Regional Community-Led Monitoring and OneImpact Training Workshops Report for TIMS III

Tanzania, Mozambique, Zambia, and Zimbabwe

TIMS
TB IN MINING SECTOR IN SOUTHERN AFRICA

Report Prepared by: ACMERET Solutions

Executive Summary

Background

This executive summary provides an overview of the key steps and achievements of the Community-led Monitoring (CLM) and OneImpact workshops conducted in Tanzania, Mozambique, Zambia, and Zimbabwe. Tuberculosis remains a significant public health challenge in Tanzania, Mozambique, Zambia, and Zimbabwe mining communities. The high-risk environment in mines and poor living conditions contribute to the spread and prevalence of TB. However, community-led monitoring and interventions have shown promising results in addressing this burden. With financial support from the Global Fund, this regional training aimed to strengthen national TB coordination capacity for programs targeting mining communities utilizing the OneImpact Platform. Participants had the knowledge and skills to implement effective monitoring strategies and use the OneImpact framework for enhanced TB control.

Training Details: The training involved 210 participants, with 50 participants in each of the three countries (Tanzania, Zambia, and Zimbabwe) and 60 in Mozambique. The training sessions took place in various locations and on the following dates:

- Tanzania: April 3rd to 14th, 2023, in Mwanza and Moshi.
- Mozambique: April 18th to 25th, 2023, in Xai Xai, Gaza Province.
- Zambia: May 15th to 26th, 2023, in Solwezi (North Western Province) and Kitwe (Copperbelt).
- Zimbabwe: June 12th to 23rd, 2023, in Bulawayo, drawing participants from Kwekwe, Shurugwi, Bubi, and Sanyati districts.

Participant Profile: The training included mineworkers, ex-mine workers, family members of miners, community leaders from mining areas, health center managers, and district, provincial, and national TB and Leprosy Coordinators in each country.

Training Components and Outcomes: The training covered the following components:

1. **TB Epidemiology and Control Measures:** Participants gained an in-depth understanding of TB epidemiology, including transmission dynamics, risk factors, and prevention strategies specific to mining settings. They learned about the latest diagnostic and treatment options and explored effective TB control measures.

2. **Community-led Monitoring:** Community leaders were empowered with skills in conducting TB service monitoring activities within their mining communities. Participants learned data collection techniques, surveillance methods, and the importance of timely reporting. Effective communication strategies were also emphasized to engage community members and promote adherence to TB treatment protocols.

3. **OneImpact Framework:** The OneImpact framework complemented community-led monitoring efforts by emphasizing community participation, collaboration, and data-driven decision-making. Participants were introduced to the framework, including its key components, such as data management, monitoring and evaluation, and impact assessment. They received practical training on utilizing the framework to enhance TB control efforts in mining communities.

The training outcomes included:

1. **Enhanced Capacity:** Participants acquired the knowledge and skills to monitor and control TB within their mining communities effectively. This increased capacity will improve surveillance, early detection, and treatment outcomes.

2. **Strengthened Community Engagement:** Participants were empowered to actively engage community members, raise awareness, and promote adherence to TB prevention and treatment protocols. This increased community engagement will create a supportive environment for TB control efforts in mining communities.

3. **Improved Data Utilization:** Participants learned to effectively collect, analyze, and utilize TB-related data. This data-driven approach will inform decision-making processes, enable targeted interventions, and facilitate continuous improvement in TB control strategies specific to mining communities.

4. **Regional Collaboration:** The training will foster cross-country collaboration and knowledge sharing by sharing lessons learned and good practices from different countries. This collaborative approach will facilitate the exchange of best practices, encourage joint initiatives, and strengthen regional efforts to combat TB in mines.

The experiences and lessons from these four countries will go a long way in improving the next training in South Africa and Botswana. In conclusion, the regional training on TB in Mines Community-led Monitoring and OneImpact offered a comprehensive and collaborative approach to address the capacities and skills required to fight the TB epidemic in mines in Tanzania, Mozambique, Zambia, and Zimbabwe. This training program enhanced TB control efforts, strengthened community engagement, and fostered regional collaboration by equipping community leaders with the necessary knowledge and skills. The approach has already shown promising results to combat TB effectively in the mining communities of the target countries and make significant progress toward TB elimination goals to achieve Universal Health Care and Sustainable Development Goals.

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AMIMO	Associação de Mineiros Moçambicanos
ECSA-HC	East Central and Southern Africa Health Community
CBOs	Community-Based Organizations
CSOs	Civil Society Organisations
GF	Global Fund
KP	Key Population
HMC	Health Ministers' Conference,
RCM	Regional Coordinating Mechanism
CBVs	Community-based Volunteers
MoH	Ministry of Health
DPS	District Health Directorate
SDMAS	Serviços Distritais de Saúde, Mulher e Acção Social
HCs	Health Committees
CLM	Community-Led Monitoring
NTP	National TB Programmes
TIMS	TB in the Mining Sector in Southern Africa
SBCC	Social and Behavior Change Communication
PrEP	Pre-exposure prophylaxis
SDG	Sustainable Development Goals
SADC	Southern African Development Community

Background to TIMS III Regional Training Program

The Tuberculosis in the Mining Sector in Southern Africa, Phase III Project (TIMS III), aims to reduce the burden of Tuberculosis (TB) among the Key Populations (KP), i.e., miners, ex-miners, their families, and the mining communities in the Southern African Development Community (SADC) countries.

The overarching goal for TIMS III is to contribute to the achievement of SDG 2030 targets by ensuring that the KP in the SADC region has access to quality TB prevention and treatment services and improved working and living conditions. Under module 5 on Community Systems Strengthening, Community-led Monitoring (CLM) interventions are being implemented in 6 countries, i.e., Botswana, Mozambique, South Africa, Tanzania, Zambia, and Zimbabwe. CLM interventions under TIMS III prioritize developing or adopting a community-led monitoring (CLM) tool, which the KPs will use to report on human rights barriers/violations and access to and quality of TB services, among other issues. Against this background, this training program was implemented to close the CLM-related gaps and needs identified during country-level consultations and baseline assessment findings. ACMERET Solutions supported the capacitating of the CLM Champions to collect data using the agreed CLM tool and develop an operational plan that countries can action based on the statistics from the data collected.

Criteria for identification of clm trainees in the country

The following criteria were used in selecting 25 participants for each country to participate in the digital OneImpact and CLM training. These 25 CLM trainees are considered the TIMS CLM Champions, supporting the country's CLM implementation process by actively collecting/recording data on the digital CLM platform's behalf of the TIMS Key Population. The collected data will be used to develop reports informing the country's CLM operational plan.

The following are the criteria for selection:

1. **Geographical location:** Trainees were selected from communities located in close proximity to mining areas or peri-mining areas. This ensured that the trainees were familiar with the challenges faced by ex-mine workers, current miners, and the surrounding communities.
2. **Prior experience:** Trainees withe prior experience working with communities, particularly in the context of TB interventions were selected. This helped ensure

that they understand the challenges faced by communities in accessing TB services and can effectively use the CLM tool to collect relevant data. This was more specific to the participation of Civil Society representatives as well as Community Health Care Workers.

3. **Representation**: Trainees were drawn from representative of the different groups of key populations and community members affected by TB in the mining sector, including ex-mine workers, current miners, peri-mining community members, and community leaders. This helped ensure that the training proceedings were inclusive and reflected the perspectives of all stakeholders.

4. **Availability of mobile devices:** Trainees with access to a smartphone mobile device or a laptop to use the CLM tool effectively were selected. While this criterion ensured that the participants could collect data in a timely and efficient, it did not exclude those without smartphones if they were willing to procure one during or after the training.

5. **Language proficiency:** Trainees proficient in the languages spoken in the communities where they work/live attended the workshops. This helped ensure they could effectively communicate with community members and accurately collect data reflecting their perspectives.

6. **Commitment:** Trainees committed to the community-led monitoring interventions' goals and collecting data that reports on human rights and gender barriers to accessing TB services were selected. This helped ensure that the data collected was accurate, reliable, and helpful in improving TB services in the mining sector.

These criteria helped to identify the most suitable candidates for the training program in each country, ensuring that they have the necessary skills, experience, and equipment to effectively use the CLM tool and collect data on human rights and gender barriers to accessing TB services in the mining sector.

Training objectives

- To create a cadre of TIMS CLM Champions who can collect and analyze CLM data using OneImpact.
- Increase knowledge on advocacy to address TB service delivery gaps and Improve knowledge, skills, and competencies to engage policymakers on evidence generated using OneImpact.
- Understand the relationship between Gender, Stigma and Human Rights and TB services - (integration of CRG concepts to End TB goals/targets)
- Identification of relevant human rights and gender barriers to TB services
- Importance of monitoring human rights violations in TIMS III interventions - Monitoring of human rights violations by KP
- Understanding the importance of promoting gender equality in the mining industry to reduce barriers to TB services
- Role of KP in mobilization and ensuring accountability for TB services

General training ground rules

1. Phones on silent
2. Speak through the chair
3. Respect each other's opinions.
4. No side meetings
5. Timekeeping
6. No unnecessary movements.

Generic training expectations

- To acquire knowledge on how to manage TB programs in the community
- Learn a more practical approach to reporting TB in the mines.
- Gain more knowledge on the OneImpact Platform.
- To understand the specific dynamics of TB in the mining sector.
- To go back equipped with TB knowledge on transmission and prevention strategies.
- To learn more about Community-led monitoring.

The Training Approach

The training employed participatory methodologies to ensure that the CLM Champions appreciate and understand data collection, analysis, and interpretation to inform strategic advocacy initiatives informed by the data. Based on the tested and approved OneImpact platform, the training used training strategies addressing the specific CLM needs of people affected by TB, first responders(Health Care Workers), lead community and/or civil society organizations and advocates, health district officers, and national TB programme staff. The facilitators prepared training materials for facilitator-led, participant-led, and group presentations. The training materials highlighted the key principles, operational and technical protocols, and mechanisms to

ensure data privacy and network security for OneImpact CLM. The list and figure below highlight the various strategies used in the training.

- Group Work and Discussions
- Facilitator led Presentations
- Participant-led Group Presentations
- Question and Answer sessions (Q&A Session)
- Simulations and Skits and Video shows

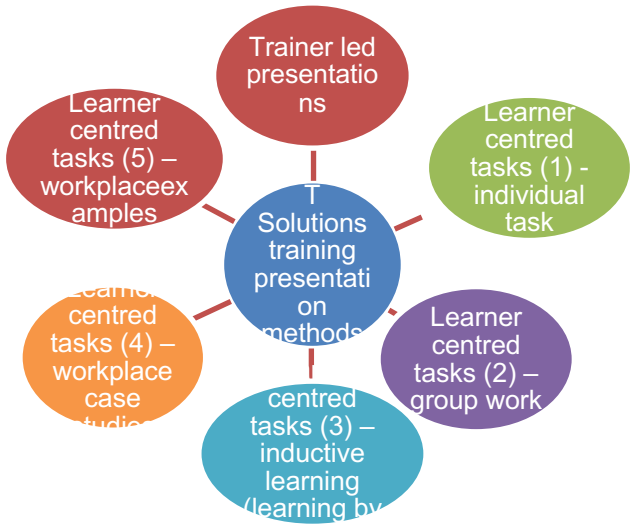


Figure 1: Training methods for the country workshops on CLM and OneImpact

Anticipated Training Outcomes

The following section presents the anticipated training outcomes for implementing partners and policymakers

Implementing Partners

- Report TB challenges on behalf of the TIMS KPs by increasing TB prevention and treatment knowledge among the CLM Champions.
- Understand concepts and components of CLM data use
- Reflect on how CLM data might be shared for program improvement decisions at different levels
- Assess readiness, capacity, and resource needs for CLM data use and plan to address gaps
- Communicate CLM data and advocate for its use
- Assess, track, and report on the use of CLM data
- Further, improve CLM design and implementation to maximize data use in decision-making.
- Understand the concept of CRG.

- Understanding the importance of promoting gender equality in the mining industry to reduce barriers to TB services

Decision-making authorities

- Understand the scope, importance, and value-added of CLM data to national health programs.
- Reflect on how CLM data might be accessed and used for program improvement decisions at different levels.

Background to TIMS III

The ECSA-HC Gender and Human Rights Specialist provided a synopsis of ECSA-HC's coordination and leadership structures in all the country's training programs. This generic presentation provided a solid foundation for workshop participants to understand how the TIMS project is structured and its regional and country-level implementation structures. Her presentation covered the following key issues across all the countries covered in this report:

Overview of ECSA-HC

She explained that the East, Central and Southern Africa Health Community (ECSA-HC) is a **regional inter-governmental health organization** that fosters and promotes regional cooperation in health among member states. It was established in 1974 under the auspices of the Commonwealth Secretariat. It was formerly known as Commonwealth Regional Health Community Secretariat for East Central and Southern Africa (CRHCS-ECSA), changed to ECSA upon becoming autonomous. The nine active member states are Eswatini, Kenya, Lesotho, Malawi, Mauritius, Uganda, Tanzania, Zambia, Zimbabwe.

Background on TIMS I and II

The Gender and Human Rights Specialist explained that the SADC region is the epicentre of TB in Africa, with 9 of 16 SADC member countries on the list of the 30 TB High burden countries. She noted that the key drivers of TB in the SADC region include HIV/AIDS (region epicentre of HIV/AIDS as well) and the Mining industry. She further explained that there was a recognition of the high burden of TB in the mines compared to the general population in the SADC region. To address TB in the mining sector, in August 2012, the Heads of state of SADC Member States signed a declaration on TB in the

mining sector, indicating five priority areas on TB, HIV, Silicosis, and other occupational respiratory diseases:

- Elimination of conditions leading to high TB rates in mines
- Actively looking for people with TB and treating them promptly
- Improving TB treatment
- Actively seeking former mine workers who could have TB and
- Creating a legal and regulatory framework that provides compensation for occupational diseases among miners and ex-miners

As a way of achieving the Declaration on TB in the mining sector, the TIMS project was initiated

TIMS Phase III

- The TIMS I and II Focused on developing and piloting models for tackling TB in the mining sector that countries and others can adopt and implemented through regional cooperation. TIMS I & TIMS II were implemented in 10 Countries (Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland (Eswatini), South Africa, Tanzania, Zambia & Zimbabwe) between 2015 and 2020
- Focused on service delivery
- Budgets
    - TIMS I - USD 30 million
    - TIMS II - USD 22.5 million

However, gaps remained despite the progress made. As a result, the introduction of TIMSIII. The coordination structure under TIMSIIIis as follows:

Global Fund: Funder

RCM: Grant holder, and AUDA-NEPAD as secretariat

ECSA-HC: The principal recipient

Budget: $10.5 Million (USD)

- The parties/organizations

Goal and Objective

The TIMS III goal is to contribute to achieving the SDG 2030 targets for TB in all Southern African countries by reducing the TB burden amongst key populations. Key populations are ex-mineworkers, mineworkers and their families, and peri-mining communities.

The objective is to ensure key populations in southern Africa have access to quality TB prevention and treatment services and an improved working and living environment.

Implementation approach

TIMS III uses a differentiated approach in the implementation of interventions. This approach is based on the following:

- Signatories to the SADC Declaration on TB in the mines
- Nature and scale of the mining industry.
- Level of integration of TIMS in the National TB programs.
- Labour sending Vs. Labour receiving countries

- All SADC member states are involved
- TIMS III budget - USD 10.5 million
  - TIMS I USD 30 million
  - TIMS II USD 22.5 million
- Implementation period – July 2021 to June 2024

Project Design/Focus

She informed the participants that ECSA-HC's programs focus on:

Health Systems and Capacity Development: Health Financing, human resources for Health.

Family Health and Infectious Diseases: Cross-border surveillance of infectious diseases and strengthening the diagnostic capacity, including the coordination of the SATBHSS and GF Regional TB Project (Diagnostics)

NCDs, Food Security, and Nutrition: She informed the participants that ECSA Developed standards for food fortification currently in use region-wide.

Knowledge Management and Monitoring and Evaluation: ECSA-HC tracks key health indicators region-wide and publication of ECSA State of Health Report

TIMS III has reduced budget because of shifting focus:

- Fostering **collaboration** between various stakeholders (Government, Private sector, and Key populations) in the region
- Strengthening **accountability**, **coordination** and promoting **sustainability** of interventions beyond the project
- Improving the Occupational Health and Safety **regulatory framework** for TB in the mining sector in the region
- Information gathering for **advocacy** and better **prioritization**

Roles of Key Stakeholders in the Implementation of TIMS III

The roles of TIMS III stakeholders was discussed. These include:

ECSA Health Ministers' Conference (HMC)

The highest governing body sets health policy for the region and defines health priorities for collective action.

The Advisory Committee (AC)

This committee comprises Principal/Permanent Secretaries of the Ministries of Health of Member States and functions as the Board of Management of the Secretariat.

The Directors' Joint Consultative Committee (DJCC)

This Directorate is the highest technical committee involved in coordinating ECSA-HC projects. It advises Health Ministers on policy matters. It draws membership from the Ministry of Health, Training Institutions, and Health Research Institutions.

Programme Experts' Committees

Draws on expertise from Member States' programme managers, external advisors, professional associates, and consultants from the region

ECSA Secretariat

The Secretariat coordinates the implementation of policy decisions of the Health Ministers. The current focus is on four program areas: Health Systems and Capacity Development; Family Health and Infectious Diseases; Non-communicable Diseases, Food Security and Nutrition; and Knowledge Management, Monitoring, and Evaluation.

Country-Specific TIMS Training Reports

Tanzania

Introduction

The TB in Mines (TIMS) first training occurred in the Mwanza region, which has large mining operations such as Geita Open Pit Mine, located 80 km southwest of Mwanza town, north-western Tanzania. The participants were drawn from Msalala, Shinyanga, Kahama, Tarime, Geita, and Mwanza. The second group was drawn from Moshi, a municipality and the capital of the Kilimanjaro region in north-eastern Tanzania. The municipality is situated on the lower slopes of Mount Kilimanjaro, a dormant volcano that is the highest mountain in Africa. A total of 25 participants attended the Mwanza training, while 25 attended the Moshi Training. The participants included ex-miners, miners, mine representatives and owners, community-based volunteers, civil society partners, and government officials. These were drawn from Mirerani, Siha, Manyara, and Arusha-based community organizations like Steps Tanzania.

Training Objectives

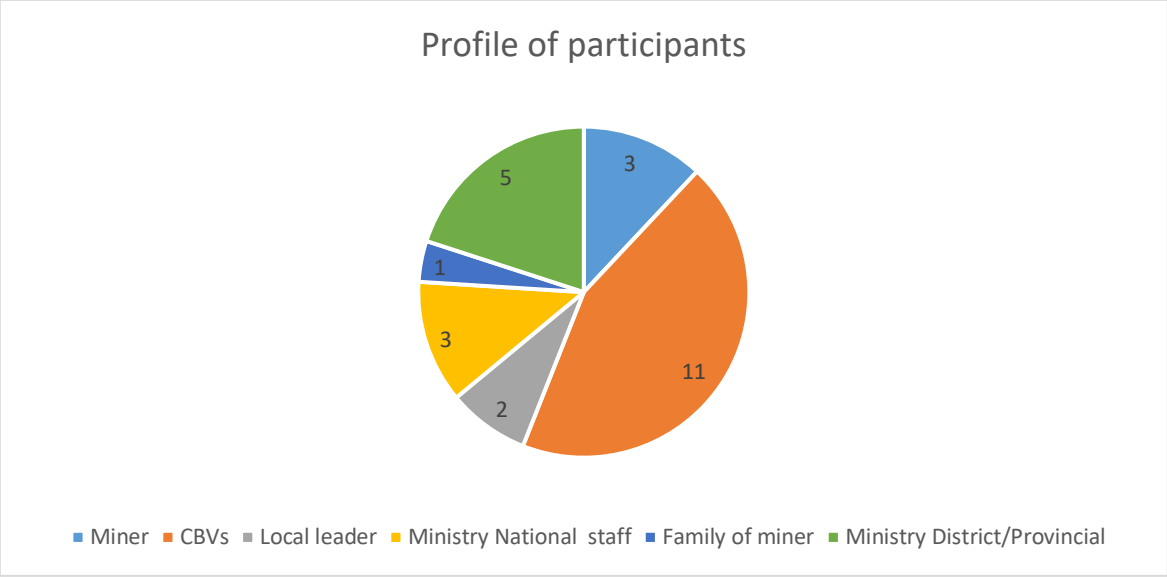
The specific objectives of the training were to:

1. Increase knowledge on TB prevention and treatment among the CLM Champions.

2. Create a cadre of TIMS CLM Champions to collect and analyze CLM data using OneImpact.
3. Increase knowledge on advocacy to address TB service delivery gaps
4. Improve knowledge, skills, and competencies to engage policymakers on evidence generated using OneImpact.

Profile of participants

The profile of the workshop participants included Miners, local leaders, Ministry of Health National Staff, family members of a miner, Ministry facility, and district and local staff. The chart below illustrates the profile of the participants.



Background to TIMS III

The proceedings of the day started with ECSA's Gender and Human Rights Specialist providing the participants with an overview of the TIMS project, highlighting the organizational structure of ECSA-HC, the rationale, and objective of the TIMS project, the key stakeholders involved in TIMS and their program roles. The conversation provided a retrospective view of TIMS I & II. The TIMS I & II programs focused on improving service delivery, including decentralized TB screening models using mobile services in member countries. The presentation also took a prospective view of TIMS III, highlighting the new focus on coordination and partnership-building networks through local civil society,

Figure 2: ECSA Gender and Human Rights Specialist listening attentively to participants's contributions on their knowledge about the TIMS project.

the private sector, and the government.

Introduction to Community-Led Monitoring

The presentation Introduced Community-Led Monitoring (CLM) led by ECSA-HC's regional Consultant from ACMERET Solutions. The consultant led the participants through a participatory process allowing them to give their local perspectives about community-led monitoring. The comprehensive presentation covered issues that define CLM and its link to Universal Health Coverage and Sustainable Development Goals. The presentation clarified CLM as a collaborative planning platform, highlighting its utility beyond airing complaints but to going further and promoting partnerships and a culture of working together to fix local problems. The significant achievements of the presentation include successfully reminding the participants that early engagement by all community

stakeholders, implementers, and decision-makers facilitates and sustains mutual CLM interventions. Likewise, mutual understanding of CLM data and its use among CLM implementers and decision-making authorities adds value to national health programs and addresses any negative perceptions of a "watchdog"-type role of CLM. The key messages for Implementing partners like MKUTA were that they should:

- Understand concepts and components of CLM data use
- Reflect on how CLM data utilization for program improvement decisions at different levels
- Adequately build capacity and resource mobilization for CLM data use and plan to address any service delivery gaps.
- Build skills to Communicate CLM data and advocate for its use
- Assess, track, and report on the use of CLM data
- Further, improve CLM design and implementation to maximize data use in decision-making.

At the level of policy and decision-makers like the government of Tanzania officials present, the presentation highlighted the need to:

- Understand the scope, importance, and value-added of CLM data to national health programs
- Reflect on how CLM data might be accessed and used for community, facility, district/regional, and national program improvement decisions.
- Build partnerships to build CLM capacity and resource needs for CLM data collaborative use and plan to address identified community gaps.
- Consider CLM as a critical and integrated contribution to national M&E systems and program review processes.

The discussion also linked why CLM is an opportunity to renew the country's effort to address community gaps as Tanzania progresses toward the 2030 Agenda for Sustainable

Development. The availability of further investments in community-led innovations, improved policies and programs that protect and promote human rights, and advanced universal health coverage are some of the conditions identified as helpful to aid Tanzania's plans to achieve the 2030 sustainable development goals and Africa's Agenda 2063. The demand for greater accountability by all decision-makers to remove access barriers faced by key populations like miners, ex-miners, their families, and their communities are some of the issues highlighted to facilitate people-centered services that leave no one behind. Concerns were raised regarding too many people who remain undiagnosed in TB programs, a situation found in HIV and malaria programs. As a result, a call was made to utilize the CLM and OneImpact platforms to correct these gaps in Tanzania.

Challenges and Barriers Faced by Key Populations in Tanzania

Participants were then involved in a group discussion to discuss the challenges or barriers facing the mining sector's key populations (miners, ex-miners, families, and communities). It was emphasized that for the TIMS Projects, Key Populations refer to: 1) Miners, 2) Ex-miners, 3) Families of miners, and 4) communities surrounding mines. The significant challenges identified are as follows:

Challenges Faced by Miners

- Lack of Protective clothes for underground Miners to protect themselves from TB and silica dust, thus increasing their vulnerability.
- Lack of coordinated TB education campaigns and information-sharing platforms for miners.
- Miners do not get time off or space to leave and seek treatment
- Miners tend to move from place to place to search for "productive areas." These movements affect their medication adherence and increase the chances of spread.
- Family and work-related stigma for Miners following disclosure of their TB-positive status.
- Mining areas tend to be far from health facilities, which creates a barrier to accessing TB services.
- Miners work under dangerous conditions with limited ventilation in the pits leading to an increased risk of spreading infections.

Challenges faced by the families of miners

- Loss of or reduced economic support from the bread-winner
- When a miner falls sick with TB, there are increased expenses during treatment which uses up family savings -The issue of Out Of Pocket (OOP) costs affects family savings.
- The family is at risk of being infected with TB once a miner is sick with TB.
- Family (spousal) tensions arise, which could be because of stigma and discrimination.

Challenges faced by communities surrounding the mines

1. Dust exposure from mining sites increases their vulnerability to TB
2. Chemical pollution. There is contamination of water sources for human and animal consumption.
3. Noise pollution from mining machinery and related noise operations like rock blasting.
4. Communities sometimes have no access to TB education.
5. Proximity and interaction with miners increase the community's likelihood of acquiring TB infections.
6. There are reported cases of increased promiscuity which also increases the chances of spreading TB and HIV. It leads to rising trends of single-parenthood
7. Increased risk of school drop-outs and childhood labor, which puts children at increased risk of TB
8. Migrants to the local area coming in to work in the mines leads to competition for social services, including health services.

Challenges facing ex-miners

1. There are cases of superstitious beliefs leading to the delayed seeking of treatment.
2. Poor adherence to medication due to the lifestyle they have lived.
3. They don't provide correct addresses making it difficult for HCWs to follow-ups. The provision of false contact details indicates a lack of information.
4. They are accustomed to superstitions and would quickly believe TB myths

Other challenges

1. Most miners are unaware of rights, e.g., the right to health and compensation.
2. Since they are in need and most are poor, they are forced to work under terrible and risky conditions.
3. They lack a robust social support structure which may lead to poor TB treatment adherence.
4. Miners suffer from other conditions that increase their vulnerability to TB, e.g., poor nutrition.
5. There are no social protection schemes for miners.

Community, Rights, and Gender(CRG)

On the second training day, the ECSA-EC Gender and Human Rights Specialist introduced the participants to Community, Rights, and Gender (CRG). The presentation and discussions highlighted why community-based volunteers should master the key gender and human rights concepts central to TIMS implementation in Tanzania. The facilitator emphasized that understanding the key concepts fits into the CLM and OneImpact as it forms the basis for the quantitative and qualitative data the participants will collect in the field. As community-based volunteers, they identify and report all gender-based violence and human rights violations through the OneImpact Platform. Also, understanding the right to health leads to realizing other human rights (e.g., the right to personal dignity).

In this session, differences between Gender equality and Gender equity concepts in the context of the mining industry were expounded to participants. This stimulated discussion which enhanced understanding to the participants. Also, differences in the vulnerabilities of men and women towards developing TB were discussed. Some key points included

1. Men and women have different needs and require different support structures/systems to ensure access to opportunities.
2. Not caring for the different needs of each gender leads to violations of human rights.
3. Human right violation leads to an increase in TB cases in the mines.
4. Women can do most of the work in the mines. Some even operate machines and detonate holes.

5. At times, women undermine themselves, feeling unable to do certain work. This is a mentality that needs to go away.

On this day, participants were also introduced to the OneImpact tool through a brief overview and downloading the application into their mobile devices. After that, through practical sessions, participants were taken through each module and trained on various ways to collect data using OneImpact.

Participants were then taken through the CLM data management processes on the third day. Key topics covered included the methods for collecting qualitative (e.g., FGDs, observations etc.) and quantitative data. The facilitator emphasized that both technological/digital systems can be used to collect data for reporting through the OneImpact Platform, depending on the situation.

Other than data collection, participants were also trained in analyzing the quantitative and qualitative data.

On the fourth day, participants were introduced to the practical applications of the OneImpact Platform. The sessions used simulated scenarios to help participants understand how to identify TB service delivery gaps and how to report them using the OneImpact Application. The Mkuta Information and M&E facilitators took a hands-on approach, taking the participants through the OneImpact modules step-by-step. Using a smartphone connected to the projector facilitated the process, as participants could follow the processes on a big screen. The figure below shows the Mlkuta team providing hands-on assistance to the participants.

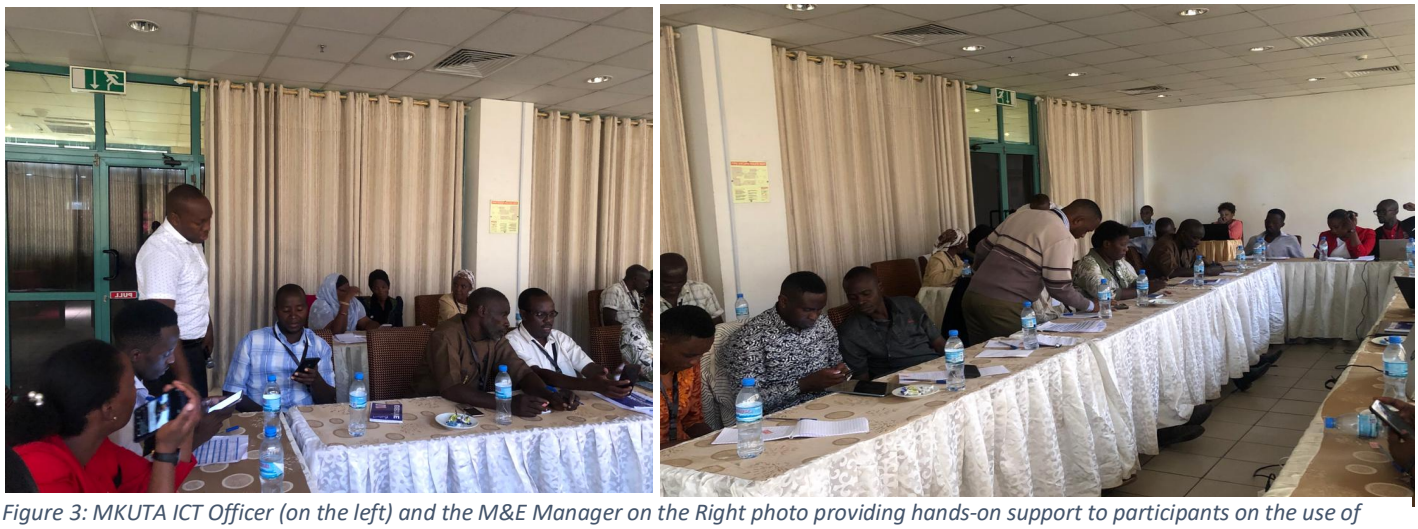


Figure 3: MKUTA ICT Officer (on the left) and the M&E Manager on the Right photo providing hands-on support to participants on the use of OneImpact on the mobile phones

The training ended with the participants discussing and agreeing on the next steps following the training, as shown in the table below:

The way forward – CLM TIMS III Training - Mwanza

Table 1: Agreed action points by the Mwanza region training participants, Tanzania

SN	Item	Responsible	Timeline
1	Create user names for champions to use assisted model	MKUTA	28th April 2023
2	Promotion of OneImpact	Health Promotion - NTLP	Ongoing activity
3	Reviewing content	NTLP – Communication, Health promotion, MKUTA	Ongoing activity
4	Creating a WhatsApp group for champions	MKUTA	Immediate
5	Obtain facility GPS Coordinates for mapping via WhatsApp	MKUTA and Champions	28th April 2023
6	Send names of Facility Managers to MKUTA	RTLCs	19th April 2023
7	Credentials for Facility Managers and NTLP Officers	MKUTA	28th April 2023
8	Engage Facility Managers	ECSA-HC	5th May 2023
9	ECSA-HC supports CLM champions in collecting data using OneImpact	ECSA-HC	3rd week of May
10	Open CLM Champions Group on Get Connected	MKUTA	19th April 2023

11	Derive targets for CLM TIMS III	MKUTA, ECSA-HC and RTLCs	28th April 2023
12	Deliver tools – reflector jackets etc	ECSA-HC	2nd week of May
14	Database of trained CLM Champions	MKUTA	28th April 2023

The following section presents the training proceedings in Moshi. While the training program was generally similar to Mwanza, the section provides unique perspectives for this specific training.

Training proceedings in Moshi Region, Tanzania

The training was attended by 25 participants drawn from KPs such as Miners, Mine owners, ex-miners, Mkuta TB coordinators, families of miners/ex-miners, and civic organizations like Steps Tanzania and the first training day introduced the participants to TIMS III, highlighting the historical aspects of TIMS 1 and II. The ECSA Gender and Human Rights Specialist took the participants through this session, setting the tone for the next proceedings.

Background to TIMS III and Overview of Training

The first presentation was an overview of the TIMS project and ECSA-HC, the training, the rationale of the TIMS, and its intended objectives. While the content of the presentation covered similar aspects as discussed earlier, interesting discussion points out of the Moshi group include issues such as:

- The need to comprehensively discuss ways small miners can be compensated when they get TB in the workplace.
- The need for creative ways to involve mine owners in active TB programs
- Why has the Global Fund reduced funding for TIMS III compared to TIMS I and II?

The facilitator reiterated the need for all stakeholders to play an active role in fighting TB in mines. Mine owners and management were called to play their role by facilitating health and safety measures to prevent TB spread. On the reduced budget for TIMS III, the facilitator indicated that the focus on coordination and partnerships reveals the change in Global Fund priorities and the need for collaborative partnerships to contribute resources towards the fight against TB in Mines. The following presentation introduced Community-Led Monitoring.

Introduction to community-led monitoring (CLM)

The Acmeret Solutions consultant took the participants through the introductory aspects of CLM. The participants were asked to share their understanding of community, what it means to be

community-led, and what monitoring entails. They were allowed to explain these terms in simple terms and in vernacular language. One of the participants provided experience in implementing CLM in the Pwani district. The participant elaborated on the importance of community sharing common goals, jointly initiating and implementing programs rather than following externally driven activities. The participant said that CLM equals to *"Nothing for us without us" – "Hakuna kitu kwa ajili yetu bila sisi wenyewe",* This statement underlines their program. The facilitator elaborated that CLM comprises four major steps: Education, Evidence Engagement, and Advocacy. Education is whereby participants receive appropriate training, such as the TIMS III workshops, while evidence is the next step that CLM champions embark on after the training. When evidence is generated, the next step is to engage the relevant partners, stakeholders, and government and advocate for changes in areas requiring interventions. The facilitator encouraged the participants to take the training seriously as it forms the basis for successful CLM programs. The three other steps rely on the level of knowledge acquired during the CLM workshops. The next section covers a discussion on the challenges/barriers faced by key populations in Moshi region.

Challenges/Barriers facing key population participation

This session was facilitated by a representative from the TB -patient-led organization Mkuta. The key points from this discussion are summarized below:

- The issue of migration of TB clients without providing adequate contact information for easy follow-up by healthcare workers.
- The issue of high stigma and discrimination against TB clients
- Challenges regarding the collection of quality sputum to facilitate TB case-finding processes. The issue of inadequate tools for collecting samples (sputum) was noted as a major challenge.
- The participants also raised challenges regarding poor transportation for Community Health Volunteers (CHVs).
- Related to the above point is the issue of Inadequate funds to facilitate community health volunteer (CHV) work.
- The lack of information about TB in mines among mine employees and owners.
- Poor cooperation of mine owners in the fight against TB in mines.

The discussion turned tense at some point as mine owners or representatives took a defensive position when some participants raised concerns regarding the lack of safety and preventive

programs at most mines particularly small to medium mine operations owned by local mine owners. The mine owners were accused of profiteering out of the suffering of poor workers, which they denied, risking the discussion into a dialogue rather than an objective group discussion. The facilitators intervened, emphasizing the need for everyone to play a part in preventing and stopping TB in mine initiatives. The facilitators noted that the objective of the TIMS III training included the need to promote collaborative partnerships that promote teamwork in the fight against TB in mines.

The second day of training started with a discussion on key concepts about TB. The discussion focused on the definition of TB, its causes, its prevention, and its relation to silicosis and treatment.

- The facilitator allowed the participants to give their views and knowledge about TB getting views and perspectives from various participants representing different sectors like Local government leaders, MAREMA, MKUTA, and the CHVs)
- The RTLC from Manyara provided updated information about TB laboratory procedures to effectively pick the presence of the bacilli in the sputum and new TB treatment regimes.

The next presentation addressed Community, Rights, and Gender issues.

The Gender and Human Rights Specialist took the participants through this section, providing a basic understanding of CRG issues in Tanzania. She emphasized how:

- Essential health service is the right of every human being.
- Violations of human rights increase the spread of TB.
- CRG concept helps to give us evidence of human rights violations in TB services.
- This evidence helps address those violations to improve services and create a strategic plan by creating an action plan.
- Identification of human rights and gender barriers was also discussed (right to personal dignity, free from discrimination, and right to information)
- The difference between Equity and Equality was well explained, and the need for Gender equality in the mining sector. The illustration on equality and equity was used to elaborate the concepts. (See figure)

The third session for the day introduced the OneImpact

OneImpact -TBKiganjani Overview and practical session

- The facilitator took the participants through the steps to download the OneImpact application.
- The participants were also taken through how to register the application online.

- Some issues were raised regarding the updated information about TB in the application (like the definition used) and the need to have a moderator of the application respond to questions asked in the application.
- The participants were oriented on the essential modules and issues reported under each module.

The Mkuta M&E Manager and the Acmeret Solutions Consultant jointly presented CLM data management tools on the third day. The joint presentation helped to allow facilitation in both English and Swahili for the benefit of the participants. The key message in this presentation is that "having the best tools lead to the collection of quality data for informed decision-making."

The presentation underscored the importance of understanding the key steps in CLM, which are:

- Education
- Generate Evidence
- Engagement of service providers and
- Strategic Advocacy

The facilitators also discussed quantitative and qualitative data collection tools, indicators, and targets for projects like TIMS. They simplified what Quantitative indicators and tools mean, reminding the participants that quantitative means numbers, statistics, or figures. On the other hand, qualitative tools were described as describing or narrating TB situations from the community. An overview of different data collection tools was presented, including questionnaires and survey guidelines as examples of quantitative tools. Focus Group Discussion Guides and Stories of change(Most Significant Change Stories) are some examples of qualitative data collection tools discussed.

The facilitators also touched on the common categories of challenges TB patients face in CLM. The four major categories are:

- Service Availability relates to whether the TB services are being provided at the health centres.
- Service Accessibility, on the other hand, relates to whether TB services are provided to everyone who requires them. Services could be available but inaccessible to others, for example, migrant TB patients.

- Service acceptability- While services could be available and accessible, another barrier could be acceptability which relates to whether the TB services meet the minimum prescribed standards.
- Quality of service- finally, TB services must meet the quality standards regarding Accessibility, Accessibility, and acceptability.

The facilitators went further to present the Mozambican CLM Case study to illustrate the concepts of availability, Accessibility, acceptability, and quality based on the ADPP program supported by USAID. The case study gave stimulus to participants who realized the role they had to play in generating evidence to advocate for change in the mining community strategically.

On the fourth day, the Mkuta ICT Officer continued with the OneImpact practical sessions initially introduced on the previous day. The participants were given opportunities to navigate the application and familiarize themselves with the key information in each module.

Mozambique

The training occurred in Gaza Province, Xai Xai town, between the 17th and 25th of May, 2023. A total of 50 participants attended the training. The training was divided into two sessions targeting community volunteers and healthcare workers. The province is located in the Southern region of Mozambique, with a population of 1,422,460. It is divided into 14 districts: Bilene, Macia, Chibuto Chicualacuala, Chigubo, Chonguene, Mapai, Chókwè, Guijá, and Limpopo.

Training Objectives

1. To strengthen the capacity of AMIMO to effectively implement the OneImpact Digital Platform and respond to the identified and emerging challenges that negatively affect the health-seeking behaviors of TB key population PLHIV in TB retention treatment and care in the health system.

2. To acquire skills and knowledge related to community-based monitoring to improve TB treatment, thus ending TB in the mineworkers-sending communities (communities of origin of Mineworkers).

Workshop expectations of the participants

The initial expectations of the workshop participants can be summarized as follows:

- To increase capacity to implement effective **OneImpact Digital Platform** in communities of origin of Mineworkers
- Acquisition of advocate skills for people affected by TB to improve services.

Training Methods

The training team used various methodologies that helped attain the workshop objectives.

- Interactive Discussions
- Reporting to plenary
- Open debate (sharing and asking questions)
- Group Presentations
- The brainstorming and role-playing
- Plenary: Interventions, paper presentations and discussions

Materials:

a) Smartphones, electronic devices with Internet access
b) Flipchart with paper marker pens in different colours
c) Copies of "The Story of Maria and her Country"" (one copy per group)
d) Pens and paper
e) Appropriate visual aids and presentation equipment
f) Copies of the grid for group work
g) Training Manuals,

The first day of training started off with welcoming Remarks and Introductions. Chief Uamusse , the AMIMO Chairperson, introduced the session by welcoming all the ECSA-HC staff, including the ACMERET Consultant and the participants. He expressed gratitude for the excellent turn-up for the training thanking the participants for prioritizing the workshop. The participants in attendance were representatives from the Directorate of Health Gaza Province; PNCT **Gaza**; Districts Directorates of Health from Limpopo and Mandlakazi districts; representatives of traditional leaders; professional Interpreters; AMIMO project staff and the young people who were recently recruited to work on the "Challenge Facility for Civil Society Round 11" as activists (Peer educators) in Limpopo and Mandlakazi districts, Trainers of trainees from ADPP. He encouraged the participants to pay attention to the workshop proceedings as learning does not end. The list of participants is attached hereof. He thanked TIMS for providing financial and technical support for this seven-day Training Workshop on OneImpact and Community Led Monitoring.

Figure 4: AMIMO Chairperson giving welcome remarks to the TIMS III Training in Mozambique

Introduction to Community-Led Monitoring

The facilitators from ADPP introduced the concept of Community-Led Monitoring (CLM), OneImpact, in the context of TB. They defined CLM as an intervention whereby people affected by TB report and analyze systematically and regularly data related to the quality of services provided, stigma and discrimination, and the violation of human rights in the delivery points (Peripheral health Centres, district hospitals, etc.) during care.

The presentation further highlighted the challenges faced by people affected by TB, which include the following:

- Information gaps in the provision of TB treatment services;
- Human rights abuses, stigma, and barriers in the TB provision of services;

Measures taken to improve service delivery by people affected with TB were also discussed, including the need to embrace programs such as CLM and OneImpact for reporting human rights violations.

Furthermore, the facilitator simplified the conceptual understanding of CLM, highlighting its collaborative approach to bringing the community on board, involving persons affected by TB (recipients of care, particularly mineworkers to this project) to ensure the quality of TB treatment and care services are available. The approach aims to promote accountability and ensure the Accessibility of acceptable and quality TB services at health centres in Mozambique. Thus, the approach equips communities and individuals affected by TB to demand quality services without stigma and discrimination. Thus, the facilitator underscored the benefits of CLM as facilitating TB service uptake and reducing the barriers encountered by TB patients by providing TB healthcare services that encourage health-seeking behaviors of those affected by TB to seek more services early. The facilitator emphasized how CLM puts the recipient of care as an essential source of feedback for quality improvement as communities monitor the availability, Accessibility, acceptability, and quality of TB screening and diagnostic services.

OneImpact Conceptual Framework

The facilitator further explained that the OneImpact community-led monitoring framework provides an easy-to-understand explanation that empowers people affected by TB to access health and support services, claim their rights, and identify and reduce stigma. Through an innovative mobile application, OneImpact CLM encourages and facilitates the participation of people affected by TB in all aspects of TB programming to activate a human rights-based, people-centred response. In doing so, OneImpact CLM combats the central challenges in the TB response at the individual and community levels while generating essential information and data to understand better and combat them at the programmatic level to end TB.

OneImpact CLM model

The facilitator from ADPP used his experience implementing the USAID-supported CLM projects to explain how the OneImpact CLM framework uses Downward accountability, a

community mechanism to report and handle challenges faced by people affected by TB, and leverages existing community systems to report back to affected communities. The figure below illustrates the key areas in which the OneImpact CLM framework helps simplify TB service planning and implementation.

Figure 5: OneImpact CLM framework

OneImpact CLM approach

The facilitator further illustrated how the OneImpact aims to put people at the heart of the TB response and is critical for ending TB. He explained that every year, the Mozambican health systems miss millions of people affected by TB because of barriers to health services, human rights violations, stigma, and a lack of access to support services. As a result, the OneImpact CLM is a direct response to these core challenges.

He illustrated how the innovative mobile application OneImpact CLM provides people affected by TB with accurate and actionable information, links them with nearby clinics, peers, community health workers, and health workers, and encourages them to report the challenges they face conveniently and routinely while maintaining their safety. In

doing so, OneImpact CLM supports people affected by TB to complete their TB journey while strengthening the responsiveness of TB programs and making TB programs more accountable, with particular attention to gender-related and human rights-related barriers to services as experienced by key and vulnerable populations.

In this way, OneImpact CLM combats the central challenges in the TB response at the individual and community levels while generating essential information and data to understand better and fight them at the programmatic levels to end TB.

The focus of OneImpact CLM monitoring

The key message was that ending the TB epidemic is a target of the Sustainable Development Goals that require the implementation of several public health, biomedical, human rights, and socioeconomic interventions in addition to research and innovation. As a result, Mozambique should join others through the adoption of the OneImpact framework to monitor:

- **Barriers to TB support services**

OneImpact CLM monitors barriers to TB support services to understand the social and economic needs of people affected by TB and to address these needs.

- **Human rights violations**

OneImpact CLM embraces human rights as an overarching goal. As such, OneImpact CLM monitors human rights violations or infringements related to discrimination, privacy, and confidentiality to promote human rights for people affected by TB.

- **TB stigma**

OneImpact CLM monitors the stigma experienced by people affected by TB to better understand and eliminate TB-related stigma, a target of the UN Political Declaration on TB, to which Mozambique subscribes.

- **Barriers to TB health services**

OneImpact CLM monitors barriers to TB health services as they relate to the Availability, Accessibility, Acceptability, and Quality (AAAQ) of TB health services to understand and break down these barriers.

Overall, the OneImpact framework in Mozambique aims to empower Communities to End TB by:

a) overcoming negative impacts

b) providing people-centered TB care

c) Response to TB based on human rights

d) Gender-transformative (Gender-transformative programs aiming to change gender norms and promote relationships between men and women that are fair and just)

e) Promote Equitable and responsible delivery of TB services.

Key Achievements of ADPP and Future Plans

The presentation provided further practical context on how AMIMO as the recipient of OneImpact CLM program could learn from ADPP's experiences regarding the implementation of CLM in the country. According to the facilitator, since the inception ((2019-2022) of the OneImpact, ADPP has attained the following key achievements.

- In 2022, the OneImpact digital platform reached almost five thousand people affected by TB.
- The ADPP managed to develop and utilize the OneImapact-assisted model;
- In 2019-2020 the organization started a small pilot scheme of 100 people affected by TB in five health facilities -85% of the people in the households were t screened, 27 children under 15 years underwent TPT following PNCT procedures;
- In 2021, OneImpact ADPP scaled up the project to 28 health units in two districts: Over 600 people were engaged;
- Between this year (2023) and next year (2024), ADPP is collaborating with PNCT to institutionalize OneImpact digital platform in Mozambique. Thus, AMIMO is expected to play an important role in this process as the host organization for the OneImpact Platform under the Global Fund and the Stop TB partnership.

Composition of OneImpact digital platform

The facilitators provided a detailed overview of the key platforms that form the OneImpact Platform It consists of three main platforms:

1. **The Application**: which entails: *knowing your rights, obtain information, have access, connecting, and involve.*

2. **The Inbox**-Correspondents comprise: *Total cases, open cases, approved cases, declined cases, and removed cases.*

3**. The Dashboard**:_This is the fulcrum on which the OneImpact digital platform revolves. In this process, the OneImpact digital platform was seen as more meaningful since it guides the stakeholders, recipients of care, and activists to access any relevant information about the rights of people affected by TB, engagement with other stakeholders, and TB cases, among others.

Empowerment of Communities: In the related development, the facilitator held that the programme empowers communities with TB through multi-channel services. These channels are: Awareness community forums, Social Behaviour Change Communication (SBCC), access to the nearest health units, reporting service gaps and barriers, and community-based surveys.

The OneImpact CLM- Assisted Model-Reaching Key and Vulnerable Populations

The facilitator then went on to look at OneImpact –CLM assisted model to reach out to Key Populations and vulnerable persons. The primary take-away message from this presentation is that the OneImpact Platforms helps achieve the following in TB programming in Mozambique:

- **Participation:** Engage and empower community voices to report challenges through the OneImpact Assisted Model.
- **Response**: Health facility staff collaborate with first responders and community health workers to respond to reported barriers.
- **Impact**: Evidence-based Advocacy and CLM data helping to change policies and practices.

The above aspects constitute the sequential or chronological flow of information from the person affected by TB (Key population – Mineworkers, Ex-miners, their families, and communities) to the project activists, and finally to the professional health staff at the peripheral health centre, district hospitals, provincial hospital, etc.

OneImpact Mozambique – The Story of Maria

The facilitator presented a digital, visual story summarizing the barriers and challenges TB patients experience at home/community and health facilities. The story of Maria raised crucial points regarding ethical considerations and confidentiality for TB patients. The issue of shared confidentiality is one important aspect illustrated in the story. Health professionals have no right to disclose TB patients' information to their families unless authorized by the patient. In this illustrative story, doctors and nurses did not take the appropriate steps to protect Maria. As a result, it led to increased stigma and discrimination for Maria.

The video helped illustrate what happens when medical personnel breaches confidentiality by revealing patients' information without authorization from Maria. It emphasized how failure to uphold confidentiality contributes to stigma, discrimination, and rejection by family.

Lessons ADPP Learnt in the Last Three Years

The facilitator summarized the lessons learned by ADPP during its CLM implementation. The lessons were meant to prepare AMIMO as the new recipient of OneImpact CLM platform. Below are some of the lessons discussed.

- The OneImpact approach helps generate evidence-based advocacy information for action.
- The OneImpact approach can complement the PNCT objectives by identifying gaps, thus ensuring that everyone has access to TB services.
- It is an effective approach to raising awareness and involvement of communities affected by TB.

  The plenary of this presentation addressed some of the issues arising. **The health professionals participating in the workshop wanted to understand.**

1) Who the target group was the OneImpact Platform aimed at equipping?
2) Who would handle the complaints as the complaints come through?
3) Who will have access to the reports to see what is reported, who is reported, and what precautionary measures are to address the complaints raised?
4) Whether all people affected by TB will be provided with smartphones?

5) The participants requested the facilitators to know whether AMIMO will entirely replicate the ADPP's methodology of implementation or will do some modifications.
6) Will there be complementarity among peer educators?
7) Will the supervisors from the districts and provinces have access to these instruments?

The above crucial questions were addressed by the facilitators, as illustrated below.

1. The facilitators emphasized that the OneImpact platform is available for use at three levels: the patient, Community Volunteer, and Health care worker levels. Each entry point has its rights and specific issues to respond to.
2. Regarding handling complaints, the facilitators emphasized that the OneImpact CLM Platform is about joint identification and resolving TB-related issues. It was stressed that it is not a 'witchhunt' or a watchdog intervention.
3. Healthcare worker managers at local clinics and AMIMO has access to the reported issues that require joint efforts to resolve.
4. Concerning replicating 'ADPP's methodology of implementation. AMIMO staff observed that " The crucial point is to acquire the practical skills concerning the application before considering modifying the system. The focus was on acquiring the skills to navigate through the OneImpact digital tool, although ECSA-HC and Dure Technologies could provide the necessary support in the event of any need to modify some sections of the application as they arise.
5. The project will not provide access to smartphones for people affected by TB. However, Community volunteers can help those with smartphones to download and utilize the platform to report their cases.

In concluding this session, there was a consensus that the OneImpact platform is essential for Mozambique to End TB.

Challenges / Barriers Facing Key Population Participation

The facilitator began by looking at how to determine barriers. Through the interactive discussion, both participants and the facilitators agreed that there are health system- and

population-level barriers holding back TB services from trickling down to the eligible people affected by TB. These are:

- Stigma related to diagnosis and treatment;
- Chronic stock-outs such as test kits, reagents,
- The absence of a comprehensive psychosocial support program;
- Lack of overall knowledge about TB or multi-drug resistant TB in the community.
- Staff absence (including arriving late/leaving early)
- Poor service (patients are not respected or treated with courtesy)
- Lack of compliance with clinical protocols
- Discrimination (based on gender, ethnicity, socioeconomic status, religion,
- Breach of confidentiality through revealing patients' information without authorization.
- Lack of sufficient information (prevention, diagnosis, or treatment, including possible risks)
- Much as medical services are free in public health facilities, there are additional payments for health care services.
- Lack of quick response to an urgent case
- Lack of informed consent (for treatments, surgeries, research, etc.)
- Loss of patient clinical files
- and delays in diagnosis characterized by lengthy waiting times for clinical consultations and obtaining drugs at the pharmacies

These significant factors negatively impact the KPs' ability to take up TB services and adhere to treatment regimes.

Understanding Available TB Services for TIMS Key Population (Miners, Ex-miners, spouses, and Mining Communities)

The AMIMO Chairperson, Mr. Uamussi, led the session. The Chairperson observed that Mozambique lacks knowledge of the extractive industry's reality. Mineworkers are at a higher risk of contracting silicosis, TB, and other lung disease due to prolonged exposure to silica dust inside mines. He stressed that mining companies employ more than 12000 workers, yet so many mining companies still fail to provide adequate protective clothing and equipment for them.

He noted that, given the mining sector's suffering, TB had been declared an occupational disease in most Southern African countries. He also emphasized that every worker has the right to health and safety in Mozambique. One participant wanted to understand how two TB health centres established in previous interventions still provided the services. The specific questions were:

1. Do Mozambican mineworkers utilize these health facilities? How do you measure the Mozambican miners' utilization rate regarding these two health facilities?
2. How accessible are these health facilities?

The response as to how Mozambican mineworkers utilize the special health units is that the current utilization of facilities is unsatisfactory as patients do not complete the treatment. Even when initiated on the therapy, they cannot stay at a given location long enough to complete the lengthy TB treatment regimen.

As a result, an urgent need for innovative strategies such as 'One Impact plays an essential role in improving TB prevention, TB case finding, and TB treatment to completion among people with TB, including mineworkers and their spouses. One health professional raised a point that they are grateful for the training in utilizing the OneImpact program, considering that they struggle to follow through with their TB clients on treatment.

Background to the Mining Sector in Southern Africa(TIMS) III

The presentation was preceded by remarks by the AMIMO president, who thanked ECSA-HC for the financial support and ACMERET Solutions for technical support on CLM and OneImpact. He requested the participants to give a minute of silence to remember all Mozambican miners and ex-miners who succumbed to TB contracted at work. He rightly declared that the underlying purpose is to wage a major battle against TB in all its forms.

The ECSA-HC Gender and Human Rights Specialist presented on the background to TIMS III . She expressed gratitude to the Mozambican team for organizing a successful meeting with participants from the government, the local OneImpact partner, and community representatives.

She also thanked the AMIMO and Partners for taking up this OneImpact and CLM initiative to benefit Mozambicans. She explained the history of ECSA-HC since its inception, initially

as the Commonwealth Secretariat in the 1970s, and how it evolved and its work towards promoting regional cooperation in health among member states namely Tanzania, Zambia, Zimbabwe, Kenya, Lesotho, Malawi, Mauritius, Swaziland, and Uganda. Other roles of ECSA include influencing evidence-based health policies in the region and facilitating implementing projects. She elaborated on the various ECSA-HC collaborating structures, as explained in the introductory sections, and how they will facilitate OneImpact CLM implementation in Mozambique. She also briefly discussed TIMS I and II and how TIMSIII is building up on the previous projects, focusing on collaboration and partnership building at the country levels. She gave a retrospective perspective of the TIMS 1 and 2 projects implemented in 10 countries. These two project phases focused on service delivery, including TB screening at sub-community levels. She stated that the TIMS3 is implemented in 16 countries (signatory and non-signatory parties).

She noted that all TIMS projects are centered in the SADC region because the region is an epic Centre of TB in Africa due to mining economic activities playing and the HIV scourge compounding the TB burden. She highlighted that Nine of the sixteen SADC member Countries are on the list of the 30 TB high-burden countries.

Furthermore, the Gender and Human Rights Specialist observed that: TB in the Mining Sector (TIMS III**)** received catalytic funding of US$10 Million, with implementation beginning in 2021 and anticipated to end in 2024. The underlying program's purpose **is** to promote gender and human rights in monitoring TB services in the mining sector. The program further addresses gender barriers that prevent mineworkers and their dependents from accessing treatment services. The ultimate goal is to contribute to achieving the Sustainable Development Goals (SDG) 2030 targets for TB in all southern African countries.

It was further observed that TIMS III had reduced budget because of shifting focus from direct country implementation to :

1. Encouraging collaboration among key stakeholders
2. Strengthening accountability, coordination, and promoting sustainability
3. Improving occupational health

The Global Fund fund the project and is implemented by ECSA-HC (Principal Recipient) under RCM as the grant holder. Other key stakeholders are Governments, KPs, the Private

Sector, and the SADC Secretariat. MoH (government), through the NTP, acts as the focal point, specifically through engaging the Key Population and providing reports concerning the status of TB and participation. Among other functions, these key stakeholders manage the regional accountability framework for TB in the mining sector.

What is Community-Led Monitoring

The ECSA-HC-appointed consultant from ACMERET Solution facilitated the session, stressing that "as we take up where we left off in our first introductory lesson on CLM on the first day, a few more bits of background information are vital to our understanding of CLM". The facilitator defined CLM as an intervention through which TB-affected individuals and communities systematically and routinely report and analyze data on service delivery and quality, as well as stigma and human rights violations from service delivery sites and during care.

In short, the facilitator stressed the significance of CLM that it:

a) Provides in-depth and unique insights into gaps in service delivery;
b) Reduces human rights and stigma encountered in the provision of TB healthcare services;
c) Improves the services and experience of people affected by TB;
d) Improves health outcomes for individuals and the affected communities.

One participant summarized it this way,

a) CLM puts the recipient of care of communities to monitor the availability, Accessibility, acceptability, and quality of TB screening and diagnostic services:
b) The data collected through CLM assist in identifying gaps and barriers in health service delivery faced by affected communities, and the same data can be used for advocacy at all levels to improve the Accessibility and quality of TB services.

In conclusion, CLM improves the delivery of health services.

The Situation of TB and Challenges in Gaza Province and the Main Challenges (Reach, treat, and cure)

The official gave a brief background on assessing TB cases in the province from 2018 to 2022. He stressed that the TB incidence rate in the province was severe, as it recorded 8,000 cases. The presentation shows that between 2020 and 2021, case notifications decreased from 8353 points to 7765 cases. He highlighted that only 30% of these cases were confirmed against a target of 55% recommended by the Ministry of Health. The districts that recorded the highest number of confirmed TB cases were Manjacaze and Chokwe.

However, he rightly noted that TB patients (people afflicted with TB) who seek TB treatment services in healthcare institutions have been negatively affected by the COVID-19 pandemic. The decrease in tuberculosis patients mainly occurred in 2019-2020, when COVID-19 precautions and movement restrictions were intense to break the COVID-19 chain. In another revelation, he underlined that in 2021, 434 people per 100,000 inhabitants contracted TB.

Figure 6: TB Focal Point Dr. Macasse representing PNCT Gaza Province at the TIMS III Workshop

However, despite the success recorded, the facilitator highlighted challenges encountered in coping, as summarized below.

- Poor laboratory network coverage, including limited functioning of the laboratories; chronic, frequent drug stock-outs
- Health facilities lacked proper storage facilities for the conservation of TB sputum samples, contributing to poor quality of specimens (sputum samples).
- Inadequate Genexpert device maintenance includes lacking reagents, consumables, and cathodes.
- Poor TB contact tracing in general, regardless of the special groups.
- TB testing among children was challenging as they often cannot expectorate sputum spontaneously.

- Weak use of the algorithms to detect child TB hence slower diagnosis and treatment of TB among infants
- Inadequate human resources, including a lack of enough clinical acumen to diagnose TB
- Limited operation of laboratories.
- Gender disparities. He noted that this issue has often been overlooked.

Key issues from plenary Discussions

The presentation generated some conversation points. For example, the participants sought to understand the status of TB among prisoners, including individuals who were incarcerated for short periods or are on remand awaiting trial. The participants further noted that Some prisoners/ inmates experience treatment interruptions as health services for TB are not readily available.

- What measures has the government implemented to maintain the gene Xpert properly?
- How did the government make all the success while there was a COVID outbreak?

Responses to the Questions Made

In response to the question on prisons, he noted that all the prisons in the province are accessing TB healthcare services. He further stressed that the role of the Ministry of Health is to provide TB treatment and care services and to advocate for those diagnosed with TB to be designated to separate places to avoid other inmates contracting the disease.

In matters about the maintenance of the geneXpert technology, he observed that the maintenance and repairing of gene Xpert is neither the duty of the government nor the province. It is the duty of the company that donated them. While this could be the arrangement, it concerns the government as the communities fail to access the required services.

Unpacking the TB National Strategic Plan 2020-2025

The presentation highlighted the gains attained in the previous strategic plan summarized as follows:

1. Reduction in the incidence of Tuberculosis, i.e., 544 cases for being cases eradicated in 2021 to 390 in 2018, which means that by 2021 the incidence of Tuberculosis was already at 361/100,000 inhabitants, and the mortality rate was reduced from 47 /100,000 inhabitants in 2021 to 37/100,000 in 2017. From a comparative view, there was a reduction, although we could not reach the established target: by 2018, we should be at 35/100,000 inhabitants.
2. Increase in the notification rate of all forms of Tuberculosis from 186,000 inhabitants in 2021 to 294 in 2016 and 396 in 2018; there was a gain because it was possible to increase the notification rate by 2021 to 319 per 100,000 population.
3. Regarding the increase in the success rate, the figures increased from 85% in 2011 to 87% in 2017 and 90% in 2018 and 94% in 2021.

The lost-to-follow-up rate reduced from 4% or less in 2011 to 1.6% in 2021.

Challenges highlighted in the strategic plan

- Financial restrictions
- Stigma and discrimination
- Influence of alcohol

Community challenges

- Long distances
- Taboos and Myths

Capabilities

- Limitation of laboratory services

Limitation of human resources

- Limitations on laboratory services
- Lack of reagents, consumables
- Lack of Geneexpert maintenance

Patient Level

Gender disparity

The Mozambican Strategic Plan 2023-2030

The Mozambican Strategic Plan 2023-2030 focuses on facilitating increased private sector participation, increasing quality sputum sample collections, and improving TB services. Likewise, it seeks to bolster TB supply chain investments to address widespread drug stockouts that negatively constrain patients' drug access. Moreover, issues of reduced waiting times for TB patients, improved medical and pharmaceutical supplies, and electronic records management, among other ICT-driven initiatives, are covered in the strategy.

The strategy also spells out its goal as reducing the incidence of Tuberculosis by 90%, since there is little time left, as well as increasing the treatment success rate greater than or equal to 90% and reducing the number of deaths from Tuberculosis by 95%, both how to reduce the number of families with Tuberculosis to zero, as well as exempting families from fees for treating the disease.

The facilitator also noted that the strategy aims to address other areas of intervention, investments targeting comprehensive packages to reach the entire population, expanding diagnosis and treatment, prevention, and creating partnerships with communities and the private sector with approaches focused on Human Rights, stigma, gender, and key population, as AMIMO works in this area for the protection of miners. The strategic plan for the deceleration of Tuberculosis was drawn up based on the prevention, diagnosis, and treatment of Tuberculosis. There are 160 health facilities, all of which can provide TB services.

Right to Health in the Mozambican Constitution

The Learning Objective of this presentation was to :

1. To explain the structure of the health system and the competencies at different levels in Mozambique
2. To understand the general norms for the operation of health services at the level of the health unit.
3. Know the common barriers to health services at the health facility level.

Right to Health

Based on the above objective, the facilitator informed the participants that the constitution provides that "All citizens shall have the right to medical and health care, within the terms of the law, and shall have the duty to promote and protect public health·

Structure of the Health Sector in Mozambique

The facilitator introduced the subject by outlining the structure of the health sector in Mozambique. She noted that Mozambique runs a decentralized health system at the national, provincial, and district levels. Besides, the healthcare system works on a referral basis; If the peripheral health centre cannot handle a case, it refers to the district hospital.

The Ministry of Health (MoH) formulates policies, strategic guidelines, and regulations. The Provincial Directorate of Health performs provincial planning functions at the provincial level in light of the strategic guidelines defined by MoH. At the district level, the SDMAS implemented the plans conceived at the district level according to the priorities defined by the sector and harmonized at the provincial level (DPS). The SDMAS, through its health network, provides primary health care to communities; strengthens the institutional capacity of the health units and supervises the activities; and all complaints and grievances that cannot be handled at the health facility level. In a nutshell, complaints and grievances are referred to the DPS.

Key Information About the Health Systems

The facilitators then explained to the participants the key elements the People affected by TB (patients) should know as their rights in seeking healthcare services. These are summarised and then outlined in greater detail:

1) The normal services of a health unit are open from 7:30 am to 3:30 pm.
2) The emergency bank and the maternity hospital are open 24 hours, and medical staff must always be available to attend to the patients.

3) If a given service is unavailable at the health centre, the health provider should refer the patient to the district hospital to access the requested service.

4) All exams, including diagnostics, are free. The patients should only pay for five meticals for the first consultation.

5) Patients who cannot afford to pay five meticals can also access consultations and medication provided they show proof that they are in a dire financial situation.

6) Patients who are in critical conditions, such as the elderly, expectant mothers, and patients with disabilities, are given priority

7) In case of stock-outs, the health professional is entitled to prescribe alternative medicines in the pharmacy.

8) It is prohibited in the public health sector for the patient to thank the medical staff with money or goods for the services provided.

The trainers gave a brief background to the barriers and asked the participants to identify the potential challenges common in health facilities. These include:

- lack of medication
- Insufficient medication dispensing
- lack of hygiene in the health unit
- Lack of equipment (beds, sheets, X-ray, etc.)
- lack of private space for appointments (two services operating in the same room)
- Absence of signs indicating the different services available at the health unit
- lack of ambulance/ambulance fuel

Understanding Community Rights and Gender (CRG) Concepts

The presentation aimed to equip the participants with knowledge and skills on handling gender issues, gender equality, and how this affects TB services linked to stigma and human rights.

The objectives of the session/ topic were defined as follows:

1. Understand the CRG concepts and how to integrate the three guiding principles underlying all the End TB goals and targets.

2. To Identify the human rights and gender barriers to TB services.
3. To establish the importance of monitoring human rights violations in TIMS III interventions.
4. To know the importance of promoting gender equality and how this impact TB services.
5. To establish the role of KP organizations in mobilization and ensuring accountability for TB services.

The Gender and Human Rights Specialist introduced her presentation, picking up from the previous presentation on TB's medical and scientific aspects. The facilitator noted that an estimated 10.6 million people became sick with TB, and nearly 1.6 million people died of TB in 2021. As a result, programs like the CLM and OneImpact seek to contribute towards reducing new TB infections and deaths. The presentation focused on

1. Human rights
2. Gender equality
3. Socioeconomic status/barriers affecting life that make somebody prone to contracting TB
4. Gender inequality

The facilitator further highlighted why countries should use the World Health Organization Human Rights Gender Equality framework, which stipulates the expected attainable standard of health, hinging on a proper record of human rights. She asserted that without adhering to universal human rights, countries could not attain the highest health standards.

Why is it important to understand Community Rights and Gender? This is because we need to generate evidence. The facilitator underscored the importance of evidence because:

- With evidence, we can inform the policymakers that the people affected by TB walk long distances to access
- With evidence, mineworkers and their dependents have the power to hold the duty bearers accountable, including the government.

- With evidence, we develop the action plan.
- The recipient communities can form a country action plan through a collaborative process based on the material evidence adduced.
- We can engage advocacy teams as a platform to form alliances, mobilize one another, and document best practices.

The facilitator highlighted that human rights apply to every individual upon birth and, therefore, cannot be constrained unless an individual commits a crime and is incarcerated by a competent court of law. She stressed that the right to life is a fundamental right of the human person, including miners, and the right to access healthcare is a social right.

Human Rights and Gender Equality

The relationship between human rights and gender equality was discussed, linking it to CLM OneImpact. The facilitator demonstrated why understanding the CRG fundamentals helps community volunteers to identify and report barriers to TB service uptake at community health centres. When conscious of fundamental human rights, they prioritize the availability of accessible, acceptable, and quality services to the community. Likewise, when community service users know their rights, they demand their rights to acceptable, accessible, and quality TB services. Thus, human rights knowledge helps communities identify and generate evidence. The conversation emphasized that Human Rights are applicable and accorded to every person upon birth. The government has the right to provide health services to its citizens. Common rights discussed include:

Right to dignity

For example, if the nurse tells you to remove your cloth in the open, you are deprived of your right to dignity because you are supposed to be attended to in a separate private room. The violation of one's dignity negatively impacts on the life of individuals and discourages health-seeking behaviours for TB services.

Right to information

For example, mine workers and ex-mine workers have the right to have unlimited access to information that helps them know about TB services.

The Social Economic Factors/ economic barriers:

The facilitator discussed socioeconomic barriers to TB service uptake that include:

1. **Gender norms – for example,** Culturally, women are obliged to cook and perform domestic chores. The men, on the other hand, is expected to provide for the family.
2. **Legal Framework:** What do the laws of compensation say about mineworkers and their dependents
3. **Gender Based Violence,** especially in accessing TB healthcare services. Who suffers most when it comes to sexual gender-based violence
4. **The existence or lack of community structures to handle or address the pressing need of KPs.** There must be a mechanism to handle these emerging issues.
5. **Lack of gender sensitivity in light of the mining industry:** There are differences between men and women in the mining sector, thus less attention to the needs of women.
6. **Cultural norms:** when we remove these social, economic barriers, we are talking about the barriers.
7. **Lack of information and education**

The point is to remove these barriers. How do you remove them? Work with the key population to inform you of the best way to remove the obstacles. The KP is experienced. Another point is that the quality of services provided to the KP must match the resources.

Why is it important for us to monitor violations?

a) To educate the key population so that they understand their rights and how to monitor their violation of the same.
b) To know the socioeconomic and economic barriers so that we can manage the root causes of human rights violations.
c) To protect and promote gender and human rights in TB treatment and care services.
d) We know their rights, and so we can deal.

Gender Equality in the Mining Sector

The facilitator sought participants' opinions concerning the understanding of Gender Equality**.** The facilitator noted that there is no wrong answer. To this effect, she encouraged the participants to share their definitions of Gender equality. One respondent mentioned that gender equality means equality between men and women. The facilitator highlighted that Equality means the same opportunities, rights, and responsibilities for men and women. For example, if there are jobs in the mining sector, these opportunities should be availed to both men and women. However, when women's and men's needs are equity-based, they consider the needs of men and women rather than provide equal opportunities. For example, those needing more support should get it if that gives them access to better, more responsive services.

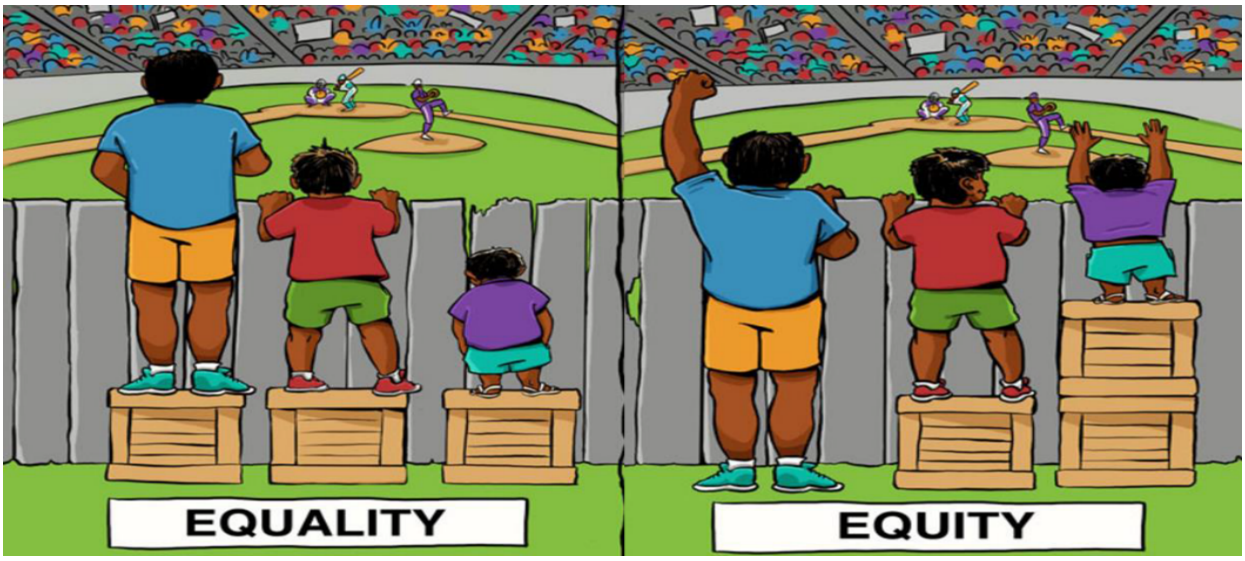


Figure 7: Illustration of Equality and Equity in TB services provision

- *On the left side, the three people were given the same opportunities without considering their needs. The provider did not go into the communities to consult with the key target population to determine their TB needs. Equality*

On the right side, the three people have the same opportunities but taking into consideration their needs. This is because the provider went into the communities to find out the needs of the vulnerable persons given available TB services

The facilitator concluded that the provision of TB services must be need-based. The TB beneficiaries and their dependents need different services, hence the need to conduct needs assessments before undertaking any interventions. The pictures capture the difference between gender equality and gender equity. The following presentation was on Gender-Based Violence.

Gender Based Violence(GBV)

The objectives of this session was outlined as aimed at ensuring that participants can:

1) understand the GBV concept and its different forms

2) The participants get to know the key aspects of Law 29/2009 and the Penal Code on domestic violence

3) To identify the rights and health services that victims of physical and sexual violence should be offered.

The facilitator led an interactive session allowing the participants to discuss their understanding of the difference between sex and gender. Some of the participants correctly differentiated th two concepts; defining sex refers to the biological differences between male and female individuals. On the other hand, gender was described as how people identify themselves.

The facilitators then provided detailed elaborations of the key concepts. The process involved reading paragraphs illustrating the various types of rights violated in each case.

By reading each paragraph, questions would emerge as outlined below:

- What type of GBV occurred, and what is the evidence or justification?
- What health rights were violated, and what is the evidence of their violation?
- What mechanism should be pursued to solve the problem?
- What type of services are needed to mitigate the situation?

The session also included group work in which participants were grouped into small groups and discussed the questions mentioned above. The participants then presented

their group answers to be heard, the right to be served, and the right to be attended to at local health clinics. The process helped the participants identify violations that may occur in the community to facilitate its reporting.

The Concept of Gender

To provide further elaboration on the concept of gender, the facilitators provided more examples to illustrate the Gender Concept in the context of TB, helping the participants to understand the concept comprehensively. The four elements explaining the idea of gender were summarised and then outlined in greater detail as follows:

1. Gender focuses on the norms, attitudes, behaviors, and ways of relating that define what it means to be a man or a woman in society.
2. Gender refers to the socially constructed relationships between men and women defined by society.
3. Gender equality means equal rights and freedoms for equal opportunities for participation, recognition, and appreciation of women and men in socioeconomic and political spheres.
4. Gender inequality - different opportunities and rights between women and men.

The facilitator observed that:

1. GBV results from the power relations that exist in gender relations. This violence is based on the inequality of power between women and men in society.
2. Both men and women can be victims of **GBV**, although the majority are women and girls.

Legal and Political Framework

The facilitator then explained the legal framework in greater detail to show the participants where the survivors of GBV could apply for legal assistance. The session also discussed specific laws and policy documents that guide gender-based violence in Mozambique. These include:

1. Law 29/2009 on domestic violence
2. Criminal Code
3. Family Law
4. National Action Plan to Prevent and Combat Violence against Women (2008-2012)

5. The multisectoral mechanism for integrated assistance to women victims of violence (Council of Ministers, June 2012)
6. Dispatch (January 2011) approves the standards of integrated care for victims of gender violence.

According to the Mozambican Law 29/2009 on Domestic Violence, domestic violence is a public crime. Anyone should report it to the police or judicial authorities whenever it is committed. The complaint can be made by: Family members, Health workers, police, and others.

The legal framework addresses the issues of sexual and physical abuse and their denigrating effects on the survivors of abuse.

Finally, the facilitator led a discussion to determine if participants knew the health services that should be offered to victims of physical and sexual violence. The conversation highlighted the Rights of Victims of Violence, which include the Right to Health, the Principle of equality, confidentiality and information, and the right to non-discrimination and privacy. The discussion also alerted the participants to the service protocols that entail physical and sexual violence.

1. Care Protocol - **Physical Violence** - Among others, include Instituting the treatment of injuries according to the diagnosis, encouraging the victim to participate in therapeutic sessions, and Reporting the case to the police authorities.
2. Care Protocol - **Sexual Violence** - urgently refer the survivor to a medical consultation; the survivor should not wash or change clothes before being seen at the health center. The protocol also explains the counseling and testing for HIV/AIDS and syphilis and post-exposure prophylaxis to HIV for survivors.

The facilitator explained that treating the survivors and providing prophylactic and curative therapies should be a priority in care. Finally, since the survivors need integrated care, the health professional must network and collaborate with other service providers such as police, courts of law, and the welfare department, including social workers.

The Concept of Human Rights

The third session of this training focused on the concept of human rights. The objectives of this session were to:

- Define and identify human rights and their connection with health rights
- Identify the types of human rights and forms of violation
- Establish the Government's obligations related to the right to health

The facilitator started the session with a brainstorming session to introduce the participants to the subject. The participants had some idea about human rights but could not easily link them to TB service provision. The facilitator then helped the participants contextualize the concept of human rights, as summarized below.

a) Human rights are rights that all human beings should have because they are human beings.

b) Human rights are rights without which human beings cannot live with dignity, such as the right to life, health, education, and others.

c) Rights set minimum standards for how all people should be treated by the state and by other persons or institutions. The following steps included discussions on the various forms of human rights violations as below.

Forms of Violation of Human Rights

The facilitator made the participants realize that potential opportunities for human rights violations present themselves daily hence the need to pay attention to situations that limit community access to TB services. The major categories of human rights violations are summarized below:

1. **Per action**: It occurs when the state, through its agent, actively acts and violates a human right, for example, when a nurse physically attacks a patient
2. **By default:** This occurs when the health professionals do not execute their duties per the established rules and procedures. For example, when a doctor in a public hospital does not provide urgent medical assistance because the citizen does not have money.

The Definition of Health

To illustrate potential human rights violations, the facilitator had to define health as a standard measure to benchmark and identify potential violations. Citing the World Health

Organization, the facilitator defined health as a *"state of complete physical, mental and social well-being and not the mere absence of disease or infirmity".*

• Talking about health also means talking about access to health units, medical treatment, the quality and human dignity of services, and the social conditions that affect health (sanitation, environment, premature marriages, education)

The Concept of the Right to Health

The facilitator interacted with the participants, discussing the concept of the right to health which includes:

1. Availability – whether the required TB services are available at the health centres
2. Accessibility i.e., whether the available services can be utilized by those who require them.
3. Acceptability, i.e., Whether the available and accessible TB services are of meet the required standards of care,
4. Quality, i.e., whether the TB services meet the prescribed quality national and international standards. Quality (services must be scientifically and medically adequate and of good quality. The next conversation focused on the government obligations related to health provision in Mozambique.

Government Obligations Related to the Right to Health

The facilitator took the participants through several state obligations regarding health services provided in the country.

• The facilitator emphasized that the state should:

a) **Respect the Right to Health**: Government should not hinder, directly or indirectly, the enjoyment of the right to health or interfere with how people exercise their inalienable rights.-

b) **Protect the Right to Health**, enacting and implementing laws favorable to the realization of the right to health, and put in place mechanisms and institutions that guarantee respect for the right to health.

c) **Promoting the Right to Health:** this ensures that the citizens are fully aware of their health-related rights and use them by disseminating accurate health information to communities about health rights.

d) **Comply with the Right to Health:** government must put in positive measures to ensure that health-related rights are enjoyed, enacting health legislation, broad policy guidelines, and adequate health budgets for medicines, expansion of health facilities.

In summarizing the discussion, the facilitator reminded the participants that the Mozambican Constitution (2004) provides for the right of all citizens to medical and health care. The next session presents discussions on the 4th day of the training.

Presentation of the Charter of Rights and Duties of Users

The day began with a review of the previous day led by the ACMERET Solution Consultant, who expressed great satisfaction with the quality and level of creative presentations and participants. He gave a review of the salient aspects of the previous series of sessions, emphasizing that the field staff should raise awareness of the rights of key populations to understand health-related laws.

The facilitator for the session then introduced the objectives of the presentation as aimed at enensuring that participants can:

1. Articulate the major contents of the Charter of Rights and Duties of Users.
2. Identify the objectives of the Charter
3. Establish the rights bestowed to the users.
4. Understand what duties users have.
5. Understand and discuss the negative impact on health when the principles of the Charter are not respected.

The facilitator introduced the theme by explaining to the participants that the Ministry of Health adopted the Charter on Patients' Rights and Obligations (Carta dos Direitos e Deveres dos Utentes) in 2006. It prohibits discrimination based on health status and guarantees the confidentiality of patient information. It emphasizes the centrality of human rights in health services, highlighting human dignity, equality, and ethics as fundamental values.

What is the Charter of Rights and Duties of Users?

The session began with a brainstorming exercise with the facilitator asking the participants to share their understanding of the Charter of Rights and Duties of Users

with the support of examples. The participants did not demonstrate knowledge of the Charter of Rights. As a result, the facilitator explained it relating to TB service provision. The facilitator emphasized that the charter of Rights:

- is an instrument where rights and duties are related to health.
- It guides the patients on how to enjoy their health rights.
- It is a mechanism through which the Duties of Users are best to present complaints and claims when their rights are violated.

Objectives of the Charter

The facilitator laid out the objectives of the charter as aiming at:

1. Placing the user as a central figure in the health system.
2. Reaffirm fundamental human rights in the provision of health care and, in particular, protect human dignity and integrity and the right to autonomy.
3. Develop a good relationship between users and professional health workers and encourage more active participation on the user's part.
4. Facilitate and strengthen new opportunities for dialogue among users, CBOs, professional health workers, and management of health facilities.
5. Promoting human dignity and courtesy in serving all users, especially vulnerable groups.

The facilitator underscored the point *`'that this instrument is so significant that every citizen should be aware of these objectives. Nevertheless, due to the lack of a reading culture among our people, we do not know our health rights.''*

The following presentation focused on a related topic of human dignity in health services in Mozambique.

Human Dignity in Health Services

An essential aspect of identifying potential violations in TB services provision is understanding what constitutes dignified services in public health. As a result, the following presentation focused on this crucial aspect. The facilitator summarized human dignity in health services in three aspects, as illustrated below:

1. Humanization in the health sector provides better service to beneficiaries and better conditions for workers.

2. Humanization presupposes, in the first place, the understanding of the meaning of human life, which also involves ethical principles and cultural, socioeconomic, and educational aspects.
3. Communication is key to humanization. Humanization depends on our ability to speak, listen, and dialogue with others.

Having discussed human dignity in health, the facilitator moved on to discuss the aspects of health service users' rights.

Users' Rights

The aspects of users' rights were introduced as part of the basic ideas that help participants identify and report potential human rights violations in TB services provision. The facilitator emphasized that in the course of service provision,

1. The user must be welcomed and treated with compassion, comfort, and harmony at the health service centres. One of the respondents asserted that *" the activists should defend the people affected by TB by going to health facilities and informing them about their rights"*.

2. The users have the right to receive information about health promotion and preventive, curative, rehabilitative, and terminal care appropriate to their health. The participants added that

"It should not be a matter of receiving medicines in the hospitals, but they should know the type of medicines prescribed by the medical personnel, when to take the medicines, taking into consideration that TB medicines are strong, the People affected by TB are entitled to know the after-effects. The right to information is violated if the patients do not obtain that information.

3. The users should not be discriminated against based on sex, race, socioeconomic status, religion, political and religious affiliations, or even the disease they suffer from.

4. The users have the right to confidentiality and privacy as stipulated. However, the participants noted in their group discussions that *"in some health facilities privacy is not sufficiently respected, and confidentiality of the TB patients is not maintained".* This contravenes the Charter on Patients' Rights and Obligations."

5. The users have a right to all information regarding their illnesses, treatment, and the costs

6. The users must consent before they receive any medical treatment, test, or examination. Likewise, the users can decline or halt any medical intervention.
7. The users have a right to be referred for a second opinion to a healthcare professional of their choice, i.e., they have a right to ask to be referred to a different hospital for continuous treatment.
8. The users' cultural values and philosophical and religious convictions must be respected. The participants raised concerns regarding some communities that believe in prayers to solve TB. The concerns were addressed, encouraging the Champions to educate the community on the role of clinical and religious interventions in treatment processes. The facilitator clarified that messages on the need to follow clinical advice should be emphasized with prayers as complementing the medical interventions. Thus, the message put across was that prayers Do Not replace medicines.
9. The user has the right to submit suggestions and complaints.
10. Children up to 8 years of age, when they need hospitalization, have the right to be accompanied by their mothers, who, although they do not have the right to a bed, will be provided with conditions to rest at night.

The issue of (grand)mothers taking children to hospitals raised a discussion around gender roles. The question was, Why are mothers the ones mostly taking children to hospitals? Some argue that mothers are more compassionate and closer to their children than fathers. However, other participants raised a concern that sometimes the conditions require fathers to be there, yet they do not feature during such times.

The Acmeret Consultant concluded the conversation by highlighting that *:*

> *" Much as I appreciate the issue raised by the male participant about gender roles, it is high time fathers to realize that time is changing. To this effect, fathers must take care of their sick children by not entrusting care only to mothers because they consider this as part of their role. Days have gone when the responsibilities of accompanying children to the health facilities are solely for mothers and grandmothers as it was in the past".*

After the exciting conversations on User rights, the following presentation focused on the flip-side to look at the rights and duties of people affected by TB.

Rights And Duties For People Affected With TB

The facilitator brainstormed with the participants through the interactive discussion to outline the Rights and Duties of People Affected by TB.

Some of the key rights and duties discussed include:

1. Users have to take care of their health.
2. Provide health care with relevant and accurate information for diagnostic, treatment, and counseling purposes.
3. Respect the rights of other patients and health professionals, and support staff.
4. Use the health care system properly and not abuse it, including collaboration with health professionals.
5. Comply with treatment procedures and respect the operating rules of health services.
6. The users must ask about the related costs of the treatment and arrange for payment.
7. The users must denounce illegal charges and other forms of incorrect behavior by health workers.
8. The users must not give any form of bribe to health personnel in exchange for better services.
9. The user must pay user fees within his economic possibilities. These modest amounts, within the reach of the majority of the population, are called user fees, and users have to pay.

Presentation About the OneImpact digital platform

The last two days were dedicated to participants' theoretical and practical training on the OneImpact Platform. The facilitators for ADPP Mozambique took the participants through the system, highlighting its core components and their reporting functions.

Composition of OneImpact digital platform.

The facilitators drew the participants' attention to the composition of the OneImpact digital platform, which consists of three major platforms, namely:

1. The **Application**: This platform has the major reporting functions, which entail: Knowing your rights, Getting information, having access, Getting Connected, Getting involved, and Survey.

2. The **Inbox**- The inbox platform records the Total cases, open cases, verified/approved cases, declined cases, and removed cases.

3. The Dashboard: The dashboard is the managerial platform that records and plots graphs based on the supplied information to help management make informed decisions from the data.

An important aspect of the session was the practical approach whereby the participants worked in pairs (one as client and the other as community-based volunteers) and simulated capturing TB data in the community. The process involved connecting a smartphone to a projector to allow participants to follow the proceedings and see the data being captured in real-time.

The participants were equipped with the knowledge to select the User, the province, districts, and the nearby health facilities, among other crucial functions of the OneImpact Platform.

. Additionally, the process helped the participants navigate the system to compile and compose reports. The specific skills gained during these practical sessions are as follows:

- Ability to send the TB reports
- They are equipped with the skills and knowledge to select the right services to report. These include human rights violations like the unavailability of medicines, rude staff, and dirty workstations.
- Skills to select the different TB services being sought at local health centers. These include Drug-resistant TB, multi-drug-resistant TB
- Identify the Key Populations seeking services. These are Mineworkers, ex-mine workers, families of mine/ex-mine workers, and mining communities.
- Skills to establish the number of people residing with a person ill with TB in the household (mineworkers and their dependents, spouses, and children)
- How to select the sex, age, and type of users i.e., People with TB, health providers, representatives of CSOs, and persons accompanying the sick person).

- Select the preferred health centre to receive the service, for example, Chidengelle health centre.

Key Issues from Group Presentations

Several comments, observations, and ideas came from the plenary after the OneImpact simulations.

For example, it was observed that there was a need to balance the time taken to talk to the clients and capture the information in the OneImpact tool. It was also noted that an ideal community-led OneImpact is when TB clients directly report their issues rather than rely on the Assisted model platform of OneImpact.

The use of local languages managed to help participants express themselves better and deliver the right messages. The presenters explored possible ways to make the presentations live to improve their audience's understanding of the concepts. The audience also suggested that community volunteers must prepare and plan to use the Assisted Model Platform to cater to many clients who do not have smartphones or cannot use the OneImpact.

Group Presentations

Below is a summary of the spectators' observations, comments, and supplements.

1. The activists engaged the people affected by TB using unique approaches according to their emotions, attitudes, and moods.
2. The plenary/audiences made various constructive criticisms, observations, and comments that added value to the Oneimpact digital platform program. One observer gave a useful insight: "We need to inform the people affected by TB about the importance of Oneimpact digital platform. It is one of the solutions to understand better the barriers, challenges, and anxieties that impede people affected by TB from accessing TB healthcare services in health facilities."

The Area Coordinator for AMIMO (Mr. Paulino Lai) advised activists to adopt a friendly approach (enabling environment) whenever they engage people affected by TB in meaningful conversation. It is a requirement first to study the moods of the people affected by TB, as these will give a basis for where to begin or starting point. Activists were advised to avoid unless otherwise asking questions such as:

- Are you a drug-resistant TB patient?
- Where did you confirm that you have multi-drug-resistant TB?

He emphasized that the sensitive information should be gleaned from the medical card or other documents from health centers, district hospitals, or provincial hospitals.

General Comments

Following the presentations/simulations, the participants made general observations:

- They noted that their TB clients might not have smartphones, which should not limit the activist from providing services. The activists should devise all possible ways to assist the people affected by TB in the target communities through the Assisted Model Platform.
- There should not be any people affected by TB to be left out because of technology- observed Dr. Zacharia Grand. In the simulations, the activists asked the people affected by TB to say the type of TB they suffer from.

The Acmeret Consultant and ECSA Gender and Human Rights Specialist added their voices on the need for community volunteers/activists to focus on helping patients access treatment services rather than on the OneImpact technology. While the technology is welcome and facilitates effective data collection, it should not impede on the need to provide accurate information and pay attention to the needs of TB patience during the conversations. The focus is on delivering TB services.

The rationale of having data is to know and identify the type of barriers the people affected by TB encounter. The point is to understand the program. What we must have at the back of our mind is that we shall not solve all the barriers but reduce them. A concern was raised about how the system will operate in areas with limited internet connectivity. The facilitators addressed the concerns when illustrating how the Off-line OneImpact system functions. The participants were informed that once the system has been connected to the internet, it can work Offline. The data collected through the offline mode is updated when one connects to the internet. Overall, the practical training on the OneImpact Platform effectively prepared the community volunteers for real-life experiences in the field. Some participants faced challenges balancing the navigation on

the platform and conversing with the clients. These are challenges that eventually get fixed through continuous practice in the field. The ECSA and Acmeret facilitators commended that the methodology adopted for the OneImpact sessions was the most appropriate and effective. The use of simulations and physical participation helped the participants to boost confidence, especially among the young participants, and the elders, like the Amimo Area Coordinator and Director, brought stability as their experience helped the younger participants to navigate complex scenarios. As a result, the ECSA and ACMERET facilitators promised to adopt this approach in the future, beginning with the next training in Zambia. In their concluding remarks, the facilitators urged the community to volunteer to ensure the success of this regional program which is a continuation of nationalist visionaries Samora Machel, Mwalimu Julius Nyerere, Mugabe, Kaunda, and the founders of post-colonial Africa who envisaged one Africa politically and now through health programs like the TIMS Project.

The Role of Community Health Committees and Co-Management Committees in Mozambique.

The role of Health Committees and Co-Management Committees is an essential governance structure that supports OneImpact CLM for TB programs in Mozambique.

The objective of this presentation was to:

1) To analyze the composition of the health committee and its role.

2) To identify actions that ensure the proper functioning of the health committees.

3) To identify the composition and role of the co-management and humanization committees

4) To establish the link among the health committee, co-management and humanization committee, and health workers.

5) Understand the health committee, its role, and composition

Figure 8: One of the ADPP Facilitators taking the participants through the role of Health Centre Committees in Mozambique

The session started with a discussion to determine what the participants already knew about health committees and their roles in the community and at the health facility level. She defined the health committee as the link between the community and the health facility. She highlighted that the governance structure allows community participation in health governance or management. It creates an enabling environment for the community to participate in health management.

Role of Health Committees

The facilitator led participants to discuss the role of health committees that, include:

1. The dissemination of health messages, planning and implement health campaigns in collaboration with peripheral health centers and district hospitals to promote health;
2. Communicate and disseminate health services information to the public.

3. Educate communities about their rights through conducting community health education sessions;

4. Listening and resolving complaints through holding regular meetings to provide feedback on resolving barriers, monitoring the availability of drugs and materials;

5. Participate in budgeting processes at the local level, thereby advocating for community priorities related to health services;

Apart from the role of health committees, the facilitator also discussed the composition of health committees as below.

1. Members include community members, vulnerable people, influential people, for example, multi-purpose workers, CSOs, traditional healers, and health volunteers.

2. Persons elected by eligible community members and traditional community authorities in a free and fair environment.

3. Gender balance is recommended in Health Committees, highlighting the essential role of women in promoting health at home, in the community, and health facilities

4. It is recommended that the functioning Health Committees have more than 15 people.

The training ended with a group photo below

Zambia

The CLM OneImpact training took place in Solwezi, the provincial capital of the mineral-rich North-Western Province. Solwezi is also the administrative capital of Solwezi District, one of the eleven districts in the North-Western Province, and Kitwe, a mining town in the Copperbelt region. The training took place between the 15th and 26th of May, 2023. It is the second largest city in Zambia and the copper-belt region's main industrial and commercial centre. A total of 25 participants from Kasempa, Mwinilunga, Solwezi, Kalumbila, and Mushindamo attended the workshop. Facilitators included the Ministry of Health National TB Program Staff and CITAMPlus, the CSO designated to implement the OneImpact CLM program in Zambia. In Kitwe, an HIV Specialist joined the Policy and Advocacy Officer and Program Manager for CITAMPlus. Twenty-three participants attended the workshop in Kitwe drawn from the Ministry district offices, Copperbelt Health Office, ex-miners, Twatasha Health Centre, Kamakonde, Kakoso, Chiwempala, Chipokota Mayamba, and Alexandra clinic attended the workshop. The workshop proceedings in both districts were the same, with different dynamics. For example, the Solwezi group was more vocal and active than the Kitwe group.

Workshop Proceedings

The proceedings began with participant registrations and introductions, followed by the workshop ground rules and expectations.

Ground rules

1. Speak through the chair
2. No side meetings
3. Phones on vibrations, silent
4. There is no wrong answer. Respect each others' opinions
5. Timekeeping/ Management
6. Start and end with a prayer
7. Full and active participation

Workshop Expectations

Learn about data collection for TB programs

Know how to educate miners and ex-miners on TB and health issues that affect them.

Knowledge of TB prevention of TB in mines

Learn about how to resolve the challenges that KPs face.

The team agreed to appoint a timekeeper and someone who prays at the beginning and end of each day.

Opening Remarks

The North Western Province Healthcare Specialist officially opened the meeting on behalf of the Provincial Director. He thanked ECSA-HC and ACMERET Solutions for organizing this crucial regional TIMS meeting. He urged the participants to use this opportunity to build the capacities required to coordinate and implement TB in Mines programs in the province. He reiterated the need for solid stakeholder coordination to ensure the program succeeds.

Figure 9: TheNorth Western Province Healthcare Specialist giving opening remarks in Solwezi, Zambia

TB in the Mining Sector in Southern Africa (TIMS) Phase III

The ECSA-HC Gender and Human Rights Specialist proceeded with an overview of the TIMS Project and the history and structure of ECSA-HC as done in previous workshops in Tanzania and Mozambique. The issue arising from the presentation is that it exposed how the miners and ex-miners lack essential information about TB in mines. The facilitator took time to explain how ECSA-HC works with National TB Program country teams to collect, analyze and report data on situations of miners in the member ad non-member states, particularly in East, Central, and Southern parts of Africa.

She further elaborated on the contributions made by the TIMS projects in various countries, including providing mobile clinics, supporting occupational health clinics for TB, and helping miners and ex-miners get compensation for injuries or related challenges experienced through their involvement in the mining sector. In Zambia, the facilitator informed the audience that the

TIMS project had been involved in TB in the Mines advocacy and information dissemination activities involving one late comedian. Over 80000 ex-miners have also been helped to pursue compensation with a South African organization that processes the claims.

Introduction of the Challenge Facility for Civil Society

The next presentation was on the Challenge Facility for Civil Society. The Citamplus Program manager made this presentation, linking it to the OneImpact CLM program. He highlighted that the Challenge Facility is a Stop TB Partnership grant mechanism for TB-affected communities and civil society to transform TB, Rights-based, gender transformative, people-centered, and accountable programming in most parts of the developing countries. He informed the participants that the Stop TB partnership grant mechanism is accessible to CBOs, CSOs, and affected communities. It is community-driven, gendered, people-centred, rights-driven.

Introduction to Background to CLM

The next presentation introducing CLM came from the Citamplus policy and advocacy officer. She highlighted that CLM aims to identify institutional barriers to services, human rights violations, lack of PPEs in mines, stigma, and discrimination which affects Zambia's ability to achieve its SDG and UN high-level targets. Some institutional barriers include the lack of capacity to engage effectively with decision-makers.To achieve CLM, Zambia will use the OneImpact platform. It gathers specific information and indicators on TB services' access, acceptability, quality, and availability. CLM aims to strengthen accountability and engage in TB advocacy at all levels.

The presentation addressed CLM in the context of community engagement to address TB challenges faced by Miners, Ex Miners, Mining community, First responders,Data Collectors, Decision Makers, and the Private Sector. She illustrated the challenges using the Where, How and Why approach.

Table 2: Illustration of CLM Focus areas

WHERE	**What**	**How**	**Why**
Mining districts	TB challenges	Using CLM and OneImpact Tools to collect data from mining districts	To facilitate • Advocacy-Evidence based • Program design and improvement • Accountability • Human Rights-Compensation

The TB Burden in Zambia

The ECSA-HC Gender and Human Rights Specialist and the Zambia Ministry of Health Chief Community Officer prepared the presentation. The Chief Community Health Officer made the presentation highlighting that Zambia is among the 30 Countries with a High HIV/TB Burden globally. She indicated that in 2021, WHO Classified Zambia as one of the countries with a global MDR-TB burden. Regarding TB notifications, she noted that the numbers steadily increased by 52% compared to the previous year. Out of these notifications, Lusaka ad Copperbelt contributes 60% of Notifications.

Gaps in the Current TB Response in Zambia

She highlighted that the high TB Mortality remains an issue in Zambia. In addition to that, the following issues were flagged as gaps in the national TB response:

- Low coverage of contact investigation for both contacts of DS-TB and DR-TB Patients and low DR-TB and Childhood TB Case detection.
- TB Awareness and demand creation for TB services are still sub-optimal
- No baseline data for community, rights, and Gender (CRG) and TB stigma
- Low TPT Coverage among U-5 Contacts of TB Patients
- Inadequate CBVs supporting TB Community activities
- Limited access to GeneXpert in rural areas and sub-optimal coverage of radiology services
- TB sample transportation faces frequent interruptions
- Electronic data capture and reporting not fully rolled out.

She further made an illustration of the bottlenecks in the TB sample transportation system, citing a study by eTB which shows that out of a

100 sample was collected in the community, and about

60 of them were transported to the health facility and

40 of them were sent to a diagnostic centre, and only

20 of these results were issued, and only

10 sample results were issued back to the clients.

The illustration above helped show the gaps confronting the TB program in Zambia.

The Situation of TB in North Western Province and the Main Challenges (Reach, treat, and Cure)

The session proceeded as a discussion led by the Catamplus Program Manager. The discussion focused on the missed TB Cases and the reasons for the high number of missed cases. Some of the contributing factors noted include the high ignorance about TB, Misdiagnosis of TB by health workers, poor data management, low TB notification, and reporting.

North Western Province 2022 TB Program Data

The Provincial TB and Leprosy coordinator presented on the TB situation in the North-Western province. The presentation helped the participants to appreciate the success stories and challenges the province faces in the fight against TB in Zambia.

The Priority areas for TB implementation were identified as listed below:

Table 3: TB Priority areas for implementation in North Western Province, Zambia

TB Case Finding	Program Supervision
Childhood TB	TB/HIV Collaborations
Contact tracing	DR TB Case Management
Expand Access to diagnosis.	Community Participation
Public-private partnerships	Electronic health records
TB Treatment/Case Management	

In terms of diagnostic services, the provincial coordinator indicated that the province has 32 Diagnostic centres of which 23 have the gene -XPERT Machines, 32 Microscopes, 11 X-Ray Machines, and 1 Mobile truck- Available for use at the district level coordinated under the Ministry of Labour-Occupational health. The province has one Confirmed senior TB Clinical Officer.

Solwezi district, with 930 case notifications, was ahead of all districts in this respect, with Kalumbila recording nearly half of the cases.

The major activities conducted in the province include

- TB Training
- Case finding
- Community-based sensitization
- TB Data quality audits

Achievements/ Challenges

The following are some of the challenges that the district faced in 2022

Achievements	Challenges
Increased childhood notifications from 10-11%	Low case finding
Conducted ICF in Correctional facilities	Low TPT intake in contacts
Activated 12 facilities for ICF	
Strengthened sample courier	
Trained 26 HCWs in electronic data reporting	

Challenges/Barriers Facing Key Populations Participation

Lack of access to information and distance to health centres were highlighted as significant challenges. The workshop established that while policies are available in some cases, what is lacking is the KP's understanding of how the policies protect them and the corresponding responsibilities. As a result, the facilitator emphasized that communities must equip themselves with information to design evidence-based advocacy programs.

Information is power, money. Therefore communities should focus on acquiring and updating their knowledge of TB and related problems. Other presentations by the Chief Community Health Officer were on Understanding available TB Services for TIMS KPs- and Unpacking the TB National Strategic Plan 2020-2025.

On the second day, the concept of CRG was introduced by the Chief Community Officer with support from the ECSA Gender and Human Rights Specialist. The focus was on the domestic violence law. The focus of the discussion was on the difference between sex and gender. Sex is the biological makeup of men or women, and gender is the roles played by males and females and the roles associated with each sex.

Human Rights

Human rights are entitlements by virtue of being human.

Rights Holders-Individuals- Participate and uphold personal responsibilities.

Duty Bearers- State- Respect human rights, and uphold the law.

Duty and right holder must work together for the best results-Two way process

GBV- Violence that leads to psycho, physical, and sexual harm.

Types of GBV

Sexual (defilement, Rape, Marital, Incest, Sexual harassment, Female Genital Mutilation)

Physical Violence- Psychological/emotional, Economic, Child Marriage, Intimate partner violence.

Causes of GBV In Zambia

The issue of Power imbalances and strong Cultural norms and religion are some of the factors highlighted as contributing to GBV in the North Western Province of Zambia.

Some of the major results of GBV include:

- Unwanted pregnancies
- Disability
- Depression
- Fistula and perpetual psychosis
- Diseases and infection HIV/STI

What are Key Populations?

Those who meet the following conditions.

1. Increased human rights violations.
2. Lower access
3. Increased vulnerability

What are Community systems ?

Structures, mechanisms, processes, and actors through which communities act on the challenges and needs they face

In Community systems strengthening, we should let the people take the lead in health matters that affect them.Community-based monitoring facilitates accountability, local monitoring, collating, and publishing of local data for local decision making.

Understanding CRG Concepts

The Chief Community Officer facilitated this session and emphasized that to effectively fight GBV, communities in Zambia require to understand key concepts of CRG. She highlighted that Zambia does not have baseline data for CRG issues. As a result, current efforts to effectively monitor CRG

issues remain ineffective. This affects the ability to compare and estimate the scope of the problem.

Identification of HR and Gender Barriers

Rights to health contribute to the realization of many other human rights:

- Right to Personal Integrity
- Right to be free from discrimination
- Right to information

Socio-economic barriers

The issue of strong cultural norms was a recurring factor highlighted as the major cause of human rights violations in Zambia. Some participants highlighted lobola as partly responsible for the socio-economic challenges contributing to GBV as the process commercializes an old practice designed to unite families and communities. It was noted that in some instances, successful ladies even pay their lobola to secure a marriage.

Other issues, such as female genital mutilation, were also noted as human rights violations in parts of the North-Western Province of Zambia. The participants also mentioned a cultural practice that allows r free-sex during specific cultural ceremonies in some provincial communities. While these practices could have been useful without HIV and TB, they have threatened women's health. They also highlighted challenges with confidentiality in some healthcare settings.

Discussion on the Zambian Health Charter

The Chief Community Health Officer of the Ministry of Health Zambia facilitated the discussion on the patient's charter. She used the English and Kaonde versions of the Charter to elaborate on key issues from the Charter. The discussion on the Patient's Rights and Responsibilities was guided by the key points as illustrated in the official document below:

Table 4: Summary of Patient's Rights and Responsibilities in Zambia

PATIENTS RIGHTS	PATIENTS RESPONSIBILITIES
All patients have the right to: 1. Respectful and safe access to health services	**All patients have the responsibility to :** 1. Respect the healthcare providers
2. Treatment without discrimination	2. Desist from verbal or physical abuse or violence against healthcare providers

3. Informed Consent	3. Desist from vandalizing health facility amenities, furniture, or equipment
4. Freedom from abuse	4. Follow the course of treatment and instructions
5. Personal or Physical Privacy	5. Be considerate of other patient's rights
6. Confidential Treatment	6. Report anything that appears unsafe
7. Complete information regarding the health condition	7. Keep all appointments
8. Access personal medical records	8. Provide accurate and complete information to healthcare providers
9. Freedom to provide suggestions or grievances	9. Fulfill financial obligations
10. Timely referral or transfer to another facility	10. Observe all safety policies and procedures of the facility

Role of Community Health Committees and Co-Management Committees in Zambia

The Chief Community Health Officer facilitated this session. She elaborated that the CHCs have a number of community roles: they disseminate information to communities on prevention and promotion, coordinate and supervise community health activities and initiate and participate in health-related issues at household and community levels. To support this, they identify, facilitate and coordinate training needs for the community; identify health problems in the community in conjunction with others, bring them to the attention of the health centre and develop action plans to address community health needs. They also have oversight roles in monitoring and evaluating health-related activities, conducting household registration once a year and seeking information each month on the existence of infectious and other diseases of relevance/concern, and holding services accountable for resources used. She proceeded to discuss the role of community based volunteers as a structure supporting CHCs to execute its governance and oversight roles. She noted that the CBVs however face a number of challenges in the course of discharging their duties. These include

- Strong religious beliefs that affect acceptance of health interventions.
- Poor logistics for delivery of community services.
- No identification and IEC materials to help communicate key messages
- Issue of dress code and wisdom to deal with community scenarios to avoid unnecessary resistance.
- Habits- eg carrying mineral water into the community.
- Poor disposal of medical waste
- Issue of eating or receiving gifts and food from communities.

On the fourth and fifth days, the CITAMPLUS program manager and Ivan from Dure Technologies co-facilitated on the OneImpact Platform. Despite challenges with internet connectivity, the session proceeded satisfactorily as the key processes were presented virtually and displayed on the big screen projector. Participants could ask questions, stop the Dure Technology representative from seeking clarification, or repeat specific steps. The session had the added advantage of getting direct support from Dure Technology, and it capacitated the Citamplus facilitators for the next training in Kitwe. On the last day, the participants could do simulations on the OneImpact Platform, indicating that learning had occurred the previous day. The participants demonstrated knowledge of key aspects of TB program modules, although some could struggle to deliver accurate information and enter the patient data into the OneImpact Platform concurrently. As indicated in previous sections for Mozambique and Tanzania, these common challenges were not unique to Zambia.

Figure 10: Workshop Participants performing a simulation on the use of OneImpact in Solwezi, Zambia

The major feedback on the simulations is that community-based volunteers should continue practicing using the OneImpact Platform to ensure easy capturing of the community issues and equipping KPs to download the application and report cases independently. The ACMERET Consultant for ECSA-HC highlighted that while community-

based volunteers could use the Assisted Module for reporting community issues, the ideal situation is for KPs to identify and report cases on their own.

The meeting ended with acknowledgments from DR Nchengamwa, the North Western Province Healthcare Specialist, on behalf of the Provincial Health Director. He thanked ECSA-HC for the financial and technical support to implement the TIMS in the North Western Province and for organizing a successful meeting. He also thanked ACMERET Solutions for the technical support on the CLM and the participants for actively participating in the meeting. He encouraged the participants to go and apply what they learned so that the communities could enjoy quality health services. The participants were also accorded a chance to give a Vote of Thanks. They acknowledged how the workshop proceeded, particularly the practical manner in which learning took place. They promised to go and deliver as expected. ECSA-HC donated 25 T-shirts for the Community-based volunteers to help with identification as they conduct their services in the community.

Kitwe Training

The second Zambian CLM training occurred between the 22nd and 26th of May, 2023, in the mining town of Kitwe. The participants included mine workers, ex-mine workers, Community-based volunteers, the Ministry of Health clinic, and district, provincial, and national staff. Kitwe is in the Copperbelt, which comprises 10 districts, 3 rural and 7 urban. The province borders the DRC. The ***Border Districts*** in the region include Chililabombwe, Kitwe, Masaiti, Mufulira & Ndola

The CitamPlus Program Manager chaired the session, which started with the registration of participants, introductions, and finding out what participants expected from the workshop. Some of the participants' expectations are as follows:

- To acquire knowledge on how to manage TB programs in the community
- Learn a more practical approach to TB in the mines.
- Gain more understanding of TB
- To get an understanding of TB concerning the mining sector.

- To go back equipped with TB knowledge
- To learn more ways of preventing TB.
- To know more about TB transmission
- To know more about Community-led monitoring.

Likewise, ground Rules were put in place to ensure order in the proceedings. These include ensuring that:

- Phones are in silent mode
- Participants speak through the chair
- Respect each other's opinions
- No side meetings
- Participants stick to the allocated time
- There are no unnecessary movements.

Remarks from ECSA Gender and Human Rights Specialist

She expressed gratitude for the Zambian team's ability to organize the workshop with representation from the KPs, including miners, ex-miners, and health and community representatives. She expressed optimism that the meeting will bring out insights on the TB issues on TB in Kitwe mines and how the OneImpact Platform would be useful in addressing some of the challenges. She also hoped that the workshop would build the participants' capacities to identify and address TB challenges in the community.

Figure 11: ECSA Gender and Human Rights Specialist giving special thanks and overview of the TIMS Project in Kitwe, Zambia

Background to the Stop TB Partnership Challenge Facility

The CitamPlus program manager was the next facilitator, introducing the Stop TB Partnership Challenge Facility. His discussion focused on three major TB initiatives in Zambia, which are:

1. Challenge TB Facility-
2. Tb Reach and
3. Diagnostic services

Just like in the Solwezi workshop, he took the participants through the history of the Stop TB Challenge. He highlighted that over 1500 NGOs and governmental organizations benefited from the facility since its inception in 2001. The Fund prioritizes TB patient-led organizations and is coordinated through UNOPs, based in Geneva. He further informed the participants that CITAMPlus is the focal organization for Stop TB Partnership in Zambia

The Facility's focus is to strengthen community initiatives to coordinate TB in communities, including procuring TB drugs, providing diagnostic support, and rolling out new data collection tools. Furthermore, the facility empowers communities and key populations, strengthening community systems and promoting community leadership in the TB response, ensuring that responses are people-centered, rights-based, and gender transformative.

Challenge TB Facility

USAID and Global Fund Strategic Initiatives supported to find missing people with TB. It focuses on empowering communities often not recognized as partners in community initiatives. A lack of resources for community initiatives compounds it. Through the challenge, the Facility for civil society provides grants to communities, civil society, and grassroots organizations for technically sound innovative interventions. It remains a creative, unique funding granting mechanism for TB at the grassroots level. Facilitates community-driven and high-level advocacy to overcome barriers to TB access. The facility aims to develop recognized civic organizations participating in global, national, and international TB advocacy work.

What does the Challenge Facility Do?

1. Community-led monitoring and accountability empower and engage people affected by TB to know their rights and report the barriers preventing them from being diagnosed and treated. The information is used for strategic advocacy.
2. Promote human rights. Ensures that laws and policies are consistent with human rights and social justice principles. Prohibits stigma and discrimination against people with TB and ensures all people affected by TB have their privacy and confidentiality protected and have access to remedies when their rights are violated. Empowers people infected by TB to participate in all components of TB response, including prioritization, design, implementation, monitoring, review, and governance. Establishes an enabling environment with legal rights to access TB prevention, diagnosis, treatment, care, and support that is acceptable. Ensures that programs and actions are tailored to the needs of KPVs and gender-responsive. Protects the privacy of KPVs
3. Supports gender equity in TB- The challenge Facility supports a gender-based approach to TB that aims at addressing the social, legal, cultural
4. End TB Stigma- National Governments committed to ending TB and all forms of discrimination in line with the political declarations. It supports countries in upholding this commitment; the Stop TB partnership developed the TB Stigma assessment tool through a collective effort with multiple partners.
5. Reach key and vulnerable populations- The Stop TB Partnership global plan to end TB describes key and vulnerable populations as people who have increased exposure to TB bacilli.
6. Empower communities and civil society- TB-affected communities and civil society must be engaged productively. This includes prioritizing interventions and approaches, implementation, monitoring, review, advocacy, and governance. Meaningful engagement also speaks to focusing on TB survivors and key TB populations.
7. Strengthen national partnerships- 1n 2019, stop TB partnership re-ignited its support for country-level partnership platforms that aim to realize the ambition.
8. Award those who care.

Introduction to Community-led Monitoring

The CitamPlus Policy and Advocacy Officer led the discussions on Community-led Monitoring. She highlighted that the rights-based approach empowers ordinary citizens and communities to have greater access to participatory processes in programs that affect them. She underscored that CLM generates evidence to inform program design and improvements. She told the participants that Solwezi and Kitwe were selected due to the high prevalence of TB cases due to the presence of major mining companies and more prominent mining communities. As a result, innovative initiatives using the OneImpact are being rolled out to facilitate programs to stop TB. She regretted that communication on the need to ensure participants bring smartphones compatible with OneImpact was not done effectively at the community level but anticipated that the workshop would resolve the gaps.

The Copperbelt TB Program

The Provincial Coordinator informed the participants that the Province has,

In total, 174 facilities offer TB treatment services in the Province, and 82 Health facilities perform diagnostic TB services. About 48 of these also have Gene Xpert machines, 79 conduct Microscopy.

Mining is the top-ranked economic activity in the province.

The TB coordinator indicated that the Program's priority focus is on:

Table 5: Kitwe Workshop: Copper Belt Province's TB Program Focus

• TB case finding • Childhood TB • Contact tracing • Expand access to TB diagnosis • TB treatment • Public-private partnership	• TB/HIV collaboration • DR-TB Case Identification • Community participation • Program supervision and monitoring • Electronic health records in TB

Her presentation also showed that TB notifications in 2022 generally declined compared to the numbers for 2021. The decline was attributed to partners' support, which ended for some programs, e-TB and GF.

The Covid-19 pandemic contributed to the decline in TB activities in the province. She also informed the participants that Childhood TB notifications at 6% are low against a target of 10-15%. She further indicated that outreach screening activities involving two mobile trucks are targeting hot spots in the district to increase the number of notified cases. Apart from the challenges, the Province at above 90% TB treatment rate is doing well, although the percentage is based on a few identified cases. She expressed optimism about Private-Public partnerships as

a possible way to raise more resources to reach out to more clients. The engagement of Community Volunteers and Gatekeepers is another strategy the province wishes to expand. Other initiatives include strengthening Program supervision and the M&E Smart Care-electronic system. TB Collaboration at 98% was considered good, but the coordinator emphasized that 100% is ideal for ending TB.

DR TB Challenges in the Copperbelt

- Challenges with gene xpert, culture,
- Support for DR TB. A World Bank funded used to provide food supplements and program support. The Program, which ended, used to provide food supplements that motivated TB clients to take their medicines.
- Low TB Case Notifications
- Low pediatric TB case finding 5-6%.
- Declining DR-TB case notifications
- Low TB cure rate

Key interventions o improve the Copperbelt TB Program are as follows:

- Enhance Regular Tech Support and onsite orientation in HIV/TB services
- Quarterly TB mentorship and technical support to raise the index of suspicion among clinicians and improve TB case management
- Training of clinicians in childhood TB,
- Roll out of other TB diagnostic methods for children (stool, LAM)
- Regular ACF and ICF activities by use of 2 Mobile TB Trucks
- Routine Contact tracing and facility-based routine Intensified Case Finding
- Conduct Quarterly Data review
- Rolled out cascade training in the 2022 new TB guidelines
- Collaboration with Occupational health safety institutions, the association of miners workers, and CSO operating in mining Districts.

What worked well in the TB Program?

- Childhood research
- Supporting Zonal leaders (Training, Transport, and Lunch)
- Stipend to CBVs (150)
- Engagement of Private Pharmacies and Facilities in TB Case Finding and referrals
- DR-TB Quality Improvement project
- Procurement and distribution of 19 LED Microscopes, 5 Gxpert machines, cartilages, slides, and other TB reagents

- Data review and TB/HIV Collaborative meetings
- Procurement and deployment of 6 Laboratory power back-ups
- ICF in Correctional facilities
- ICF Site Activation
- Sample courier (Intra and Inter districts)

Challenges/ Barriers facing key population participation in the Copperbelt region- Discussion

The CitamPlus HIV Speciali facilitated the discussion. She grouped the participants to discuss the challenges that TB KPs face as they seek treatment services. The following are the key issues from the groups:

Group 2 Presentation

- Lack of information about TB services
- The negative attitude of health workers
- Stigma and discrimination both in the commnunity and at home.
- Lack of policy to protect the welfare of key populations
- Poor health-seeking behaviour
- Long duration of TB treatment
- Severe side effects from some TB regimes
- Myths and misconceptions about TB transmission and treatment.

Comments: The group also highlighted that most Miners and ex-miners are more aware of silicosis than TB. Thus, TB remains linked to HIV. Therefore programs to disseminate correct information on TB are urgently required in the Copperbelt region.

Group 1 Presentation

Challenges faced by KPs

- Lack of transport and logistics- some are far from communities, no connecting road networks.
- Discrimination- TB is always associated with sexual infidelity.
- Lack of education on lifestyle changes, especially when on treatment, affects adherence. Will result in DR TB

- Poor reception from health care workers. Nurses are also scared that they may get infected. It affects the reception of health workers.
- Lack of adequate family support

Figure 13: Participants doing group work in Kitwe, Zambia

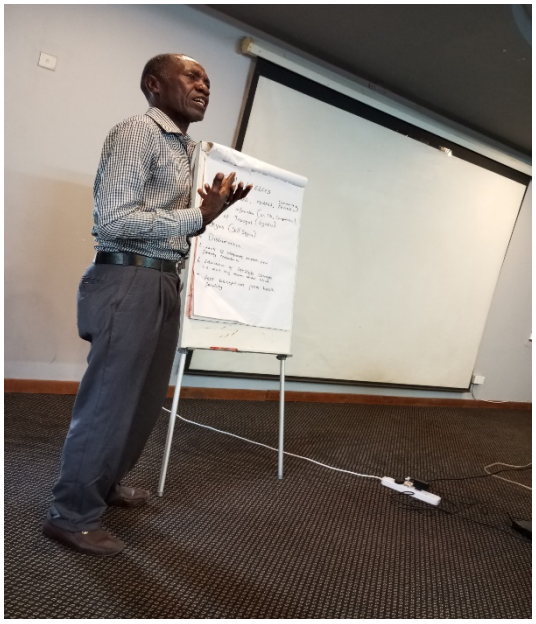


Figure 12: Participant making a presentation on behalf of the group

Understanding available TB services for TIMS KPs 9miners, ex-miners, and mining communities)

Just like in the Solwezi Workshop, the Chief Community Health Officer from the Zambia NTP team presented on this subject. She indicated that the Copperbelt contributes to the high TB burden in Zambia, which made the WHO classify the country in 2021 as among the 30 high TB burden countries globally. She indicated that Lusaka and Copperbelt contribute about 60% of TB Notifications annually. She mourned the high TB mortalities, which she said could have been avoided if cases had been identified early. She also called on the community volunteers to make a difference in communities by actively ensuring contact investigations are followed through for both DR-TB and DS-TB patients and increased early detection of DR-TB and childhood TB cases. She further encouraged the participants to pay attention to pediatric contact tracing, which she said was not being prioritized. Other interventions like TB awareness and demand creation were highlighted as low in the Copperbelt. As a result, she called upon the participants to work collaboratively to ensure TB services cascade down to the communities. Just as she noted in the Solwezi training, she indicated that the absence of baseline data for community rights and gender(CRG) and TB stigma remain a programming gap in the Copperbelt and the country. She also indicated that the low numbers of Community-Based Volunteers remain a challenge. As a result, projects like TIMS are providing the necessary support to equip the available CBVs to

effectively improve TPT coverage among U-5 contacts of TB patients, among other key TB indicators. She also discussed how the poor TB sample transportation system is impacting TB services in the country. She noted that poor sputum specimen collection remains challenging even in the Copperbelt, which has 7 out of 10 urban districts. There are cases where saliva is collected instead of quality sputum specimens. Lastly, she noted that the electronic data capture and reporting system, which is not fully rolled out, could receive a boost through the OneImpact. The system, which does not get down to communities, will now receive input from the OneImpact, which collects data directly from service users.

On the second day, the Chief Community Health Officer started the day by introducing basic knowledge about TB, covering its medical and community aspects. The presentation aimed at equipping the community-based volunteers with accurate information about its causes, transmission modes, effects, and treatment regimes available in Zambia.

Figure 14: The Zambia NTLP Chief Community Health Officer presenting on the basics of Community TB, Kitwe, Zambia

On the second day, the major issues discussed were mostly CRG and the patient's rights. The participants were encouraged to bring out any Human or patient rights they had witnessed violated. The participants brought out the issue that it was not only the patients whose rights were always violated but that also even the health service providers sometimes faced abuse from the clients and that, in some instances, they were even beaten up.

Many local scenarios were used, and participants were shown how gender-based violence could affect someone who was taking TB medication and cause them to adhere poorly to medication or fail to complete their treatment.

The aspect of tradition and culture was very topical as an integral cause of GBV in the Copperbelt as the participants brought out harmful practices mainly affecting women, making it difficult for a woman to either seek medical care or take TB drugs. As people living in a mining community, the participants did indeed allude to the fact that they had seen several miners being discriminated against after being found to have contracted TB. The participants revealed very unusual coping mechanisms for work-related stigma in some mines in the Copperbelt region. For example, they revealed that some miners had resorted to paying for fake results to keep their jobs. Alternatively, some miners would pay colleagues to supply their urine to pass the test if they test positive for TB or silicosis to escape possible termination of employment.

It was also noted that the mines' testing facilities mainly concentrated on silicosis and did not usually test for TB. The index of suspicion amongst the medical personnel in the mining facilities was also low, and the participants encouraged the government to take TB training at these private clinics.

In concluding this session, the ECSA-HC Gender and Human Rights Specialist took the stage to round off the discussion, ensuring the participants grasped the key concepts. She achieved this objective by asking the participants to restate the key issues they learned from the earlier discussions. The process was a crucial triangulation process to the vernacular conversations earlier in the session.

On the third day, the participants were taken through Community-Led Monitoring details. The presentation linked CLM with the current community structures in the Copperbelt health system to help participants understand where CLM and their input fit in. Their roles as champions for CLM OneImpact were spelled out, including how to engage key community stakeholders and gatekeepers while implementing the One Impact.

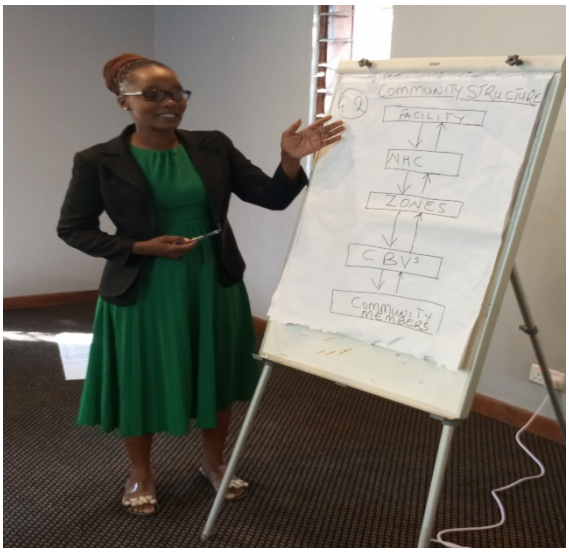


Figure 15: A participant illustrating the community reporting structures in Kitwe, Zambia

The participants were taken through the steps of identifying stakeholders and engaging them and were reminded that all communities are different and needed to ensure that they did not go against any of the rules in the communities. The presenter also reminded community CLM champions to follow reporting structures, etiquette, and procedures when conducting community work. Their conduct in society determines whether the community receives its key messages.

The Consultant and ECSA encouraged CITAM to lead the project in close partnership with the Ministry of Health. They were happy that steps to address this gap were made as the Program Manager for CITAMplus successfully led all the key aspects of OneImpact, unlike in the Solwezi Training, where the training relied on Dure Technologies. As a result, the workshop proceeded without Dure Technology's direct support. They only provided help, such as passwords and other back-end support, for the training to succeed.

On this third day, the participants were introduced to the application. They were taken through the step-by-step processes from downloading the application and installing it to viewing the dashboard. The hands-on process took the participants through the key OneImpact modules, including the survey and the dashboard. The processes of capturing client information and tracking the status of the reports were done until the cases were resolved.

On the fourth day, the participants were paired up into groups to facilitate simulations of the practical capturing of TB data into OneImpact Platform. Based on the approach's success in the Mozambican training, the program coordinators for ECSA and the ACMERET Solutions Consultant agreed to replicate this good practice in the Zambian training. In this simulation, one participant acted as a client, and the other as a Community-Based Volunteer.

They were then asked to play out how they expected to perform in the community, whilst the other participants in the room would rate them on how they had performed. This act was able to bring out any issues that the participants might find in the community band the different situations in which they could find themselves while out in the field.

The added advantage of this approach is that these interactions also helped the participants continue using the application and gain the expertise needed to familiarize themselves with it once out in the field.

There was also a general discussion of what kind of data was currently being collected for TB in the facilities by the community CBVs, and the response to all these was that the data was about diagnosis in the TB registers. There is no qualitative data on service delivery, which the OneImpact tool was trying to address.

On the fifth and last day, the OneImpact Simulations focused primarily on the dashboards. The process continued to help the participants understand how their reports would be processed once received by the healthcare workers who manage the dashboards. The last day was mainly about continuing the practice of using the one impact tool, especially the dashboard, and later, the participants were informed on the next steps, followed by the closing of the meeting. The participants were informed that they would be provided with official contracts stipulating a stipend and support for internet data, which they would receive monthly to support the data collection process for three months. The data will be cleaned, analyzed, and reported in a regional validation meeting as part of the training outcomes.

Zimbabwe

Kwekwe and Shurugwi CLM Training

The workshops were conducted at the Rainbow Towers, Bulawayo, from the 12th to the 23rd of June, 2023. The participants were drawn from Shurugwi and Kwekwe districts from the Midlands Province and Sanyati and Bubi Districts for Mashonaland West and Matabeleland North Provinces, respectively. The 50 participants included community-based volunteers and district and facility health staff involved in TB programs. The facilitators were drawn from the Jointed Hands Welfare Organization and Ministry of Health NTP Community Health and Advocacy coordination teams. The trainers collaborated in all crucial aspects of the training, making it one of the best organized and facilitated CLM workshops.

The chairman on the first day was the Zimbabwe National Community TB Coordinator. He allowed organizations to introduce their teams before self-introductions by the participants. The other two members were the Ministry of Health team members, the National Communications and Advocacy Officer, and a Transport coordinator. The Jointed Hands Welfare organization team included its senior program manager, a Data Officer, and a program Officer. The ECSA-HC team constituted an Admin and Finance officer led by the Gender and Human Rights Specialist. The ACMERET Solutions Consultant was also introduced as part of the technical team responsible for the country's training programs.

Figure 16: On the left, participants helping each other to navigate OneImpact. On the Right, the CitamPlus HIV Specialist chairing discussions on the OneImpact Simulation

The National Communication and Advocacy Officer made the welcome remarks. In the welcome remarks, he shared that if one wore a tight small-sized shoe, it would make one angry and irritated the entire day, which translated to mean that one has to have the right attitude for the training if they are to benefit from this training.

The day's Chairperson gave the administrative announcements regarding the accommodation and transport reimbursements and related provisions to keep the participant's training comfortable. The logistics required at least a day to be addressed by the ECSA-HC team; hence the participants were informed to make initial arrangements for the day.

The first presentation was from the ECSA Gender and Human Rights Specialist who provided the Background to TIMS III. This established norm of starting with the background of the TIMS project proved very effective in providing a solid understanding of the history and future of the TIMS project for the participants.

She reiterated that while Key Populations could mean various target populations like HIV+ or Men Having Sex with Men, the TIMS project focuses on Miners, Ex-miners, their families, and their mining communities. She concluded the presentation by asking the participants what constitutes KPs in the TB program. The participants were able to name the four KPs. The language dynamics that required to switch from English and Ndebele and Shona required the facilitator to confirm if the participants had followed through with the proceedings.

The JHWO Senior Program Manager made the second presentation and discussed the STP Challenge Facility's Background. Like the Zambian experience, the facilitator asked the participants if they knew about the Challenge Fund for Civil Society (CFCS). The common knowledge that the participants have is that we are non-governmental organizations, whereas we are also named civil society organizations. So, the CFCS was then mentioned that it is Challenge for Civil Societies.

The Programs Manager informed the participants that the USAID and Global Fund are the primary funding partners for the CFCS. Some funded programs under CFCS include the JHWO's Multisectoral Accountability Framework (MAF. This program ensures that all

players within civil society and the government, influential people, and the private sector are involved in the fight against TB. Just like in Zambia and Mozambique, Zimbabwe was in its 11th round under the CFCS, and the JHWO was the grant-holder in Zimbabwe; the same was CitamPlus and Amimo are the holders in Zambia and Mozambique. The lively presentation occasionally broke into short songs, helping to emphasize some key community messages.

The ACMERET Solutions Consultant made the third presentation for the day for ECSA-HC who introduced the CLM. The presentation was discursive as it required the participants' attention as it was the heart of the training. He started by asking what a community was and then asked from the discussed definitions what Community led monitoring (CLM) is. He emphasized that Community Led monitoring is the future of implementation as the funders are returning to the basics of getting accurate information from the community that is receiving health and social services from health facilities.

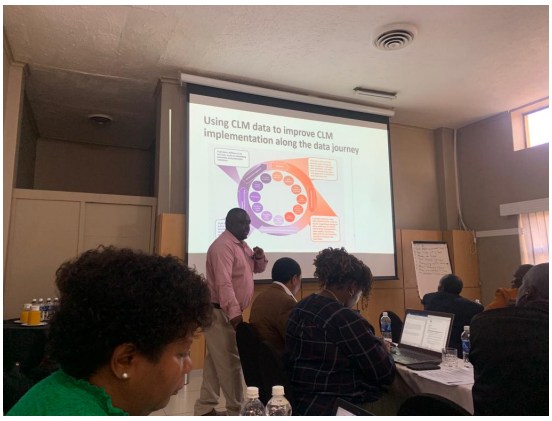


Figure 17: ECSA-HC Consultant from ACMERET Solutions making a presentation on CLM, Bulawayo, Zimbabwe

He mentioned that the idea of CLM was not new , but the emphasis is renewed to ensure that health systems improve as originally conceptualized under the Primary Health Care approach. In his presentation, he also mentioned that data should be packaged in a communicable and evidence-based way. This evidence is quantitative and qualitative. He mentioned that if the data comes only as quantitative or qualitative, the story will remain incomplete until the two come to complement each other. He explained that Quantitative means numbers while Qualitative means data presented as descriptions or narrations about TB issues from the communities. Once the story is complete, evidence to inspire

advocacy programs becomes available. CLM promotes factual rather than emotionally driven decisions. Advocacy programs were street-based and emotionally driven in the past, but current approaches require gathering, analyzing, and presenting factual information to influence decision-making. His presentation covered the various tools that CLM uses to collect data, including quantitative and qualitative data collection questionnaires, reporting templates, and paper-based or computer-based platforms.

The National Communications and Advocacy Officer from the Ministry's NTP made the fourth presentation on the Overview of the TB Programme in Zimbabwe. The presentation was lively, with many relatable and live case studies that intrigued the participants. In his presentation, he shared the international and national standpoint of TB. He informed the participants that, Zimbabwe has moved out of the top 30 countries with high TB notifications although there is still much work to be done. He used graphs to illustrate the declining TB cases, particularly from the early 2000s when the Ant-retroviral programs were rolled out.

Figure 18:The National Communications and Advocacy from the NTLP, Zimbabwe team making a presentation on the Overview of the National TB Program in Zimbabwe, Bulawayo, Zimbabwe.

He asserted that this decline helped researchers to relate HIV and TB co-infections since the increase in ARV uptake led to a declining case of active TB cases in the country. Likewise, TB cases increased in the 1980s when the first case of HIV was identified.

The facilitator also attributed the success stories in the fight against TB to the availability of new diagnostic technology, including the Gene Xpert and new solar-powered equipment that is more accurate. He showed a map showing the national GeneXpert distribution in each district. For example, in the Shurugwi district, the testing machine is at the Zvamapande clinic. He reminded the participants about the SDGs targets by 2030 and the country's plan to achieve these goals for TB. He argued that the goals are achievable as the statistics show that work is happening on the ground. He also emphasized the importance of family as the foundation in supporting the elimination of TB and other related problems, such as drug abuse.

The fifth presentation zeroed in on the district TB program for Shurigwi, one of the OneImpact CLM districts in the Midlands Province. The district TB Coordinator presented focusing on TB in the target districts.

The presentation drew evidence of work done in 2021 showing the effects of Covid-19, although they managed to achieve better results. He mentioned that the performance-based stipends for health staff contributed to the achievement of most set targets in the district. He, however, expressed disappointment over the high death rates at 12%, which is twice above the national target of 5%. The presentation raised two questions a the end. An inspired CHW asked why scenarios in which they screen cases and refer to the clinic where they are told that it's ordinary flu despite TB symptoms and later die of TB. The CBV wanted to know what steps should be taken in such situations. The second question was on what actions CBVs should take in cases where women on ARV/TB treatment do not disclose their status if it threatens their marriage, compromising their ability to adhere to the TB treatment.

The JHWO Programs manager also added his concerns based on evidence following a recent donor visit to the districts with the USAID which showed that gaps still exist in areas such as Pediatric TB diagnosis. The district TB Coordinator indicated that despite the investments in pediatric TB training that include the use of stool to pick TB, nurses and some laboratory staff were not comfortable working with stool as a TB specimen. He

mentioned nurses' disapproval and disgust with collecting stool samples for childhood TB. The second comment was that the district had good examples of advocacy issues collected through community dialogues. The third comment was that of transportation of the CBVs as they will be going to sites, and he said that they could create public-private sponsorship with private companies to buy motorbikes which they can use for publicity and marketing of their contribution to the community as corporate social responsibility and for marketing of their services.

Another issue highlighted affecting the district TB program is the reduced stipends, which are at USD8 per day, down from $29 per day. He said Doctors prefer to stay in town to attend to their private patients, who will pay as high as $90 daily. The Communication and Advocacy Officer commented that when health staff refuses to conduct procedures like stool sample collection, it shows a lapse in the nursing management hierarchy as someone should supervise these processes. The chair also explained why sputum was also being collected through stool as children are unable to pass sputum from their mouths hence being collected through stool.

Due to the delays in starting on day one, two presentations were moved to the second day, and the day ended with a word of prayer.

On the second day, the training started on time at 0830 with a song and word of prayer followed by a recap by the JHWO Program Officer. As the rapporteur for the previous day, she allowed the participants to contribute to the recap. To recover the previous day's time, the presentations were delivered during the first hour since the training started earlier than the previous day.

In the second day, the facilitator introduced the presentation on challenges that KPs face using a scenario where clients would be turned away because the Health Facility Staff was not trained in a particular skill. The JHWO Programs Manager addressed the issue through his presenation, which started with correctly identifying the TIMS KPs. He used potograhic illustrations to check if the participants had understood the previous day's presentation by the ECSA-HC Gender and Human Rights Specialist. Some of the Barriers mentioned by the participants during the presentations were as follows:

1. Time to seek medical help as the miners would want to go back underground and search for money because the delay in going to the health facility would mean that they may lose money.
2. The distance to the health facility may be too long to travel on foot or by public transport.
3. Unavailability of a Health Staff that might help in terms of TB, a particular nurse responsible for collection sputum.
4. Ignorance from the Miners to access Health Facilities.
5. Lack of Information on Health education on TB from Foreman of Miners
6. The miners would still not go to the Health Facility even with referral forms.

As these contributions came in, the Presenter enlightened the participants that they are not policing agents but should work collaboratively with health staff.

The National Community TB Coordinator made the next presentation on the Objectives of the National Strategic Plan 2021-2026 and the TB services offered by the government for the TIMS KPs. 8 objectives were highlighted, and these were:

1. To increase the treatment coverage of drug-susceptible TB from 83% in 2018 to 90% by 2026
2. To increase the treatment success rate of patients with drug-susceptible TB from 83% in 2017 to 90% by 2026
3. To achieve universal HIV testing and ART coverage for TB cases by 2021 and sustain coverage through 2026.
4. To cumulatively detect 2,680 patients with RR/MDR TB between 2021 and 2026
5. Increase the treatment success rate of patients with RR/MDR TB from 57% (2016) to 75% by 2026.
6. Decrease the proportion of households facing catastrophic costs due to TB from 80% in 2019 to 50% by 2026
7. Scale up leprosy prevention alongside integrated active case detection.
8. Strengthen Programme coordination and management and enhance accountability.

The services being given to TIMS KP in the country are:

1. Conducting TB screening campaigns in artisanal mining zones at least once every quarter
2. Holding coordination meeting with IOM on TB services regarding TB screening among miners, cross border, and migratory communities
3. Holding annual collaborative meetings with IOM and the correctional service commission
4. To hold meetings to develop the mobile TB vans' schedule and review the service quality under the mobile TB trucks.
5. To conduct targeted TB screening using x-ray trucks, especially in hot-spot areas/slums/correctional facilities.

He added that there are now nine mobile X-ray trucks – 1 per each traditional province, including 1 for both Metros, and X-ray equipment and laboratory equipment are housed in the truck. Trained and skilled provincial teams supported by district teams, clinic staff, community health workers, and local leaders would be moving around with the truck targeting the KPs. The trucks offer free TB screening, HIV testing, Diabetes screening, Hypertension screening, and COVID testing to community members.

The ECSA-HC Gender and Human Rights Specialist presented the third session on Gender and Human Rights in monitoring TB Services. The interactive presentation was a co-presentation with the JHWO Program Manager, who provided the local Shona and Ndebele translation to ensure the conversations were clearer to all participants.

Figure 19: The ECSA-HC Gender and Human Rights Specialist and the JHWO Programs Manager Co-Presenting during the Bubi-Sanyati group training in Bulawayo, Zimbabwe

She began by checking if the participants understood TB service challenges in the context of gender and human rights. From their understanding, she began asking questions like TB, its symptoms, and Human rights. The presentation covered the following objectives:

1. Understanding the relationship between gender, stigma and human rights and TB services - (integration of CRG concepts to End TB goals/targets)
2. Identification of relevant human rights and gender barriers to TB services
3. The importance of monitoring human rights violations - Monitoring of human rights violations by KP
4. Understanding the importance of promoting gender equality in the mining industry to reduce barriers to TB services.
5. Role of KP in mobilization and ensuring accountability for TB services

On the human rights legislative framework for Zimbabwe, she highlighted specific Constitutional and legal provisions that protect women and human rights in Zimbabwe. She cited Chapter 4 of the Constitution, which sets out a wide range of rights for Zimbabweans. Similarly, Sect 29 talks about the right to life, Section 49, the right to personal liberty, Section 75, the Right to education, and Section 76, the Right to basic health. She emphasized that the Constitution says that the State "Must" take reasonable measures to ensure the availability of healthcare services, including providing facilities, equipment, and medicines. Thus, human rights are not negotiable.

Similarly, Section 76(3) talks about Special vulnerable groups should have access to healthcare services. Specifically, she cited other Legal Frameworks protecting HR, including the Health Act (chap 15:16), which talks about universal health access. The important message from the figure is that in real life, men have more than they require,

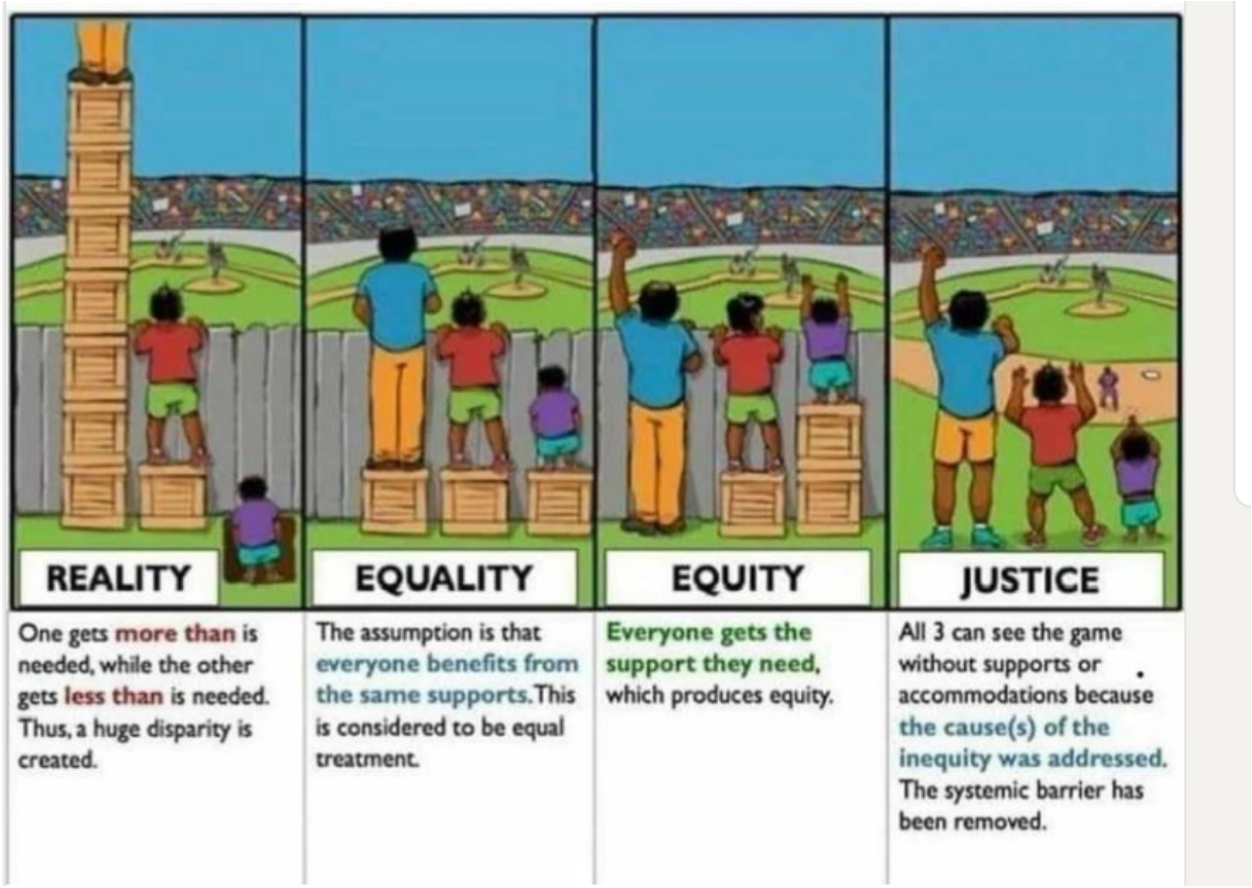


Figure 20: Illustration on Reality and Justice

while women and children get less than they need. As a result, most programs have focused on providing safety nets to negotiate around the barriers to TB services. Yet, what is needed is a focus on neither equity nor equality but on justice which involves removing the barriers in the first place.

Thus, the government and civil society should focus on removing barriers affecting TB service uptake, as illustrated in the improved version below.

She concluded that using platforms like OneImpact and CLM aims to address questions beyond equity and equality to promote justice.

The next presentation by the JHWO Program Manager was on TB Related Stigma and Discrimination. He used story-telling to illustrate some of the key points from the previous

presentation by the ECSA-HC Gender and Human Rights Specialist. The facilitator wanted to hear the stories from the community about the stigma and discrimination experiences. He emphasized that when CBVs can identify TB-related stigma and discrimination, they will be able to report the cases using the OneImpact Platform

The fifth and last presentation for the day was done by the National Communication and Advocacy Officer, who discussed the Patient Charter. The facilitator emphasized that enjoying one's rights should not infringe on other people's rights. The charter is designed to standardize service provision at health facilities. The following are some of the rights and Responsibilities provided in the Charter.

Table 6: Zimbabwe's Patient Charter Rights and Responsibilities

Patient's Rights	**Patient's Responsibilities**
Right to Privacy Right to choice of care Confidentiality Right to safety Right to adequate information and consent Right to redress of grievances Right to Participation and Representation Right to health education Right to a healthy environment TB patients are free to move around unless they are quarantined. *It is a legal requirement that clients accept treatment where the condition may affect the wider public.*	Patients must take medical advice. Admission and your stay in the hospital Inform your relatives Keep your clothes and valuables safe

The facilitators introduced the OneImpact Platform to the participants on the third day. The process included step-by-step support from the Ministry of Health ICT Officer and JHWO Data Officer. The process began with opening Gmail accounts for the participants,

which is essential for enabling the creation of login details. Likewise, they were introduced to OneImpact from the google play store. However, they first used the old OneImpact Platform for practice to avoid interfering with live data since the platform is active in Zimbabwe. They downloaded the one shared on WhatsApp. This is a training Instance of OneImpact; this would not affect the data quality captured in the live data.

As this was happening, Dure technology had started with their upgrade of OneImpact; this also delayed the start of the OneImpact app as there were changes made to the live instance, not made to the training instance. However, corrections suggested Gender statuses by other countries were addressed, and the application has become simpler with different colors.

The JHWO Program officer presented on the OneImpact Dashboards. The participants were encouraged to enter data into the platform, and she would demonstrate how reported issues are resolved. On the fourth day, the facilitators checked the suitability of android phones for most participants. They encouraged the participants to procure new phones in town, which cost between $USD65 and $ USD$75. Most participants voluntarily purchased the phones using their own savings in time to take advantage of the facilitators to help them navigate the new phones. They took this opportunity as a way to contribute to community service by using personal phones to report CLM data in the project. Even the participants with good Android phones bought new phones dedicated to the OneImpact Platform.

The Sanyati/Bubi District Training

The second training for Zimbabwe involved participants from Sanyati and Bubi districts. The meeting occurred between the 19th and the 23rd of June, 2023. The program for the meeting was the same as the previous group; hence this section will highlight aspects of the training peculiar to this group. The group was made up of representatives from mine clinics, community-based volunteers, miners, and ex-miners. Based on the lessons learned in the last group, the facilitators informed the participants about the need to procure an Android smartphone to facilitate effective learning.

The Ministry of Health and Child Care Communications and Advocacy Officer welcomed the participants and officially opened the workshop.

The Gender and Human Rights Specialist presented the first presentation covering the background of ECSA-HC and TIMS projects. The presentation, as usual, covered the key issues that include:

1. Overview of ECSA-HC
2. Background on TIMS I and II
3. TIMS Phase III
4. The key stakeholders to the TIMS project
5. Key ECSA-HC structures and their roles in the TIMS project.

Issues from the overall background presentation include challenges faced by the previous coordinator of TIMS in Zimbabwe. The JHWO Program manager informed the group that the Ex-miners represented by the former WENELA miners generally had coordination challenges, with some of the leaders driving personal agendas at the organization's expense. He assured the participants that the current TIMS III project would address the previous concerns to ensure successful implementation. He also mentioned that JHWO is still working closely with the EX-WENELA members in its programs.

The next presentations by the JHWO Program Manager on the STP Challenge Facility and on the introduction to CLM by the ECSA-HC Consultant from ACMERET Solutions covered similar issues as presented in the previous group. The only difference is that the second group was more active and required the dynamics of ensuring sensitivity to language as it had more Ndebele-speaking participants than the previous group. As a result, the presentations required more interpretations of some crucial issues.

The next presentation, the fourth for the day, focused on the basics of TB. Key issues from this presentation include the changes to TB treatment regimes. The participants sought clarity on the duration of TB treatment under the new regimes. The facilitators clarified that the TB treatment for HIV+ clients is three months, while for those for HIV- it is six months. The new guidance in TB was that all contacts should get TB preventative treatment, including MDR TB. The facilitator clarified another concern regarding the side effects of some of the treatment regimes. He explained that, like most medicines, patients respond differently to medical treatment. Some with co-morbidities may get worse, while

others respond positively to treatment. As a result, sometimes, clients with TB experience hearing problems. The fifth and last presentation was on the barriers that key populations face in Sanyati and Bubi districts. The issues raised were similar to the Kwekwe and Shurugwi teams presented in the previous week's training.

On the second day, the presentations focused on the district-specific TB programs for Sanyati. The District TB and Leprosy Coordinator took the participants through the TB situation in the district. With a population of 336,573, the number of Health facilities catering to this population is 26, of which 24 provide and report High TB notifications, and only three health facilities provide Diagnostic TB services. He noted that in the first quarter of 2023, the district did not have lost-to-follow cases. However, challenges experienced in the district include patients failing to access X-ray services due to financial constraints. Some clients also experienced medical supply lapses due to a national logistical challenge in the distribution system. They also did not have medication. He also noted that most artisanal miners find it difficult to balance between seeking medical help and the opportunity cost of being away from work when they depend on daily work to survive. As a result, the Coordinator suggested that the mobile TB screening services must be decentralized to the mining pits. Other challenges noted include the violent nature of the mining operations in the illegal mine pits.

Additionally, the lack of identification documents makes follow-up on TB patients difficult. For example, some are called 'Rasta" a nickname for anyone with a dreadlocked hairstyle. When health staff come to check on 'Rasta" they find out that there are many people with such a name. This problem was observed in the Sanyati area bordering Kadoma, a popular mining area in Mashonaland West Province.

The second presentation on CRG, the national strategic plan 2021-2026, and the Zimbabwean Patient Charter were presented by the ECSA-HC Gender and Human Rights Specialist, The Zimbabwe NTP Communication and Advocacy Officer, and the Community TB and Leprosy Coordinator, respectively. The issues presented in these sessions are similar to those covered in the previous section.

From the third o the fifth day, the participants underwent the OneImpact practical training. Based on lessons learned from the previous week's training, the facilitators ensured that the participants had suitable smartphones, and the facilitator's phone was connected to the projector to ensure all the participants could follow the proceedings easily. Using the facilitator's phone through a projector is a good practice learned in Tanzania, Mozambique, and Zambia. The process was much more efficient as the facilitators improved from the previous week's lapses. Thus, the second group had more time to do the OneImpact simulations.

Figure 21: The Ministry of Health and Childcare ICT Officer facilitating on OneImpact while the JHWO Data Officer is providing hands-on-support to participants in Bulawayo, Zimbabwe

After the simulations, the JHWOs and ECSA-HC took the participants through the next steps, including announcements on the support the CBVs would receive to implement the program for the next three months and preparations to sign the contracts.

The meeting ended with the ECSA-HC and the ACMERET Solutions Consultant giving their closing remarks to appreciate how the training was coordinated. What was striking was the close collaboration between JHWO and the Ministry's teams. The officials expressed gratitude for this exemplary way of coordinating regional programs and hoped their

experience would be shared at a regional conference to help other countries learn from them. The Ministry's Communications and Advocacy Officer officially closed the meeting.

Lessons learned from the Regional CLM Training

- Teamwork between the Ministry NTP and local civil society appointed to coordinate OneImpact is crucial for effectively coordinating and delivering impactful CLM training programs. The Zimbabwean case exemplifies excellent coordination between the NTP and JHWO. The training program was jointly agreed upon, and the two partners did most presentations.
- Introducing OneImpact Practical sessions early, as happened in Zimbabwe, provided adequate time for participants to grasp the practical aspects of the OneImpact CLM, which require more time to acclimatize.
- Giving the local teams the responsibility to lead the training was an opportunity to build the capacity of the NTP and local coordinating Civil Society Organizations. The Zambian Case, where the team took over the facilitation, was a good lesson and opportunity to build its capacity as they took over the OneImpact session in the second training in Kitwe. Mozambique missed this opportunity as ADPP did all the presentations with AMIMO, the OneImpact as participants throughout the training. The ECSA-HC team and the ACMERET Solution Consultant agreed to introduce the changes in Zambia as a lesson from Mozambique. Tanzania's Patient-led Mkuta staff were able to train on the OneImpact alone.
- When community-based volunteers are valued and encouraged in their work, they take extra steps to make their work conditions better without waiting for donor support. The Zimbabwean situation where participants from the two training used their savings to buy phones specifically for OneImpact is an example of how communities can locally mobilize resources to contribute to their welfare and health systems strengthening.
- Having the same key facilitators from ECSA and ACMERET Solutions helped standardize the country training, incorporate good practices from a country, and replicate them in the next training in another country.

Recommendations For the Regional Training

- Some participants suggested printing and distributing the training materials for future reference in the field.

- TIMS member states must commit to supporting ECSA-HC staff, particularly regarding agreeing and settling on training dates. Despite many engagements, the South African team could not provide a definite date on time, forcing the program to stretch beyond the initial timeframe.
- Future training programs may need to separate CBVs from healthcare workers to ensure the delivery of training materials for specific groups. Some of the content would be too rudimentary for some clinical staff as experienced in Tanzania, where some participants made presentations on some topics to accommodate them. Separating the participants would also reduce incidences where participants are not free to speak out about issues that negatively impact them when seeking TB services. The Zimbabwean case of CBVs refusing to spell out some issues was because some participants were nurses. As a result, CBVs were not free to express themselves.

Next Steps for the Regional Training

- Prepare for the South African and Botswana CLM Oneimpact Training upon confirmation of the dates by the country teams.
- Prepare the final report for all countries.
- Receive reports on the activities done after the three months up to the end of September 2023.

Annex 1: List of Participants for Tanzania: Mwanza Group

NAME	TITLE	COUNCIL/Organization
1.Azizi Khamisi	Trainer	MKUTA
2.Laurent Mpanda	Miner	MSALALA DC
3.NKOBA LUZUMBI	TB/HIV Officer	KAHAMA MC
4.LEONARD LUHUNGA	Volunteer	SHINYANGA DC
5.LOICE D CHONKO	Volunteer	
6.AZIMINA NG'WAHYA	Volunteer	SHINYANGA MC
TARIME DC		
7.Lilian Achieng	Provider	Tarime DC
8.Maria Hosse	CHW	Tarime DC
9.Neema Johanes	CHW	Tarime DC
10. Gabriel Daniel Nyamhanga	Local Leader	Tarime DC
11. Lucas Ryoba Wambura	Miner	Tarime DC
12. Alphonce Ngocho	Family of miner	Tarime DC
GEITA		
13. Mbaruku Ndihuye	Volunteer	Geita DC
14. Shija Madila Mwigei	Miner	Geita DC
15. Limi Masunga Shemel	Volunteer	Geita DC
16. Majuto Thadeo	Provider	Geita DC
17. Samwel Shosha	Local leader	Geita DC
18. Chokera Chokera	Volunteer	Geita DC
19. Dr. Michael Mashala	RTLC	Geita DC
20. Rachel Jacob	CHW Coordinator	Mwanza
21. Happy Ogulu	CHV Coordinator	Shinyanga
22. Enael John	Coordinator	TTCN

23. Thomas Mkwabi		SHIDEPHA+
NTLP		
24. Onay Lwanzali		Dodoma
25. Yusto Erasto		Dodoma
26. Juma Said		Dodoma
27. Julias Ley	ECSA Finance Officer	
28. Anita Kyaruzi	ECSA-HC Gender and Human Rights Specialist	
29. Dr Meckie Achayo	MKUTA-Dar Coordinator	
30 Alistair Elias	Trainer MKUTA-Dar	

Annex 2:List of Participants in Moshi, Tanzania

S/N	Name	Title	Location
1	Adam Mandala	RTLC	Manyara
2	Thobias Magati Chacha	CHV	Mirerani
3	Dr Frank Thobias	CHV Coordinator	Mirerani
4	Curtius Msosa	MAREMA	Mirerani
5	Rhoda Itaeli Kifumu	Family of Miner	Siha
6	Anastazia Cosmas	CHV	Mirerani
7	Rehema Ismail	CHV	Mirerani
8	Shakra Mushi	CHV	Mirerani
9	Salim Mohamed Kombo	CHV	Mirerani
10	Komba Moses	Miner/RCM	Mirerani
11	Alberto Sanga	CLM Coordinator	Steps Tanzania
12	Rehema Abdalla Saidi	MAREMA	Mirerani
13	Enaeli Tarimo	CHV	TTCN
14	Daudi Julius Obingli	CHV	Mirerani
15	Athumani Selemani	CHV	Mirerani
16	Vincent Mauvi	CHV	Mirerani

17	Dr. Meckie Achayo	Coordinator	MKUTA-Dar
18	Wahihansia Marco Mmari	Family of Miner	Siha
19	Rachel Njau	MAREMA	Mirerani
20	Zephania Mungaya	MAREMA	Mirerani
21	Emmanuel Peter	MAREMA	Mirerani
22	Charles Philip Msangya	WEO	Mirerani
23	Abrahamu Moses	WEO	Mirerani
24	Dr Deogratius Mazengo	MOI	Mirerani H/C
25	Prince Pontio	Lab Tech	Mirerani H/C
26	Julias Ley	ECSA Finance Officer	ECSA
27	Anita Kyaruzi	ECSA-HC Gender and Human Rights Specialist	ECSA
28	Dr. Meckie Achayo	MKUTA-Dar Coordinator	Mkuta
29	Alistair Elias	Trainer MKUTA-Dar	Mkuta
30	Azizi Khamisi	Trainer Mkuta Dar	Mkuta

Annex 3: Mozambique Participants List

SN	Name and Surname	Organization/Position
1	Moises Uamusse	Amimo Chairperson
2	Josefate Macassa	Provincial TB Coordinator, Gaza
3	Paulino Lai	Amimo Gaza Province Coordinator
4	Abilio Muianga	Community Activist/CBV
5	SergioRenaldo Joao	Community Activist/CBV
6	Salomao Come	Community Activist/CBV
7	Dalito Rui Artur	Community Activist/CBV
8	Luis Nitrogenio	Community Activist/CBV

9	Ercelina Villancuios	Community Activist/CBV
10	Josefate Macassa	Community Activist/CBV
11	Isabel Fernando Da Costa	Community Activist/CBV
12	Raquelina Alberto Soto	Community Activist/CBV
13	Luisa Albino	Community Activist/CBV
14	Dercia Valoi	Community Activist/CBV
15	Ernesto Gonsalves Joao	Community Activist/CBV
16	Suzete da Graca	Community Activist/CBV
17	Isaura Crimilda Soto	Community Activist/CBV
18	Candida Mafuiane	Community Activist/CBV
19	Helder Manuel Joaquim	Community Activist/CBV
20	Fatima Abubacar	Community Activist/CBV
21	Pedro Domingos Marques	Community Activist/CBV
22	Amelia Laura Salomao	Community Activist/CBV
23	Abiba Fernando Said	Community Activist/CBV
24	Naci da Nucha Sergio	Community Activist/CBV
25	Inelcio Julio Manhique	Community Activist/CBV
26	Nucha Alvaro Massingue	Community Activist/CBV
27	Edna Alfredo Marime	Community Activist/CBV
28	Zubaida Matsinhe	Community Activist/CBV
29	Rosita Mazuze	Community Activist/CBV
30	Evarista Chissico	Community Activist/CBV
31	Amandia Justicia Munguambe	Community Activist/CBV
32	Melvina Yolanda Moiane	Community Activist/CBV
33	Lisia Ricardo Penicelo	Community Activist/CBV
34	Marnelia Recibo Kussaia	Community Activist/CBV
35	Caldina Eduardo Muhate	Community Activist/CBV
36	Celia Jaao Bila	Community Activist/CBV
37	Rosa Adelino Chauque	Community Activist/CBV
38	Sara Salomao Zunguene	Community Activist/CBV
39	Pedro Abilio Mondlhane	Community Activist/CBV
40	Dr. Zacharia Grand	ACMERET Consultant
41	Pedro Abilio Mondlhane	
42	Dino Joao Matsinhe	Community Activist/CBV
43	Edna Hilaris Fuel	Community Activist/CBV
44	Manuel Gabriel Chirindza	Community Activist/CBV
45	Christina Mnuel Sitoe	Community Activist/CBV
46	Almiro Abrue	ADPP CLM OneImpact Facilitator
47	Odete Simon Sitoe	ADPP CLM OneImpact Facilitator
48	Zaida Vasco Machava	Community Activist/CBV
49	Odete Rafael Ombe	Community Activist/CBV
50	Lourenco Muianga	ADPP CLM OneImpact Facilitator
51	Sara Etelvina Zove	Community Activist/CBV
52	Domingos Checo	Community Activist/CBV
53	Carlos Alberto Macuacua	Community Activist/CBV
54	Rafael Bila	Community Activist/CBV
55	David Makonzi	AMIMO Consultant

56	Mouzihno Vasco Machanga	Community Activist/CBV
57	Marcia Mario Sitoe	Community Activist/CBV
58	Marcia Augusto Malembo	Community Activist/CBV
59	Antonio Mulhanga	Community Activist/CBV
60	Anita Kyaruzi	ECSA Gender and Human Rights Specialist
61	Faith Ngoi	ECSA Finance Officer
62	Christine	ECSA Admin Officer

Annex 4: Zambia Participants List, Solwezi

SN	Name	District	Position
1	Richard Tembo	Kasempa	HCW
2	Julien Chimpapi	Kalumbila	HCW
3	Tongatonga Waston	Solwezi	CBV
4	Janice Mbamvu	Mwinilunga	CBV
5	Jennipher Kasebeleka	Mwinilunga	HCW
6	Batani Lackson	Kasempa	CBV
7	Mondela David	Kalumbila	CBV
8	Teddy Sweta	Kalumbila	CBV
9	Sara Muteba	Kasempa	CBV
10	Levy Sinkonde	Solwezi	Ex-miner
11	Felix Chipoya	Kalumbila	CBV
12	Memory Kamalondo	Mwinilunga	CBV
13	Norris Chipulu	Solwezi	HCW
14	Kutemba P Konde	Solwezi	HCW
15	Nicholas Sinkamba	Solwezi	Miner's Union
16	Mwansa Kawanya	Solwezi	Ex-miner
17	Oliver Mwikisa	Solwezi	HCW
18	Lucy Nayame	Mwinilunga	CBV
19	Imidy Lubole	Mushindamo	CBV
20	Lydia Kangungo	Kalumbila	CBV
21	Gabriel Chombo	Solwezi	Provincial TB Co.
22	Lukaki Josphat	Mwinilunga	CBV
23	Sweta Matherine	Kasempa	HCW
24	Andrian Sambamba	Kalumbila	CBV
25	Brenda Moonga	Kasempa	CBV
26	Dr Zacharia Grand		Consultant Acmret
27	Wanga Zulu	NTLP	Chief Community Officer
28	Zakeyo Mvula	NTLP	CEHO
29	William Mwanza	NTLP	Administrative Assistant

30	Anita A Kyaruzi	ECSA-HC	Gender and Human Rights Specialist
31	Faith Ngoi	ECSA-HC	Finance officer
32	Hamis Bani	ECSA-HC	Procurement Officer

Annex 5:Zambia Participants List, Kitwe

SNO#	NAME OF PARTICIPANT	DESIGNATION	INSTITUTION
1	Cindy Maimbolwa	Policy Advoncy office	CITAMPLUS
2	Julius Maloba	Clinical officer	Chipokota mayamba
3	Frank Salimu	CBV	Chipokota mayamba
4	Gerald Kaula	CBV	Chipokota mayamba
5	Posile Zulu Nkhata	TB Officer	NTLP
6	Cleoves Kanchule	CBV	Alexandra clinic
7	Vainess Chiteshe	TB FP	Alexandra clinic
8	Mildred Chipulu	TB FP	Kakoso 1st level
9	Mvula Zakeyo	CEHO	NTLP
10	Linda Chiwala	CBV	Chiwempala
11	Pauline Mwewa	TB Nurse	Chiwempala
12	Catherine Chola	Human Resource	National X-miner Allied Workers Association of Zambia
13	David Chola	Hygiene Officer	Occupational Health
14	Jennipher Chama	CBV	Kamakonde
15	Ebby Maimba	CBV	Kakoso 1st level
16	Susan Kalunga	CBV	Kamakonde
17	William Mwanza	Administrative Assistant	NTLP
18	Martha Mwape	CBV	Twatasha Health centre
19	Katuta Kawanda	TB Nurse	Twatasha Health centre
20	Lucky Zulu	NEAWAZ President	National X-miner Alied Workers Association of Zambia
21	Lottie Mwale	M&E	CHEP
22	Dr. Zacharia Grand	Consultant	Acmret
23	Jane Theu	HIV AIDs Specialist	CITAM PLUS
24	Mweetwa Napoleon	X-Miner	National X-miner Allied Workers Association of Zambia
25	Wanga Zulu	Chief Community Officer	NTLP
26	Westone Mwanza	TB Coordinator	District Health Office

27	Sharon Musakanya	TB Coordinator	District Health Office
28	Chisalaba Kunda	TB Coordinator	Copperbelt Health Office
29	Isaac Phiri	Program Manager	CITAMPLUS
30	Anita A Kyaruzi	Gender and Human Rights Specialist	ECSA-HC
31	Faith Ngoi	Finance officer	ECSA-HC
32	Prince Mwenda	Community Focal person	Twatasha Health centre
33	Hamis Bani	Procurement Officer	ECSA-HC

Annex 6: Zimbabwe Training Participants List

	NAME	ORGANIZATION	POSITION
1	Harriet P Munyanduki	JHWO	Programs Officer
2	Leon Mbano	JHWO	Data Officer
3	Garikai Clive Foya	MoHCC	ICT Officer
4	Andrew Nyambo	MoHCC	ACSM Officer
5	Kwenziweyinkosi Ndlovu	MoHCC	CTBC Officer
6	Anita Kyaruzi	ECSA-HC	Gender and Human Rights Specialist
7	Diana	ECSA-HC	Finance Officer
8	Christine	ECSA-HC	Administrator
9	Maxwell Dick	MoHCC	DTLC Sanyati
10	Memory Ndlovu	MoHCC	DTLC Bubi
11	Trust Nkomo	MoHCC	CBV
12	Senzeni Nduna	MoHCC	CBV
13	Maria Sibanda	MoHCC	CBV
14	Ntandoyenkosi Mpofu	MoHCC	CBV
15	Shyline Tshuma	MoHCC	CBV
16	Philani Ncube	MoHCC	CBV
17	Peggy Moyo	MoHCC	CBV
18	Nomusa Ncube	MoHCC	CBV
19	Gladys Chinulah	MoHCC	CBV
20	Janet Mpofu	MoHCC	CBV
21	Sylvia Makoni	MoHCC	CBV
22	Debra Madenyika	MoHCC	CBV
23	Barbra Muzila	MoHCC	CBV
24	Marian Manava	MoHCC	CBV
25	Fungai Musiyiwa	MoHCC	CBV
26	Kudakwashe Mutabeni	MoHCC	CBV
27	Asiyathu Phiri	MoHCC	CBV
28	Fransisca Mudzviti	MoHCC	CBV
29	Zanele Moyo	MoHCC	CBV
30	Thandiwe Ndlovu	MoHCC	CBV
31	Warren Katete	MoHCC	Driver

32	Peter Dube	JHWO	Programs Manager
33	Faith S Nkala	BHBC	Programs Officer
34	Sipho Ngwenya	MoHCC	CBV
35	Nolia Lucas	MoHCC	CBV
36	Evernice Marumbe	MoHCC	CBV
37	Jaison Chinhamo	MoHCC	CBV
38	Simbarashe Chivasa	MoHCC	CBV
39	Tendai Masiya	MoHCC	CBV
40	Chipiwa Shoko	MoHCC	CBV
41	Brenda Chingwere	MoHCC	CBV
42	Kilamusi Selemani	MoHCC	CBV
43	Kanikani Athanas	MoHCC	CBV
44	Runyararo Siwela	MoHCC	CBV
45	Francisca Mwanza	MoHCC	CBV
46	Virginia Fambirachimwe	MoHCC	CBV
47	Virginia Connick	MoHCC	CBV
48	Moses Mulenga	MoHCC	CBV
49	Lisa Mapani	MoHCC	CBV
50	Hilda Muchengeti	MoHCC	CBV
51	Winnie Lucias	MoHCC	CBV
52	Vetty Malunga	MoHCC	DTLC Shurugwi
53	Kudakwashe Mudzingwa	MoHCC	CBV
54	Rosemary Mwale	MoHCC	DTLC Kwekwe
55	Tradder Sengurai	MoHCC	CBV

Annex 7: Tanzania Training Agenda

Day 1:

TIME	TOPIC	RESPONSIBLE
0830HRS – 0900HRS	Arrival & Registration	**ECSA-HC**
0900HRS – 0930HRS	Welcome Remarks and Introductions	**ECSA & MKUTA**
0930HRS – 1030HRS	Background to TIMS III Overview of Training Introduction to Community Led Monitoring (CLM)	**ECSA-HC** **ACMERET**
1030HRS – 1100HRS	Health Break	
1100HRS – 1200HRS	Building Blocks for CLM Champions: Understanding TB Prevention and Treatment Basics	**MKUTA/ACMERET**
1200HRS – 1300HRS	Challenges/Barriers facing Key Population participation	**MKUTA**
1300HRS – 1400HRS	Lunch	
1400HRS – 1600HRS	Understanding available TB services for TIMS KP (miners, ex-miners, per-mining communities) Unpacking the TB National Strategic plan	**NTLP**
1600HRS – 1630HRS	Health Break	

Day 2

TIME	TOPIC	RESPONSIBLE
0900HRS – 0930HRS	Recap Day 1	**ACMERET**
0930HRS – 1030HRS	Understanding CRG: Gender Issues	**ECSA/MKUTA**
1030HRS – 1100HRS	Understanding CRG: Stigma and Human Rights	**ECSA/MKUTA**
1100HRS – 1130HRS	Health Break	
1130HRS – 1300HRS	Overview of TBKiganjani: Downloading App and Highlighting Modules	**MKUTA**
1300HRS – 1400HRS	Lunch	
1400HRS – 1530HRS	TBKiganjani: Reporting Challenges and Data Collection	**MKUTA**
1530HRS – 1600HRS	Customizing the TBKiganjani App – Miner Specific modules/indicators	ALL
1600HRS – 1630HRS	Health Break	

Day 3

TIME	TOPIC	RESPONSIBLE
0900HRS – 0930HRS	Recap Day 2	**MKUTA**
0930HRS – 1030HRS	Data Management for OneImpact Implementers	**ACMERET**
1030HRS – 1100HRS	Data Analysis Methods in OneImpact Monitoring	**ACMERET**
1100HRS – 1130HRS	Health Break	
1130HRS – 1300HRS	TBKiganjani: Reporting Challenges and Data Collection TBKiganjani Dashboard: Responding to challenges	**MKUTA**
1300HRS – 1400HRS	Lunch	
1400HRS – 1500HRS	Data Utilisation and Advocacy for Decision	**ACMERET/MKUTA**
1500HRS – 1600HRS	Case studies of OneImpact in other countries	**ACMERET**
1600HRS – 1630HRS	Health Break	

Day 4:

TIME	TOPIC	RESPONSIBLE
0900HRS – 0930HRS	Recap Day 3	ACMERET
0930HRS – 1100HRS	Practical Training	MKUTA
1100HRS – 1130HRS	Health Break	
1130HRS – 1300HRS	Practical Training	MKUTA
1300HRS – 1400HRS	Lunch	
1400HRS – 1530HRS	Practical Training	MKUTA
1530HRS – 1600HRS	Signing of Contracts by CLM Champions	ECSA
1600HRS – 1630HRS	Health Break	

Annex 8:Mozambique Training Agenda

Day 1: 18th of April

TIME	TOPIC	RESPONSIBLE
0830HRS – 0900HRS	Arrival & Registration	**ECSA-HC**
0900HRS – 0930HRS	Welcome Remarks and Introductions	**ECSA, NTP & AMIMO**
0930HRS – 11HRS	Background to TIMS III Background to STP Challenge Facility Overview of Training Introduction to Community Led Monitoring (CLM)	**ECSA-HC** **Moises, AMIMO** **Almiro, ADPP** **Almiro, ADPP**
11HRS – 1130HRS	Health Break	
1130HRS – 1230HRS	The situation of TB in Gaza province and the main challenges (Reach, treat and cure)	**TB Focal point DPS Gaza**
1230HRS – 1300HRS	Challenges/Barriers facing Key Population participation	**ADPP**
1300HRS – 1400HRS	Lunch	
1400HRS – 1430HRS 1430HRS – 1600HRS	(cont.) Challenges/Barriers facing Key Population participation. Understanding available TB services for TIMS KP (miners, ex-miners, per-mining communities) Unpacking the TB National Strategic plan 2020 - 2025	**ADPP - All** **NTP (Dr Baschir?)**
1600HRS – 1630HRS	Health Break	

Day 2: 19th of April

TIME	TOPIC	RESPONSIBLE
0900HRS – 0930HRS	Recap Day 1	**ACMERET/MOISES**
0930HRS – 11HRS	Understanding CRG: Gender Issues and Gender Based Violence (Key issues in the domestic violence law) (30 min) Group discussion and in common	**ALMIRO /ECSA**
1100HRS – 1130HRS	Health Break	
1130HRS – 13HRS	Understanding CRG: Stigma and Human Rights - Concepts and Human Rights characteristics Examples of how Human Rights is/can be violated. Right to Health in the Mozambican Constitution	**ALMIRO /ESCA**
1300HRS – 1400HRS	Lunch	
1400HRS – 1530HRS	Presentation of the Patient Card about Rights and duties (Carta dos direitos e deveres)	**ALMIRO/CASTRO**

	Group discussions and in common	
1530HRS – 1600HRS	Rights and duties for people affected by TB	**ALMIRO/CASTRO**
1600HRS – 1630HRS	Health Break	

Day 3: 20th of April

TIME	TOPIC	RESPONSIBLE
0900HRS – 0930HRS	Recap Day 2	**MKUTA/MOISES**
0930HRS – 1030HRS	Discussion about common barriers among people affected by TB	**ALMIRO/CASTRO**
1030HRS – 1100HRS	Presentation about OneImpact digital platform (APP)	**ALMIRO/CASTRO**
1100HRS – 1130HRS	Health Break	
1130HRS – 1300HRS	Presentation about OneImpact Dashboard Response protocol (First Responders)	**ALMIRO**
1300HRS – 1400HRS	Lunch	
1400HRS – 1500HRS	The role of Community Health Committees and Co-Management Committees in resolution of barriers	**ALMIRO/CASTRO**
1500HRS – 1600HRS	How to use the dashboard information for advocacy and TB Response improvement	
1600HRS – 1630HRS	Health Break	

Day 4: 21st of April

TIME	TOPIC	RESPONSIBLE
0900HRS – 0930HRS	Recap Day 3	ACMERET/MOISES
0930HRS – 1100HRS	Practical Training for activists and First Responders	ALMIRO/CASTRO
1100HRS – 1130HRS	Health Break	
1130HRS – 1300HRS	Practical Training for activists and First Responders	ALMIRO/CASTRO
1300HRS – 1400HRS	Lunch	
1400HRS – 16HRS	Practical Training in pairs	ALMIRO/CASTRO
1600HRS – 1630HRS	Health Break	

Day 5: 22nd of April

TIME	TOPIC	RESPONSIBLE
0900HRS – 1030HRS	Simulation (Activists use assisted model)	ALMIRO/CASTRO
1030HRS – 1100HRS	Health Break	
11HRS – 1230HRS	Simulations (First Responders)	ALMIRO/CASTRO
1230HRS – 1300HRS	Conclusion	ALL
1300HRS – 1400HRS	Lunch	

Materials:

Package to AMIMO:

1. Manuals Human Rights (5 modules, x pages)
2. Manual OneImpact APP (30 pages), - 5 copies
3. Manual for OneImpact First responders (9 pages) – x copies (one for each First Responder and 3 extra)

Training materials:

1. Print resolution protocol (x pages) – 15 copies
2. Print patient card for each participant (x participants)

Annex 9: Zimbabwe Training Program

COMMUNITY LED MONITORING (CLM)

TRAINING

12 – 16 JUNE 2023

BULAWAYO, ZIMBABWE

DAY 1

TIME	TOPIC	FACILITATOR
0830 – 0900	Arrival and Registration	ECSA - HC
0900 – 0920	Welcome Remarks and Introductions	NTLP & JHWO
0920 – 0930	Administrative announcements	NTLP
0930 – 1100	Background to TIMS III Background to STP Challenge Facility Overview of Training Introduction to Community Led Monitoring (CLM)	ECSA - HC
1100 – 1130	**Tea Break**	
1130 – 1230 1230 – 1300	Overview of TB programme in Zimbabwe The situation of TB in the target districts (Kwekwe & Shurugwi)	NTLP DTLCs
1300 – 1400	**Lunch**	
1400 – 1430 1430 – 1600	Challenges/Barriers facing Key Population participation (discussion) Understanding available TB services for TIMS KP (miners, ex-miners, per-mining communities) Unpacking the TB National Strategic plan 2020 – 2025 including NSP Addendum (2024 -2026)	JHWO NTLP
1600 - 1620	Facilitators' end-of-day meeting	NTLP
1620 – 1630	**Tea Break**	

DAY 2

TIME	TOPIC	RESPONSIBLE
0830 – 0900	Recap Day 1	Secretariat Rapporteur
0900 – 1030	Understanding CRG: Gender Issues and Gender Based Violence (Key issues in the domestic violence law) (30 min) Group discussion and in common	ECSA-HC/NTLP
1030 – 1100	**Tea Break**	
1100 – 1300	Understanding CRG: Stigma and Human Rights - Concepts and Human Rights Characteristics Examples of how Human Rights can be violated. Right to Health in the Zimbabwean Constitution	JHWO
1300 – 1400	**Lunch**	
1400 – 1530	Presentation on the Patients' Charter Group discussions	NTLP
1530 – 1600	Rights and Responsibilities for people affected by TB	NTLP/ JHWO
1600 - 1620	Facilitators' end-of-day meeting	NTLP

1620 – 1630	**Tea Break and End of day**	

DAY 3

TIME	TOPIC	RESPONSIBLE
0830 – 0900	Recap Day 2	Secretariat Rapporteur
0900 – 0930	Unpacking Community Led Monitoring (Data collection, Stakeholders)	JHWO
0930 – 1030	Introduction to OneImpact Zimbabwe digital platform (APP)	MOHCC - ICT
1030 – 1100	**Tea Break**	
1100 - 1300	Practical use of the OneImpact Zim App	MOHCC – ICT JHWO NTLP
1300 – 1400	**Lunch**	
1400 - 1500	Introduction to OneImpact Dashboard Response protocol (First Responders)	NTLP JHWO
1500 - 1630	Practical use of OneImpact Dashboard	MOHCC – ICT JHWO NTLP
1630 - 1650	Facilitators' end-of-day meeting	NTLP
1650 – 1700	**Tea Break and End of day**	

DAY 4

TIME	TOPIC	RESPONSIBLE
0830 – 0900	Recap Day 3	Secretariat Rapporteur
0900 – 1000	The role of Community health structures in the resolution of barriers	JHWO
1000 – 1100	How to use the dashboard information for advocacy and TB Response improvement.	NTLP JHWO
1100 – 1130	**Tea Break**	
1130 – 1300	Practical Sessions on OneImpact Zim App	JHWO/ICT
1300 – 1400	Lunch	
1400 – 1600	Practical Sessions in pairs	JHWO/ICT

1600 - 1620	Facilitators' end-of-day meeting	NTLP
1620 – 1630	**Tea Break and End of Day**	

DAY 5

TIME	**TOPIC**	**RESPONSIBLE**
0830 – 1030	Simulation (Activists use assisted model) Simulations (First Responders)	JHWO/ICT
1030 – 1100	**Tea Break**	
1100 – 1200	Implementation briefing	NTLP JHWO
1200 - 1230	Way forward	JHWO
1230 – 1240	Closing remarks	NTLP
1240 – 1300	Administrative and logistical wrap up	ECSA - HC
1300 – 1400	**Lunch and END OF TRAINING**	

Training Materials:

1. Patients App User Manual
2. Zimbabwe Response Manual
3. Program Dashboard Manual
4. Powerpoint slides
5. Smart phones/ Tablets