kenya ^{hbc}	215 (50)	39	79	88	83	0.9 ¹⁹⁹⁵
2	Lesotho	525 (158)	75	83	73	63	0.9 ¹⁹⁹⁵
3	Malawi	128 (131)	59	78	85	81	0.42 ²⁰¹¹
4	Mauritius	10 (11)	8	49	90	90	0 ²⁰¹²
5	Swaziland	582 (213 ¹⁹⁹⁵)	77	43	73	48	7.7 ²⁰⁰⁹
6	Tanzania ^{hbc}	130 (87)	39	79	88	80	1.1 ²⁰⁰⁷
7	Uganda ^{hbc}	123 (84)	50	69	77	39	1.4 ²⁰¹¹
8	Zambia	289 (215)	54	68	88	82	0.33 ²⁰⁰⁸
9	Zimbabwe ^{hbc}	261 (87)	70	46	81	73	1.9 ¹⁹⁹⁵
i	Botswana	307 (212)	63	75	81	36	2.5 ²⁰⁰⁸
ii	Ethiopia ^{hbc}	158 (184)	10	64	87	82	1.6 ²⁰⁰⁵
iii	South Africa ^{hbc}	618 (219)	65	62	79	74	1.8 ²⁰⁰²
iv	South Sudan	ND	12	ND	ND	ND	ND
v	Mozambique ^{hbc}	189 (117)	58	34	85 ²⁰¹⁰	83	3.5 ²⁰⁰⁷
vi	DRC Congo ^{hbc}	166 (61)	16	51	87	82	2.5 ²⁰⁰⁶
vii	Namibia	443 (189)	47	68	84	74	3.8 ²⁰⁰⁸
viii	Angola	249 (99)	9.6	79	55	36	1.4 ²⁰⁰²

CNR = Case notification rate TSR = Treatment Success rate CR = Cure Rate MDR-TB = Multi-Drug Resistant-TB
 1992* - value in brackets

In May 2014, the World Health Assembly adopted WHO's - 2015 Global TB Strategy, which aims to reduce global TB incidence by 90% before 2035. This strategy calls for TB control in the context of movement towards Universal Health Coverage (UHC). For low incidence countries with less than 100 cases per 1,000,000 persons, elimination of TB (less than one case per 1,000,000 per year) is now feasible by 2050 (WHO: Towards TB elimination July 2014).

3.2. Considerations and justification for a strategic framework for cross-border and regional TB programming

TB remains a major public health problem in Sub-Saharan Africa. According to the 2013 Global TB Report nine of the high burden countries, namely the Democratic Republic of Congo, Ethiopia, Kenya, Mozambique, Nigeria, South Africa, Uganda, Tanzania and Zimbabwe are in Sub-Sahara Africa, four of which are ECSA-HC member states.

The magnitude of cross-border population movements within ECSA-HC member states, and the inflows and outflows into and from the region continues to increase in the face of the growing globalization, international trade, climate change and persistent political conflicts. This is occurring against a background of the uncontrolled dual epidemic of TB and HIV in nearly all ECSA-HC member states, and Sub-Saharan Africa in general.

The available epidemiological data identifies mobile persons as population sub-groups with TB burden higher than the general population. The fact that the population is hard to reach and treat due to their diverse and highly mobile nature, further complicates the situation by increasing the likeliness of treatment default and TB transmission. With Universal Health Coverage being largely non-existent in the region, inadequate TB treatment characterized by inconsistent, partial and low quality treatment is common. The ultimate consequence is the development and transmission of drug resistant TB, including MDR-TB and XDR-TB that are more difficult and expensive to treat.

Although the WHO, through its resolution WHA 61.17 of May 2008 called on member states to put interventions in place that address the health of migrants as a "matter of public health importance", a situational analysis of cross-border and regional programming in TB control in the region has shown that interventions that specifically and comprehensively target cross-

border mobile populations as vulnerable population sub-groups have not been enacted. However, significant assistance for refugees and asylum seekers is visible (although driven mainly by international humanitarian organizations).

The main challenges associated with TB control in mobile populations in the ECSA-HC region include inadequate policy and regulatory environment, lack of a coordinated regional approach, low funding for NTPs, non-inclusive TB information and surveillance data, limitations to accessing quality and affordable TB diagnosis and treatment and weak cross-country patient transfer and referral systems. This situation has a potential to reverse the gains made in TB control in the region.

CHAPTER 4.0: GOAL, OBJECTIVES AND STRATEGIES

4.1 Overall goal

The overall goal of this strategy is to reduce the burden of TB in mobile populations and other vulnerable groups.

4.2. Specific objectives

Specifically, the strategy aims:

1. To improve equity in access to TB prevention, control and care services in the ECSA-HC region irrespective of migration and financial status.
2. To promote bilateral and multilateral cooperation in TB control for mobile populations across international borders in the region.
3. To promote cross-country collaboration and coordination for improved TB control across national borders.
4. To improve TB treatment outcomes for mobile populations to match local population in member states.
5. To effectively monitor and evaluate the burden of TB among mobile populations.

4.3. Broad strategies

To realize the five objectives stated above, this strategic framework outlines the following broad strategies:

Objective 1: To improve equity in access to TB care services in the region irrespective of migration and financial status.

Strategy 1.1: Promotion of social health protection for TB

TB is a chronic infectious airborne disease whose social benefits of treatment far exceed other benefits. In the interest of public health, nearly all member states are providing free TB care services for their populations within the limitations of available resources. This effectively eliminates the financial barriers to accessing TB care services and guarantees opportunities for early TB diagnosis and effective treatment. However, there are no explicit policies on extending such free TB care services to mobile populations in host countries.

Expected results 1.1

1. Health Ministers pass a resolution on increased budgetary allocation for TB control targeting budget lines for TB medicines, laboratory reagents and program technical support by 2017 and therefore facilitate the provision of free TB services to migrants and other mobile populations.
2. Revised TB control policies on free access to TB care services for all, including mobile cross-border populations by 2017.

Strategy 1.2: Elimination of discriminatory practices in accessing and the utilization of TB care services by mobile populations.

TB control policies in nearly all member states do not cover non-nationals. However, this vulnerable population sub-group requires the same access to TB care services in destination countries as the local population. Migration laws, regulations and treaties among and between member states that facilitate unhindered access to TB care services for mobile populations are required.

Expected results 1.2

1. Rapid assessment and harmonization of legal and regulatory environments for TB care services in member states carried out by mid-2017.
2. Regional standards for TB control related migrant-friendly policies, laws and regulations prepared by mid-2017.

Objective 2: To promote bilateral and multilateral cooperation for TB control for cross-border populations among member states.

Strategy 2.1: Enhanced networking and multi-country partnerships for cross-border TB control

Population movements across national borders are increasingly becoming circular with people moving between host and destination countries and back again. For populations that have been pushed out of their countries as a result of political conflicts, resettlement programs are increasingly becoming common. This situation calls for a harmonized approach to TB control issues among member states involved in the migratory process.

Expected results 2.1

1. Annual joint TB prevention and control programs meetings for regional organizations (ECSA-HC, EAC, COMESA, IGAD and SADC)
2. Half yearly joint TB prevention and control meetings for regional and international technical and donor agencies (ECSA-HC, USAID, WHO, IOM, CDC, KNCV, UNHCR, WFP, UNICEF etc.)

Strategy 2.2: Mobilize resources for regional cross-border TB control efforts.

Regionally coordinated TB control activities targeting mobile populations crossing international borders are largely beyond the scope of country-specific NTPs. Implementation of such activities will contribute to improved TB treatment outcomes for mobile populations and improved country-specific NTP performance in general.

Expected results 2.2

1. Resource mobilization strategy for cross-border and regional programming in TB control March 2017.
2. Costed three-year regional plan by mid-2017 based on the strategic framework.
2. At least one donor commitment by end of 2017.

Objective 3: To promote cross-country collaboration and coordination for improved TB control across national borders.

Strategy 3.1: Establishment of multi-sectoral cross-border committees and forums in border areas.

Currently, the provision of TB care services is guided by country-specific policies, laws and regulations. This operating environment may occasionally hinder free access to services, including follow-up visits, contact and defaulter tracing across national borders.

Expected results 3.1

1. Member states have focal points for cross-border TB at NTPs by March 2017.

2. A functional multi-sectoral cross-border TB control committee for TB control zones along national borders; incorporating TB officers, port health officers, immigration and labor officers by end of 2015.
3. Health (TB) infrastructure mapping for border areas completed by end of 2017.

Strategy 3.2: Promote dialogue on cross-border TB control among member states in the region.

With the exception of the refugee populations, member states were found not to have specific policies to address TB control among mobile populations as vulnerable population sub-groups. As a result, cross-border TB control initiatives and issues remain largely invisible both at country and regional levels.

Expected results 3.2

1. Biannual cross-border program meetings for border areas by end of 2016.
2. Biannual regional newsletter on TB control among mobile populations with effect from June 2017.
3. Annual regional cross-border TB control information and experience sharing forums with effect from June 2017

Objective 4: To improve TB treatment outcomes for mobile populations to match the local population in member states.

Strategy 4.1: Harmonization of standards in TB case detection and case holding among member states.

TB care services that are sensitive to the needs of mobile populations call for harmonization of standards and guidelines for TB control both in and outside member states. This will facilitate the continuity of care whenever populations move between origin and host countries.

Expected results 4.1

1. Priority TB control standards, guidelines, protocols and tools are identified for harmonization by March 2017.
2. Harmonized standards, guidelines, protocols and tools prepared and adopted by mid-2017.

3. Capacity building for harmonized standards, guidelines, protocols and tools completed by end-2017.

Strategy 4.2: Standardization of TB program management practices among member states.

Sub-national NTPs management practices vary between member states as dictated by adequacy of funding as well as program management competencies among middle level managers. The managers are recruited from the ranks of health professionals, mainly nurses and medical assistants.

Expected results 4.2

1. Standard competency based training course for middle level TB program managers developed by end 2017.
2. Training program for middle level program managers implemented with effect from January 2017.

Strategy 4.3: Strengthening TB treatment defaulter and contact (including MDR-TB contacts) tracing across national borders.

TB patient records for non-local populations are largely incomplete and treatment outcomes distinctively expressed as “transfer out” and “lost to follow up” is common. Such adverse treatment outcomes are associated with increased risk of spread of TB.

Expected results 4.3

1. Guidelines for cross-border TB defaulter and contact tracing developed by mid 2017.
2. TB defaulter and contacts register for mobile populations developed by mid- 2017.

Strategy 4.4: Implementation of an effective patient referral and transfer system across member states and other destinations¹.

An effective patient referral and transfer mechanism is vital in guaranteeing the continuity of care between the countries of origin and destination. Such

¹ Annex 1: ECSA-HC Inter-country TB and MDR-TB Patient Transfer and Referral system

a mechanism enhances the monitoring of treatment for the mobile patients, and therefore contributes to the successful completion of treatment.

Expected results 4.4

1. ECSA-HC Secretariat focal point for coordination of inter-country patient transfer established by March 2017.
2. Intercountry TB referral and transfer guideline developed and adopted by March 2015.
3. Capacity building for inter-country TB referral and transfer tools completed by mid- 2017.
4. Implementation of the regional inter-country referral and transfer system as from January 2017.

Objective 5: To effectively monitor and evaluate the burden of TB among mobile populations.

Strategy 5.1: Strengthening of TB information and surveillance systems to include migrant populations.

TB information and surveillance systems in member states do not routinely capture parameters and other related data on migration status. Consequently, NTPs do not have systematically collected data and information to inform the design and implementation of specific programs and activities for this vulnerable population sub-group.

Expected results 5.1

1. TB information and surveillance system tools revised to capture data on migration status by mid-2017.
2. Capacity building for revised tools finalized by the end of 2017.

Strategy 5.2: Promoting disaggregated TB treatment cohort reports and surveys to reflect the statuses of migrant populations.

The standard TB treatment cohort reports and epidemiological surveys are not disaggregated by migration status.

Expected results 5.2

1. TB case finding and cohort reporting formats for mobile populations available by March 2017.
2. TB case finding and treatment outcome reports for mobile populations available in member states by mid-2017.

CHAPTER 5.0: IMPLEMENTATION FRAMEWORK

Implementation of priority actions in this framework has the potential to positively impact the health of mobile populations as well as public health in general with regard to TB. The leadership of the ECSA-HC in the implementation of this regional strategy will be through the ECSA-HC Secretariat, Regional TB Program Expert Committee and NTPs of member states.

5.1. ECSA-HC Secretariat

The HIV/AIDS, TB and Other Infectious Diseases Unit of the Secretariat shall be responsible for the overall implementation of this regional strategy. A dedicated focal point for Cross-border TB control in the Unit will provide the technical leadership required for the regional TB program.

The Unit will prepare a resource mobilization strategy for the program, as well as annual work plans to be approved within the ECSA-HC systems.

The Unit will coordinate the implementation of the regional program, including monitoring and evaluation.

5.2. TB Program Expert Committee

The committee is comprised of NTP managers from member states and TB technical experts from local and international agencies.

The committee will be useful in consensus building for the technical aspects of the regional program.

5.3. National TB Programs

As major secondary beneficiaries of the regional program, the NTPs will be involved throughout the program implementation cycle.

CHAPTER 6.0: MONITORING AND EVALUATION FRAMEWORK

This regional strategy to be implemented by the ECSA-HC Secretariat with a focus on five key result areas will address the regional TB prevention and control challenges associated with the movements of populations across international borders. These challenges are largely beyond the mandate of country-specific NTPs. Besides the overall program monitoring at outcome level, this monitoring and evaluation framework targets processes and outputs that contribute to the overall goal of the regional strategy. The details on expected results, indicator, indicator definition and targets are shown in Table 3 below.

Table 3: Regional cross-border TB control monitoring and evaluation framework

Key Result Area	Indicator	Indicator definition	Baseline	Target 2017	Target 2018	Target 2020
Result area 1: Timely access to diagnosis and treatment for mobile populations						
Social health protection for TB	Member states providing "free" TB care services for all including mobile populations	Numerator: No. member states providing free TB care services Denominator: Total No. member states	TBD	50%	70%	100%
Non-discriminatory TB control policies, laws and regulations	Member states reporting non-discrimination based on migration status	Numerator: No. member states with non-discriminatory practices Denominator: Total No. member states	TBD	50%	90%	100%
Result area 2: Regional cooperation for cross-border TB control						
Establish Networking and multi-country partnerships	No. regional joint meetings	Joint meetings for regional	0	2 annually	4 annually	

Key Result Area	Indicator	Indicator definition	Baseline	Target 2017	Target 2018	Target 2020
		technical and trade organizations				
Develop a comprehensive Resource mobilization strategy	Costed three year plan based on the strategic framework	Costed plan	0	1	1	1
Result area 3: Collaboration and coordination						
Establish Cross-border committees	Member states with functional cross-border committees	Numerator: No. member states with functional cross-border committees Denominator: Total No. member states	0	50%	180%	100%
Establish Information sharing forums	No. regional information sharing forums	Annual forum	0	1	1	
Result area 4: Quality TB care services for mobile populations						
Harmonized standards for TB diagnosis and treatment	Member states adopted regional harmonized standards	Numerator: No. member states adopted harmonized standards Denominator: Total No. member states	0	50%	80%	100%
Standardized program management practices	Middle level program managers (border areas) benefitted from regional course	Numerator: No. middle level program managers trained Denominator: Total middle level program managers (border	0	25%	50%	100%

Key Result Area	Indicator	Indicator definition	Baseline	Target 2017	Target 2018	Target 2020
		areas)				
TB contact and defaulter tracing	Contacts and defaulters traced	Numerator: Contacts and defaulters traced	ND	50%	80%	100%
Establish Patient cross border referral and transfer system	TB patients transferred in conformity with standard procedure	Numerator: TB patients transferred in conformity with standard procedure Denominator: Total TB patients transferred out	ND	50%	80%	100%
Result area 5: Monitoring and evaluation						
Establish a TB information and surveillance system	Member states adopting revised data capture tools	Numerator: No. member states using revised data capture tools Denominator: Total No. member states	0	50%	80%	100%
Treatment outcome and survey reporting	Member states with TB reports disaggregated by migration status	Numerator: No. member states with disaggregated reports Denominator: Total No. member states	0	40%	80%	100%

CHAPTER 7.0: PARTNERSHIPS AND COLLABORATION

The implementation of this strategy will involve different partners to be identified through a structured stakeholder analysis process and include ECSA-HC Secretariat, regional intergovernmental organizations (SADC, EAC, IGAD and COMESA), regional technical agencies, development partners and NTPs for member states. The specific roles of the partners are covered below.

7.1 ECSA-HC Secretariat

Through the HIV/AIDS, TB and Other Infectious Diseases Unit, the Secretariat will provide the overall leadership and coordination of the regional program. Specific activities include the preparation and implementation of a resource mobilization strategy, the preparation of annual workplan and budget (AWPB), program implementation support, coordination of external technical assistance, and monitoring and evaluation.

7.2 Regional intergovernmental organizations

This strategy focuses on cross-border and regional programming in TB control and targets the mobile TB patients. Sensitization of the major regional trade blocs that promote the free movement of persons across national borders on the regional program will be pursued to harness broad regional consensus and support.

This strategy recognizes the importance of working with the regional intergovernmental organizations, and further proposes to engage them as part of resource mobilization strategy.

7.3 Regional and international technical agencies

Successful implementation of this regional strategy will require coordinated technical assistance from both regional and international technical agencies.

7.4.1 Development partners

USAID-EA has in the past extended financial assistance to the Secretariat in support of the regional initiative. In view of the fact that the new regional program will require significant financial investment in the context of limited resources, this strategy recognizes the need to continuously engage development partners, including Global Fund.

7.5 National TB Programs (NTPs)

The NTPs for member states are secondary beneficiaries and will be involved during all stages of the regional program implementation.

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