JOINTED HANDS WELFARE ORGANISATION

Building Resilient Communities

ANNUAL REPORT 2024

Contents

ACRONYMS

AGYW	Adolescent Girls and Young Women
ASM	Artisanal Small-Scale Miners
CLM	Community-Led Monitoring
DHIS2	District Health Information System 2
DRTB	Drug-Resistant Tuberculosis
DSTB	Drug-Sensitive Tuberculosis
DOT	Directly Observed Therapy
DRM	Disaster Risk Management
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
ISAL	Income Savings and Lending
JHWO	Jointed Hands Welfare Organization
MoHCC	Ministry of Health and Child Care
NAC	National AIDS Council
TB	Tuberculosis

ABOUT US

Jointed Hands Welfare Organization (JHWO) is a registered Private Voluntary Organization (PVO23/2013) founded in Midlands, Matabeleland South, and Mashonaland West in 2004 with 20 years of programming experience working with communities on project implementation and management.

The organization's niche is Advocacy, and the strategic thrust in the period under review is on Social Development, Health, Economic strengthening, Disaster risk management, and Strategic Information and Knowledge Management grounded in advocacy against harmful practices. Jointed Hands is a national NGO that has grown to cover all ten administrative provinces in Zimbabwe in terms of advocacy. The strategic plan was for the period ending December 2024 and a new one is in place from 2025 to 2030.

Vision

JHWO envisions a harm and disease-free society.

Mission

Advocacy against harmful norms and mitigating the impact thereof.

Core Values


Integrity


Care and support


Transparency


Credibility


Accountability


Dignity of humanity

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EXECUTIVE SUMMARY

In 2024, Jointed Hands Welfare Organization (JHWO) strengthened its multi-sectoral response to public health challenges, social development, and community resilience in 10 districts across 4 provinces in Zimbabwe. Through strategic partnerships with the National AIDS Council (NAC), the Ministry of Health and Child Care (MoHCC), and local government structures, JHWO implemented high-impact interventions targeting key populations, including artisanal small-scale miners (ASMs), adolescent girls and young women (AGYW), and orphans and vulnerable children. JHWO expanded HIV and TB service delivery across 50 high-prevalence mining sites through a network of 50 trained Peer Educators. As a result, 89% of targeted ASMs were engaged in HIV prevention programs, 80% of those tested for HIV received negative results, reflecting the success of prevention efforts, and 14 artisanal miners were diagnosed with TB and initiated on treatment, contributing to improved TB case notification rates. Additionally, 71% of TB patients received community based Directly Observed Therapy (DOT), increasing adherence and reducing treatment default rates, while a 50% reduction in laboratory access barriers was achieved through decentralized specimen collection and transport systems. HIV self-testing uptake improved following the introduction of blood-based self-test kits, with Peer Educators successfully facilitating demand creation and distribution.

JHWO's community-based interventions enhanced socio-economic stability among marginalized populations. A total of 1,300 caregivers were enrolled in Income Savings and Lending (ISAL) groups, strengthening financial independence. 7,914 participants engaged in gender-based violence (GBV) prevention sessions, leading to 100% referral of the 7 identified GBV cases for post-care services. 8,410 individuals were reached with drug and substance abuse prevention messaging, with JHWO actively participating in district-level technical working groups. Furthermore, 967 vulnerable children received educational support, achieving an 80% school retention rate across implementation districts. JHWO's disaster risk reduction and climate adaptation initiatives strengthened community resilience in high-risk areas by reaching 84,627 individuals with pandemic preparedness and disease outbreak awareness, while 7 of 12 target districts established early warning systems, enhancing response efficiency for health and environmental disasters. Additionally, 1,032 community leaders and members were trained on disaster preparedness, risk mapping, and emergency response coordination, and 58,026 community members across 11 districts were engaged in health education sessions on cholera, TB, and other communicable diseases.

JHWO influenced national health policy and programmatic decisions through data-driven advocacy by facilitating the successfully hosting the National TB Conference, engaging over 400 delegates to advance a multisectoral response to TB. As a result, 21 parliamentarians signed the Barcelona Declaration, reinforcing political commitment to TB elimination, and 20 members of the Parliamentary Portfolio Committee on Health received capacity-building on TB policy and governance. Community-led monitoring (CLM) via OneImpact Zimbabwe resolved 94% of reported service access challenges, improving accountability in TB and HIV programming. Key challenges in 2024 included reduced funding opportunities, the changing socio-economic conditions in the country which affected equitable access to health services for a larger population in JHWO areas of implementation. Despite these setbacks, JHWO remained adaptive, ensuring continuity of services.

INTRODUCTION

Jointed Hands Welfare Organization (JHWO) continues to play a pivotal role in strengthening health service delivery, social development, resilience, and disaster risk management in Zimbabwe. This 2024 Annual Report provides an in-depth analysis of JHWO's interventions, achievements, and impact across key program areas, including HIV and TB prevention, treatment, and care, social development initiatives, and strategic partnerships that enhance community-based health systems. In 2024, JHWO implemented comprehensive community-driven health interventions across 11 districts, targeting high-risk populations such as artisanal small-scale miners (ASMs), vulnerable children, and people living with HIV/AIDS (PLHIV). The organization's peer-led model remained central to service delivery, with trained Peer Educators facilitating HIV prevention, testing, and treatment adherence while also addressing barriers to healthcare access. JHWO successfully integrated tuberculosis (TB) interventions, including active case finding, directly observed treatment (DOT), and enhanced TB screening efforts among high-risk groups.

A key milestone in 2024 were the scaling up of digital health systems, including the OneImpact community-led monitoring, which strengthened real-time data collection, improved patient tracking, and enhanced evidence-based decision-making. Additionally, JHWO expanded its advocacy efforts, engaging policymakers, traditional leaders, and faith-based organizations to influence health-seeking behaviour and increase resource mobilization for TB and HIV programs. Beyond health programming, JHWO extended its impact through social development initiatives that tackled gender-based violence (GBV), child protection, and economic resilience. Efforts to reduce poverty and inequalities were realized through education support, vocational training, and livelihood programs. Furthermore, the organization assisted in disaster risk management (DRM) by equipping communities with early warning systems, pandemic preparedness training, and emergency response mechanisms to mitigate the effects of natural and man-made disasters. This report highlights JHWO's measurable outcomes, innovative approaches, and best practices, showcasing how multi-sectoral collaboration, data-driven programming, and community-led interventions have strengthened Zimbabwe's health and social welfare landscape. Moving forward, JHWO remains committed to scaling up impactful interventions, addressing emerging health challenges, and fostering sustainable community resilience.

HEALTH PILLAR

Preamble

The Health Pillar implemented strategies to promote equitable access to quality TB, HIV, SRH and Cancer services in the public health sector. The activities were implemented in the following districts: Gweru, Kwekwe, Shurugwi, Zvishavane, Chirumhanzu, Mwenezi, Gwanda, Insiza, Bulilima, Umzingwane and Harare. The activities funded by various funding mechanisms contributed toward achieving the organisation's vision through the following objectives:

- Roll out advocacy against harmful norms and practices in rural and urban communities of Zimbabwe.
- To facilitate health service provision and create demand for services through health education and screening.
- To establish Riverdale Health Centre as a centre of clinical and research excellence by 2024

Key Achievements

The achievements in 2024 highlight JHWO's capacity to deliver impactful health interventions in complex settings. Through strategic partnerships, innovative approaches, and a commitment to empowering key and vulnerable communities, the organization significantly advanced HIV and TB education, prevention, treatment, and care. These efforts have set a strong foundation for scaling up initiatives and sustaining health outcomes in artisanal mining communities.

TB Programming

2024 was the final year for the implementation of the KNTB project in which JHWO was spearheading community-related interventions in TB case finding, prevention, patient care support, and demand creation for TB services through a network of dedicated community-based volunteers (CBVs) as well as strengthening the oversight role of Health Centre Committees (HCCs) in TB programming at local level. The achievements being showcased reflects JHWO's work over the 5-year implementation period where major milestones were achieved in the southern region's TB response.

Increased community contribution to TB case finding

This activity was conducted using a dedicated team of 960 community health workers. The organization used The Results-Based Community Active Case Finding Model (RBACFM), an incentive-based performance-based model that increased targeted TB screening and case finding at the community level. CHWs used a symptomatic screening tool for adults and children before referring presumed patients for further assessment at their local primary healthcare facility.

Figure 1Community Health Workers who led the TB Case finding activities under JHWO. Credit JHWO

Through this model.

- Over 1.1 million people were screened for TB
- 54,022 presumed and referred to health facilities.
- 2,936 were diagnosed of TB.
- As a result of this, community contribution to TB notifications was 22% in 2024 a nearly 300% increase from around 8% at project inception.

Improved TB treatment and care in communities

Community Health Workers provided integrated patient-centred care, where TB patients were central figures in the continuum of care, and the social and personal circumstances of the person – not just the immediate requirements of medical treatment were prioritized. This included establishing and/or expanding social protection linkages to prevent and alleviate the burden of poverty, vulnerability, and social exclusion, that often affect people with TB and their households. In addition to this CHWs ensured that all TB patients for both DSTB and DRTB adhered to treatment by offering community-based directly observed treatment to achieve optimal treatment success.

Overall, through this approach.

- There was a significant increase in TB patients receiving community DOT from **51%** at inception to **71%** in 2024
- Treatment success rates increased from **79%** at inception to **90%** in 2024
- **DRTB** treatment success rates increased from **56%** at baseline to **71%** in Y5 (June 2024) looking at the cohort of June 2023

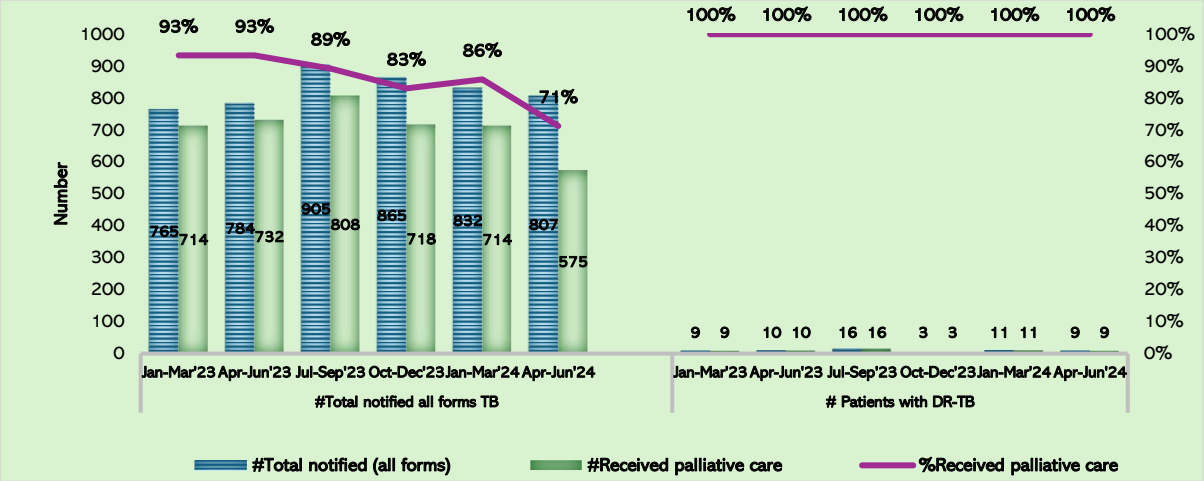


Figure 2 Proportion of TB patients receiving community DOT in eight districts

Improved access to laboratory services

JHWO continued to support and facilitate access to quality laboratory services for all TB presumptive patients. Through improved quality specimen collection, collaborated transport system and constant follow up of results, there was a **50%** reduction in the number of people failing to access laboratory services in the implementation districts.

- The percentage of presumptive TB patients with specimens sent to the laboratory increased from **79%** at baseline to **89%** in June 2024.
- Bacteriological Diagnosis Coverage rate - Pulmonary TB increased from **55%** at baseline to **63%** in June 2024.

Additionally, the JHWO Riverdale Health Centre and Laboratory served a community of **7000+** people easing the burden on public health laboratories and supporting a quick TAT of results in Gweru. The community health centre model brought comprehensive service closer to the point of need.

Through the laboratory.

- 215 samples were processed from January to June 2024
- 7 cases of TB were diagnosed translating to a 3% yield within the community

Increased TB Advocacy at all levels across the country

Hosting the National TB Conference

JHWO facilitated the hosting of the inaugural Zimbabwe National TB Conference. The event was conducted in a hybrid format, with over 400 delegates from various sectors attending both virtually and physically. Gliding under the theme "**Advancing Multisectoral Accountability and Community Engagement to End TB in Zimbabwe**," the conference inspired participants to collaborate, innovate, and commit to actionable outcomes that will transform the TB response in Zimbabwe.

Figure 3 Officials from the Ministry of Health and Child Care, (seated) Dr A. Maunganidze the Permanent Secretary for Health and Child Care Dep Minister. Hon S Kwidini and Dr T Apollo Deputy Director AIDS & TB unit flanked by (standing from left) Dr. D D Tobaiwa (JHWO), Dr S Sahu Deputy Director Stop TB Partnership and Mr R Rungoyi (STPZ) at the Inaugural National TB Conference 2024. Credit JHWO

Among other milestones, the conference achieved.

- An enhanced understanding of best practices and innovative strategies in TB prevention and treatment.
- Strengthened partnerships and networks among TB stakeholders.
- Increased advocacy for the needs and rights of TB-affected communities.
- Greater commitment to a coordinated national TB response informed by research and community engagement.

Re-launch of the Parliamentary TB Caucus

This was another advocacy win in 2024, necessitated by the change in parliamentarians as a result of an election cycle. The TB Caucus pledged to focus on two key areas: ensuring political influence on secure resources and policy changes and leveraging parliamentarians' roles in communities to ensure no one is left behind. The TB Caucus will be a dynamic force, mobilizing resources, strengthening policies, and fostering collaboration at all levels.

Engaging with Parliamentarians

JHWO's engagement with parliamentarians achieved notable milestones in strengthening Zimbabwe's TB response. Key achievements included the orientation of 21 parliamentarians, who signed the Barcelona Declaration, committing to collaborative TB advocacy. A capacity-building workshop further equipped 20 members of the Parliamentary Portfolio Committee on Health with the expertise to advocate for policies and resources addressing TB and lung diseases. Policy dialogues fostered stronger legislative engagement, resulting in the relaunch of the Zimbabwe TB Caucus. Dissemination of the Stop TB Partnership's Governance Report highlighted gaps in TB program management, prompting actionable commitments to improve governance. Media coverage amplified these efforts, boosting public awareness and support. These initiatives underscored the critical role of parliamentarians in advancing policies, governance, and resource mobilization to achieve Zimbabwe's goal of ending TB by 2030.

Figure 4 Members of the Parliamentary Portfolio Committee on Health

Engagement with religious and traditional leaders

In 2024, the engagement with religious leaders yielded significant outcomes in Zimbabwe's TB response. Representatives from diverse faith communities, including Christian, Muslim, Apostolic, and traditional sects, participated in capacity-building sessions aimed at dispelling TB myths and fostering health-seeking behavior. A direct outcome of this initiative was the successful mobilization of congregants for a mass TB screening in Mutare, where over **200** individuals were reached with TB information and screened during a women's inter-

Figure 4 Members of Religious and Traditional sects during Inter-Faith TB sensitisation

denominational church gathering. From this exercise, **32** were presumed TB cases, **2** were confirmed positive for TB and **2** were linked to treatment. Additionally, religious leaders integrated TB awareness into their community activities, expanding the reach of advocacy efforts. This collaboration demonstrated the critical role of religious leaders as agents of change, resulting in improved TB awareness, reduced stigma, and enhanced community engagement in TB prevention and control efforts.

Community level advocacy through Health Centre Committees (HCC)

Advocacy issues raised through HCC	Resolution through MOHCC
Presumptive TB clients with sputum-negative results who continued presenting with TB signs and symptoms were referred to private facilities for X-ray service. The majority of these clients were failing to afford this service. *Shurugwi District*	The DHE with support from the KNTB consortium team continued to lobby for an X-ray machine. The district received a new X-ray machine in March 2024.
A non-functional X-ray in 2023 impacted the notifications as physicians were left with only the symptom screening tool for the clinical diagnosis of the patients. *Insiza District*	DHE engaged the provincial NTP who followed up with the national office for support and procurement of the motherboard which had been damaged by an electrical short circuit. The X-ray machine was eventually fixed after 1 year of follow-up and engagements.
Chirindi clinic had a high death rate due to patients missing supply dates due to long distances of over 100kms and catastrophic costs to access health care services and treatments would be disrupted and late presentation to the facility. *Mwenezi District*	DHE engaged the facility which routinely conducted OFCAD. The facility was asked to include TB services during the outreaches and presume referred patients by CBVs during these visits and offer resupplies.
Nyama Clinic- Community members were requested to pay USD1.00 each for the payment of a security guard's salary. If they fail to pay, they are deprived of any service at the facility. *Gweru District*	With the engagement of the DHE, service charges were removed.
Repeated burglaries at Jobolinko clinic resulted in its temporary closure with all HCWs being transferred to other facilities. *Shurugwi District*	Through community engagement, local leadership agreed to have each village contribute a dollar/month towards contracting a security guard. After the security guard was contracted, there have not been any cases of burglaries.

Community Systems Strengthening: Community Led Monitoring

One Impact Community-Led Monitoring

The rollout of OneImpact Zimbabwe Community-led monitoring achieved notable milestones in strengthening the TB response and community empowerment. Training 138 cadres across 11 districts increased the user base by 130%, from 3,500 to over 8,000 registered users, with 7,305 actively engaging. The system resolved 276 reported challenges, with 94% addressed at the facility level or escalated.

Advocacy driven by platform data led to interventions such as food support for TB-affected households and escalated issues like drug stockouts in six districts, prompting national-level responses. Awareness of TB issues rose by 35%, and health-seeking behaviors improved by 26.9% among high-risk groups. Media campaigns further expanded reach and engagement. These achievements highlight One Impact's role in enhancing accountability, driving data-driven advocacy, and improving nationwide TB service delivery and health outcomes.

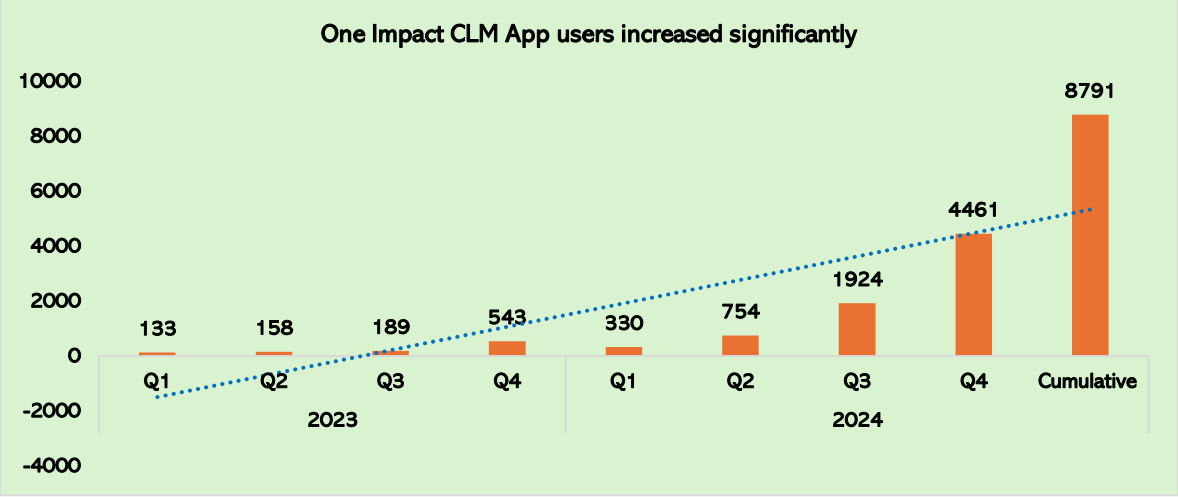


Figure 5 OneImpact CLM user registration trend

JHWO is also implementing Community Led Monitoring under Global Fund for HIV, TB and Malaria in four districts (Umzingwane, Chirumhanzu, Shurugwi and Mangwe) the following excepts are some of the case studies and key outcomes realised through Community Led Monitoring where we have realised:

Selected CLM Outcomes in 2024

Enhanced Community Awareness

- Increased awareness of health facility operating hours following the erection of signages in multiple facilities in response to service user feedback.
- Improved knowledge of available health services due to signages and community sensitization efforts based on service user feedback.

Strengthened Confidentiality for Key Populations (KPs)

- Greater privacy ensured through the creation of more private consultation areas in healthcare facilities.

Improved Facility Cleanliness

- Notable improvements in the cleanliness and hygiene of healthcare facilities because of feedback from service users.

Enhanced Health Worker Conduct

- Improved friendliness and professionalism among healthcare workers due to service user feedback addressing concerns over attitudes and patient interactions.

Creation of a Conducive and Inclusive Environment

- Development of a **waiting mothers' shelter**, improving access to services and providing a more supportive environment for expectant mothers.

Strengthened Security Measures

- Increased security at healthcare centers through the renovation and construction of fences and gates, ensuring the safety of both service users and staff.

Reduced Patient Waiting Times & Improved Satisfaction

- Decreased patient waiting times and enhanced satisfaction levels following District Health Executive (DHE) interventions, such as addressing staffing shortages and implementing **task shifting** based on service user feedback.

54 Health facilities supported with a CLM mechanism

120 Community Health Monitors collecting data

12 622 Service user Surveys collected in 2024

Chaka Clinic's remarkable turnaround is a testament to the power of community-led mon itoring (CLM) in facilitating resilient and sustainable systems for health in Chirumhanzu. In Quarter 2 of 2024, CLM data from service users in Chaka Clinic's catchment area uncovered critical issues: breach of confidentiality concerns, inefficient appointment systems, allegations of duty bearers selling HIV testing kits, and ineffective triaging of TB and coughing clients in the Outpatients Department. However, once these issues were deliberated upon during HCC feedback meetings, action plans were made to have them all addressed with the HCC taking lead and different community structures assisting to ensure services at the clinic were easily accessible, available and that service users were comfortable to consult with facility staff. Through collaborative effort and specific interventions including renovations, streamlined appointment systems, sensitization trainings, staff reorientation and enhanced triaging protocols these challenges were addressed effectively. With the onset of Quarter 3, Chaka Clinic had transformed its services, achieving zero confidentiality breaches, 90% improvement in appointment efficiency, no allegations of selling HIV testing services, and effective TB control and cough management. This shift demonstrates the impact of CLM in strengthening healthcare systems, promoting accountability, and ensuring quality care with dignity, as attested by clinic staff and community members alike.

Community Systems Strengthening has been instrumental in increasing access to HIV testing and treatment services among artisanal miners in Shurugwi district's marginalized areas across a total of 18 hotspot wards out of 31. Some of the Key **Achievements include:**

Increased HIV Testing Uptake through availability of HTS in hard-to-reach areas by means of distribution of HIV self-test kits. CLM has led to a significant increase in HIV testing uptake among artisanal miners, especially since the peer-lead approach has ensured that community cadres distribute the HIVSTKs to fellow ASMs supplied by their local health facilities. This has facilitated a 30% increase in testing rates and uptake of this service by ASMs over a 9-month period (Jan – Sept 2024) (*Source: MoHCC DHIS 2 2024*).

Improved Treatment Adherence: Community-led monitoring has improved treatment adherence among HIV-positive artisanal miners, with a 15% increase in ART retention rates over a 12-month period (Oct 2023 – Sept 2024) (*Source: MoHCC DHIS2 2024*). JHWO has piloted the model of having artisanal mine-based Community ART Refill Groups whereby selected Community Cadres have been trained by MoHCC HIV focal persons to recruit PLHIV and form CARGs where they deliver resupplies and follow through to ensure their caseloads or group members have all their routine tests done, ensure ART adherence and reduce the risk of defaulting treatment which was highly prevalent among ASMs before this intervention.

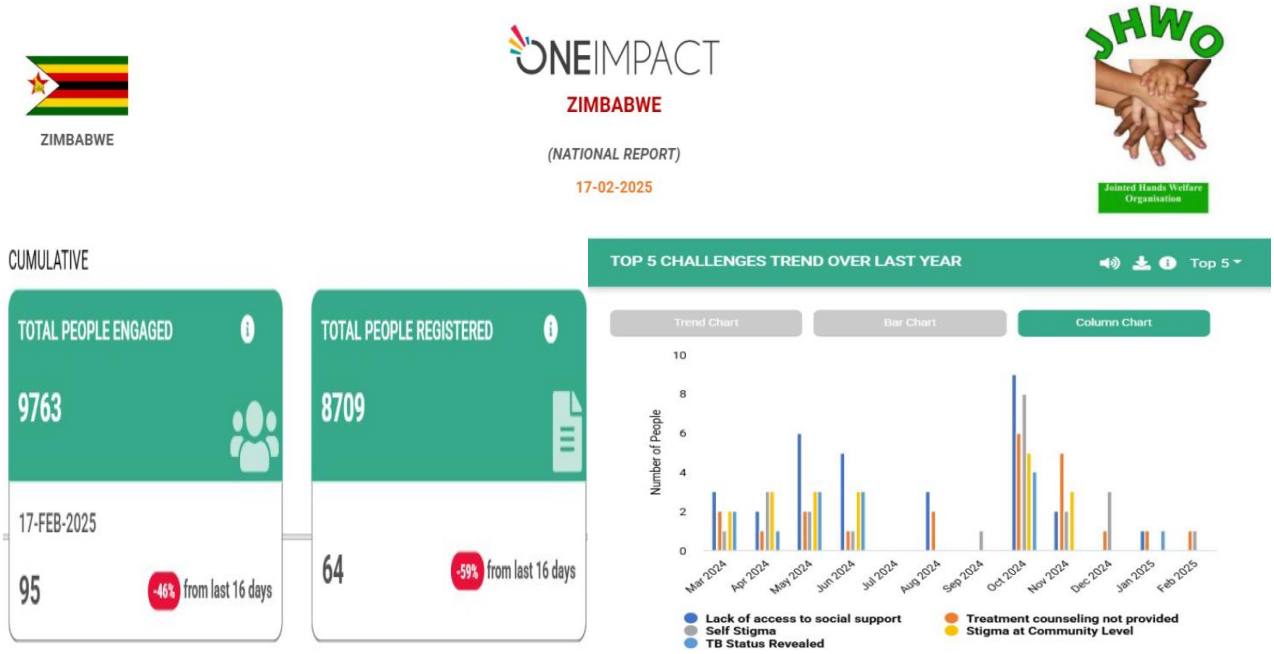
- **Enhanced Community Engagement**: CLM has fostered greater community engagement and participation in HIV/AIDS programming, with community members taking ownership of their health and well-being. Becoming more involved in the operation of local health facilities and supporting duty bearers to ensure quality service provision is provided in hard-to-reach areas.

Through Community-Led Monitoring, communities are becoming more involved in health facility accountability matters and are taking the lead in rectifying issues that pose barriers to care for KVPs. This has led to proactive initiatives to address specific needs, such as resource mobilization. For instance, communities like Mhlahlandlela, Dula, and Zimbili in Umzingwane have taken the initiative to build waiting mothers' shelters and incinerators, demonstrating their ability to drive change and improve healthcare infrastructure, rather than relying solely on government support but instead safeguarding and improving the resources they have been supported with their social responsibility.

There is improved awareness of SRH services by AGYW and self-efficacy as they seek quality services, this is supported by the increasing scores in the AGYWs' scorecards regarding issues of SRHR. Comprehensive demand creation initiatives have proved that the ambitious 95-95-95 targets can and will be achieved by 2030. These strategies have effectively guided demand generation for HIV services, paving the way for increased case finding, testing, treatment, and working towards viral suppression among PLHIV.

Umzingwane district has attested to how:

- Community cadres have emerged as crucial agents in identifying TB and HIV cases throughout the district.
- There is a noticeable enhancement in awareness and utilization of Sexual and Reproductive Health and Rights (SRHR) services among Adolescent Girls and Young Women (AGYW), reflected in their improved scorecards.
- Multifaceted demand creation initiatives have demonstrated remarkable effectiveness in achieving the ambitious 95-95-95 HIV targets especially targeting the 15-24 age group.
- These strategic efforts have successfully stimulated demand for HIV services, leading to significant increases in testing, treatment uptake, and viral load suppression within the community.



HIV/AIDS programming

Support for Key and Vulnerable Populations (KVPs)

Empowering adolescent girls and young women (AGYW) remained a key focus, with over **7,960** AGYWs and **800** healthcare workers engaged in dialogues that increased awareness and demand for sexual and reproductive health and rights (SRHR) services. These interactions fostered self-efficacy among AGYW, enabling them to access HIV prevention tools like PrEP and negotiate for their health rights, contributing directly to progress toward the 95-95-95 HIV targets. Service delivery improvements included the distribution of HIV self-test kits, leading to a **30%** increase in testing uptake among artisanal miners, and the formation of Community ART Refill Groups (CARGs) to enhance ART adherence, which saw a **15%** retention improvement. Privacy and resource challenges at clinics, such as overcrowding and drug shortages, were addressed through advocacy and community engagement, improving care quality and reducing waiting times.

The Peer-Led Model improved access to HIV prevention, treatment, and care services.

- JHWO successfully expanded access to HIV services, reaching artisanal small-scale miners (ASMs) across 50 hotspot mining sites with the help of 50 active Peer Educators. A significant number of ASMs received HIV prevention and testing services, with 80% of those tested receiving negative results, highlighting strong prevention efforts.
- Peer-to-peer sessions improved ASMs' understanding of HIV/AIDS, treatment adherence, and stigma reduction. These sessions, held four times a month, strengthened the relationship between ASMs and health facilities, increasing service uptake.
- TB awareness campaigns educated miners about symptoms, transmission, and prevention. A total of 14 ASMs were diagnosed and notified of TB, with onsite screening overcoming key barriers such as work schedules and distance from clinics.
- Community outreach campaigns provided essential health services, including HIV testing, ART initiation, and re-initiation. In Q4, 11 individuals were referred for TB specimen collection, with two confirmed TB cases. Additionally, 100 people were tested for HIV in Chirumanzu, identifying three new positive cases.
- Capacity-development efforts included refresher training on DHIS2 for 50 Peer Educators to improve data collection and reporting. HIV Focal Nurses also trained Peer Educators on administering blood-based HIV Self-Test Kits, enhancing access to testing options.
- Collaboration with key stakeholders remained strong, with the National AIDS Council (NAC) and the Ministry of Health and Child Care (MoHCC) and multiple other key line ministries. Quarterly review meetings facilitated engagement with district health officials, enhancing program effectiveness.

Increased coverage of Voluntary Medical Male Circumcision (VMMC)

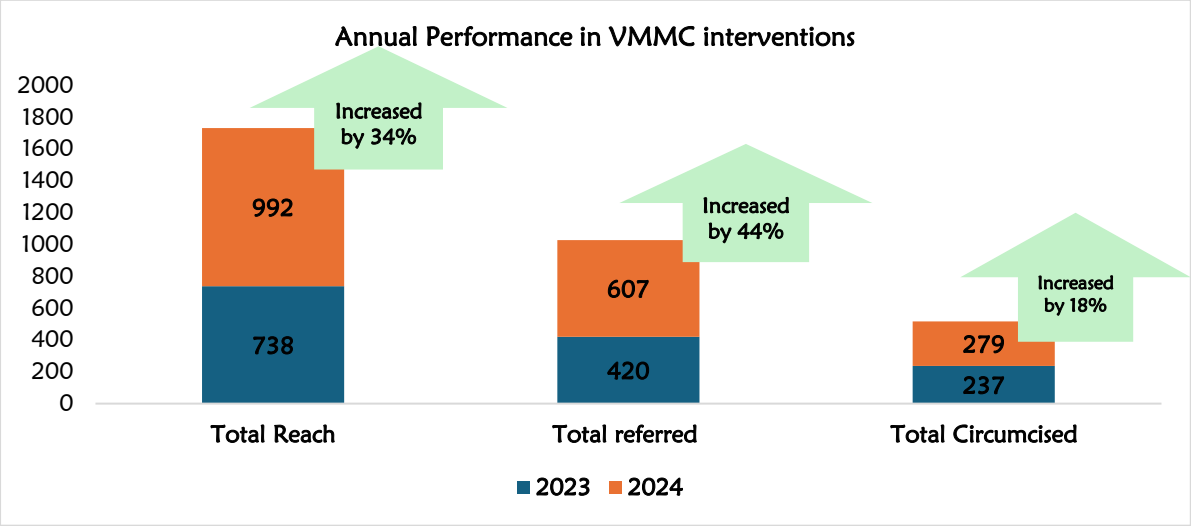


Figure 6 Chirumanzu district 2024 performance in VMMC interventions

There was increased access to HIV prevention services for youths through the Integrate Project. Between **45-50%** of youths get circumcised from all the referrals that are conducted

Viral Load Monitoring and ART Adherence Among Children, Adolescents, and Caregivers in Gweru and Bulilima Districts (FY24)

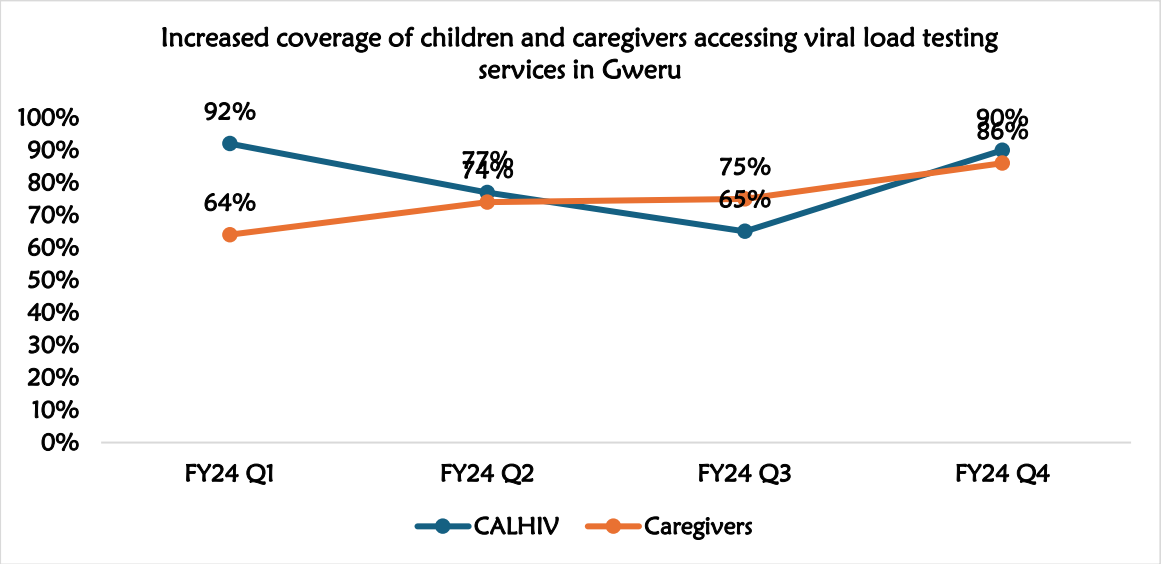


Figure 7 Proportion of caregivers and children living with HIV assisted by JHWO to access viral load testing in Gweru district

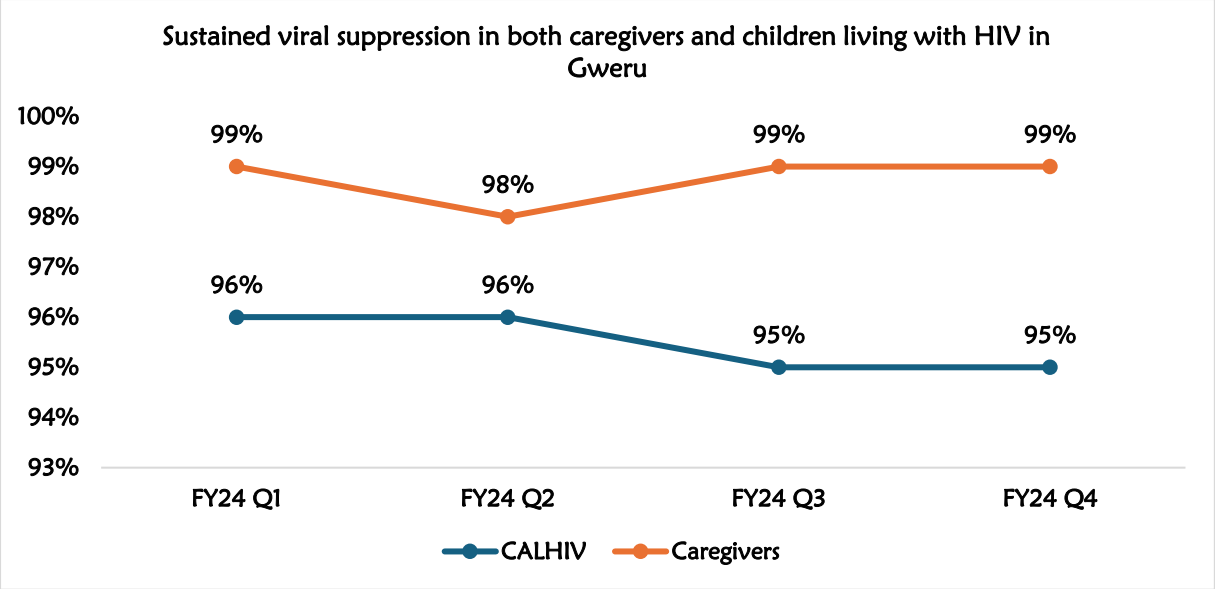


Figure 8 The proportion of caregivers and children living with HIV assisted by JHWO who have suppressed viral load

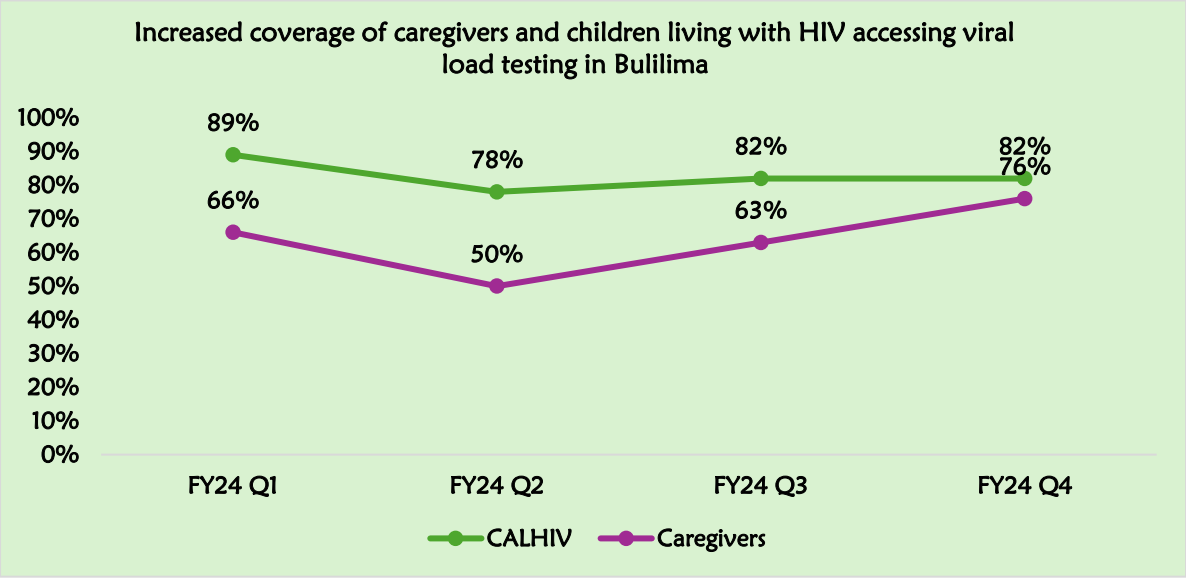


Figure 9 The proportion of children and caregivers living with HIV assisted by JHWO who accessed viral load testing services in Bulilima district

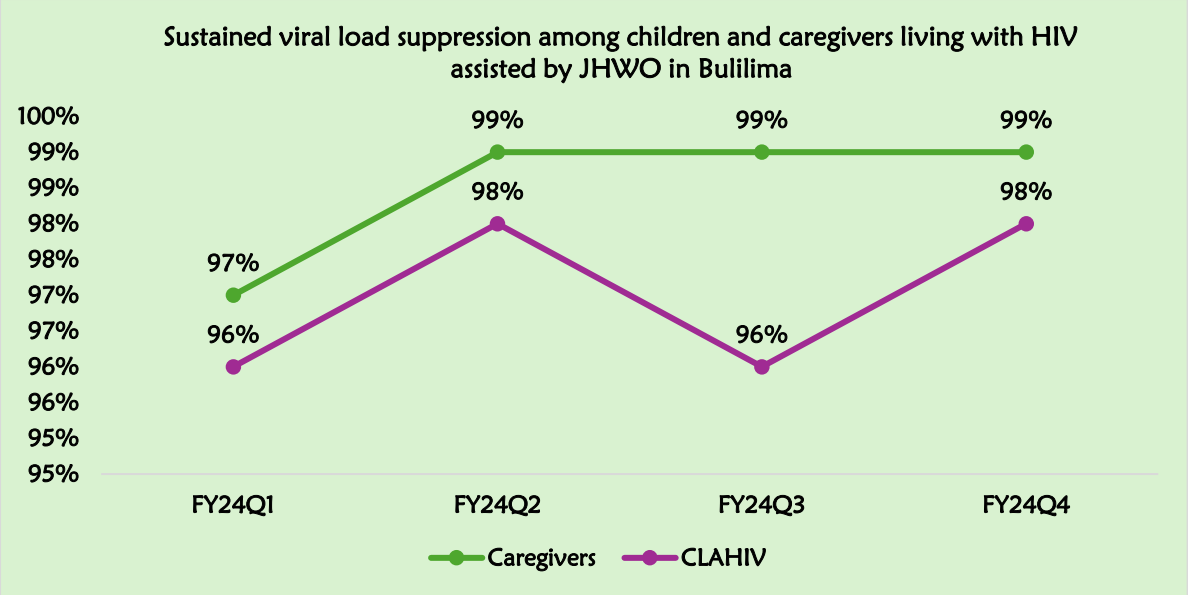


Figure 10 The proportion of caregivers and children living with HIV assisted by JHWO who achieved viral suppression in Bulilima district

Innovative Approaches and Best Practices

- JHWO played a key role in facilitating targeted interventions, ensuring that global best practices were adapted to the specific needs and realities of artisanal miners. **1)** Addressing logistical barriers – ASMs often work in remote, informal, and sometimes illegal mining sites where healthcare services are limited or non-existent. On-site HIV and TB testing eliminates the need for miners to travel long distances to clinics, increasing the likelihood of early diagnosis and treatment. **2)** The introduction of blood-based HIV self-test kits was based on the preferences of ASM workers, demonstrating a people-centered approach. Many traditional HIV tests require facility visits, while self-test kits allow for confidential and convenient testing. **3)** Expanding peer-led health models to include child protection advocacy is a critical step since mining communities often see increased risks of child labor, exploitation, and abuse. By integrating child protection into existing health programs, trusted community members can raise awareness and support vulnerable children.
- Efforts were made to safeguard children under 18 (through raising awareness on HIV and GBV) from mining-related risks, particularly transactional sex can become a significant risk, especially for children and young people who become vulnerable to HIV and other STIs.
- Community-led solutions, including the construction of waiting shelters and incinerators in Umzingwane, demonstrated the power of community ownership in addressing healthcare challenges. The transformation of Chaka Clinic in Chirumanzu exemplified the impact of CLM data. Following community feedback, the clinic addressed critical issues such as confidentiality breaches, inefficient appointment systems, and inadequate triaging of TB cases, achieving significant service delivery improvements.
- Other achievements from CLM include Community ART Refill Groups (CARGs) established for artisanal miners in Shurugwi, leading to a 15% increase in ART retention rates.

- Drug stockouts and shortages in multiple districts were addressed through escalations to the District Health Executive (DHE).
- Security concerns at healthcare facilities (e.g., Sanzukwi Clinic) were resolved through community-driven security guard hiring.
- Privacy concerns in consultation areas prompted improvements in clinical infrastructure, such as at Mazibisa RHC.
- Facility cleanliness issues were resolved through community-led clean-up campaigns.

Improved care and support for multiple myeloma patients

JHWO through the Multiple Myeloma project helped to improve multiple myeloma care focusing on early diagnosis, better access to services, and stronger research coordination. By addressing barriers to early diagnosis, these initiatives aimed to reduce late-stage detections, ensuring timely and effective treatment. A well-structured referral pathway system was established to streamline patient navigation, allowing for better coordination between healthcare providers. Additionally, increased awareness and knowledge about multiple myeloma among both patients and healthcare professionals contributed to improved diagnosis and management. These collective advancements were crucial in optimizing patient outcomes and fostering a more efficient healthcare response to multiple myeloma.

Through the project:

- 4287 community members were reached with MM awareness
- 36 MM clients received medication and tele-counselling
- 2 support group sessions were conducted with patients

Figure 11 Home visit by project staff in Bulawayo to an MM client and his wife to strengthen care and support services

SOCIAL DEVELOPMENT

Preamble

JHWO's Social Development activities are centred on reducing poverty, inequalities, and vulnerabilities among marginalized communities by 2024 through seven strategic outcomes. The pillar promotes social inclusion and gender equality by increasing awareness of key social issues like disability inclusion, gender-based violence (GBV), drug abuse, and early child marriages. It also facilitates technical and vocational training for market relevance, aiming to skill up youth through models like Siyaka, ensuring they have employability skills that match market demands. Moreover, it enhances access to basic services, particularly education and health, by providing education subsidies and health referrals to improve school attendance and progression.

Main objective

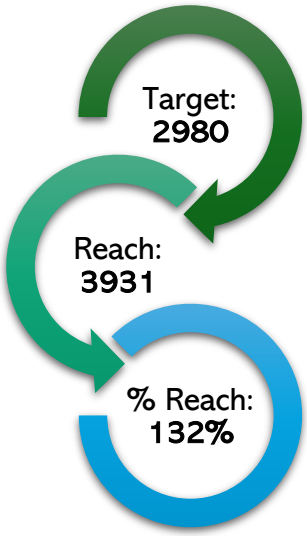
Contributing towards the reduction of poverty, inequalities, and vulnerabilities among marginalized communities by 2024.

Districts of implementation

Social Development activities were implemented in multiple districts including Gweru, Bulilima, Shurugwi, Chirumhanzu, Zvishavane, Mangwe, Kwekwe, Umzingwane, and Harare, each with specific targets for activities and outcomes.

Key Achievements

Increased proportion of vulnerable children reached with child rights education



- Child rights sessions were conducted with children aged 9-17 years across all implementation districts. These were facilitated through:
- District child protection committee meetings that were conducted quarterly
- Sinovuyo sessions :An evidence-based curriculum for children's rights.
- Incorporating follow-up sessions or peer education that sustain long-term awareness.
- Parental involvement to ensure safeguarding principles were observed

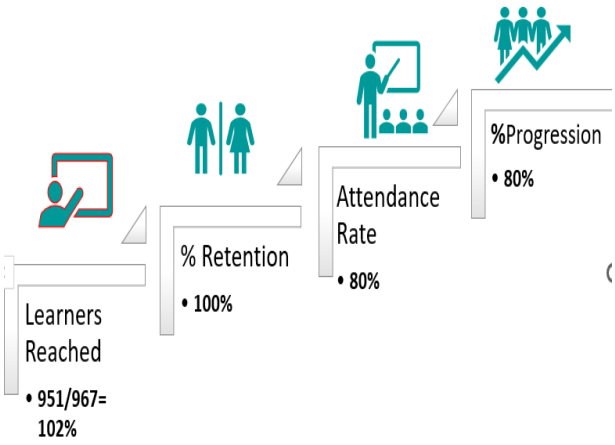
Increased advocacy against Gender-Based Violence

- Conducted **932** sessions with children and caregivers
- Reached **7914** participants
- **7** cases were identified during sessions and reported
- **7** cases assisted with post-GBV care services

Increased advocacy against drug and substance abuse

- Reached **8410** people with anti-drug abuse information
- JHWO participates in district TWGs on anti-drug and substance abuse
- Generated campaign information disseminated through mass and social media

Increased access to education by vulnerable children



- JHWO provided school stationery to **967** vulnerable children.
- There was **100%** retention during all terms
- **80%** attendance rate in both Gweru and Bulilima districts where the project is being implemented.

RESILIENCE STRENGTHENING

Preamble

The Resilience Strengthening pillar empowers communities to overcome adversity, achieve economic independence, and support their families. Through Income Savings and Lending (ISAL) groups, over 1,300 caregivers have been trained, leading to increased self-sufficiency and savings used for essentials like school fees and healthcare.

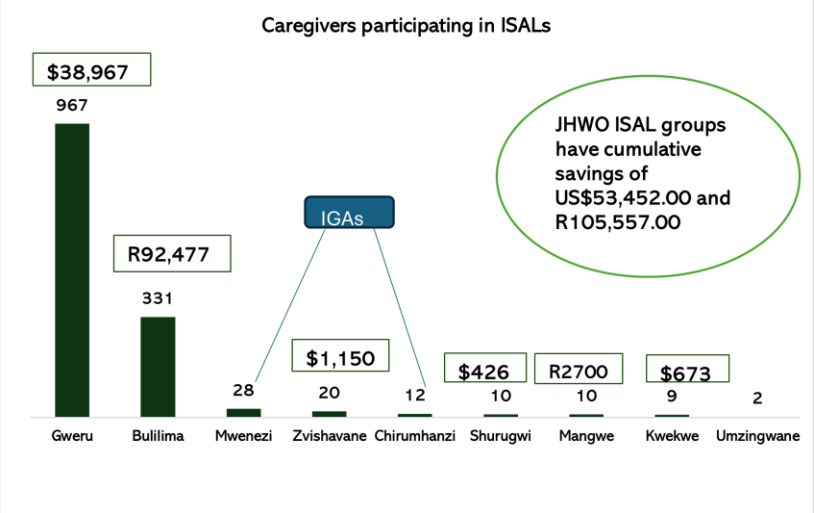
Market linkages and Income Generating Projects (IGPs) have boosted livelihoods, particularly in poultry farming, while Selection, Planning, and Management (SPM) training equips caregivers with skills to start and sustain businesses. By enhancing financial literacy, market access, and economic resilience, this pillar ensures vulnerable households thrive despite challenges.

Objective

To increase the capacity of vulnerable households to sustainably care for their families.

Key Achievements

Increased financial independence for vulnerable households



258 caregivers established viable income-generating projects

Figure 12 Caregivers savings for the year 2024

Figure 13 Caregivers scaling up their IGAs in implementing districts

DISASTER RISK MANAGEMENT

Preamble

JHWO Disaster Risk Management activities empower communities to prepare for and respond to disasters and emergencies that impact negatively on vulnerable households. Enhancing disaster preparedness for effective response in recovery and reconstruction. Implementation is done across 12 districts with 3 districts (Gwanda, Insiza, Mwenezi) implementing January to June with the rest of the year being affected by the close-out of the KNTB project through which DRM activities were layered upon. Activities under this pillar are guided by the organization's mission of advocacy against harmful norms, mitigating the impact thereof.

Objectives

- To raise awareness on natural and man-made disasters in all areas of operation.
- To enhance pandemic preparedness and disease responses in vulnerable communities.
- To recover and rehabilitate community facilities affected by natural and man-made disasters like veld fires, deforestation, land degradation, drought, floods, climate change and diseases.

Key Achievements

Increased awareness of natural and man-made disasters in all areas of operation.

Through continuous outreach efforts, JHWO has been raising awareness and sharing information on natural and man-made disasters in hard-to-reach communities. Awareness campaigns, community outreach efforts, and other participatory activities conducted in districts of implementation promoted a culture of preparedness and resilience in disaster-prone communities. 11449 people were reached with DRM awareness and prevention information. In efforts to use data for decision-making as part of disaster risk reduction, early warning systems were established in 7/12 districts. For instance, in Shurugwi, following the recording of the first 5 cholera cases in 2 artisanal mining sites – the District Joint Operations Committee engaged the MoHCC Environmental Health department and a cholera camp at Msasa was set up for better management of cases in affected areas in an outreach setup and for ease of access to ASMs in the surrounding affected areas identified through the semester 2 hotspot maps.

As part of the MoHCC-led vaccination campaigns throughout the year, 969 CBVs were engaged in social mobilization, demand creation for service uptake and raising awareness amongst communities. An estimated 3155 children under 60 months received the Polio vaccine through community referrals. 50 Peer Educators engaged community leadership, opinion leadership (popularly known as Mabhuru in ASM sites) or AWET – an organization that works with conservative apostolic white garment churches/religious sects to engage conservative or hard-to-reach populations such that children could be vaccinated and the turnout was significant compared to the previous year whereby JHWO had not specifically assisted with social mobilization for such vaccination campaigns or had been actively engaged in an outbreak.

Community dialogues with influential community leaders

Influential leadership (449 in total) in the community took part in discussing local pandemics, climate change, and environmental degradation. Strategies have been put in place to lessen the rates of treatment defaulters amongst PLHIV, encourage early treatment seeking behaviour (through Social Behaviour Change) amongst key populations and protection of the

environment in artisanal mining sites across 9 districts. JHWO has spearheaded Community Led Monitoring (CLM) through One Impact and also via the Community systems strenghthening project funded by Global Fund to ensure communities are at the fore in conducting advocacy engagements and raising barriers faced by communities in accessing quality healthcare services.

Community leadership structures have taken on board engaging community members on the importance of having robust emergency response plans in place to ensure a coordinated and effective response during disasters and close to 45% of the WARDCOs in the 9 districts have established early warning systems with some having measures in place just before the flash floods affected certain areas of implementation at community level.

Awareness raising on pandemics, disease outbreaks and communication strategies

84627 individuals (37256-M, 47416-F) were reached through awareness of pandemics, disease outbreaks, and effective communication strategies. JHWO's primary focus before any intervention is to educate communities on pandemics, how to stop the spread of diseases and raise awareness on simple and effective systems to detect outbreaks. There has been engagement of communities in proactive measures such as vaccination campaigns, peer-led outreach campaigns, health education sessions on a weekly basis across communities, vector control measures, CBVs engaging in nutrition programs, and rabies awareness campaigns. All this has been done to collectively work towards healthier and safe communities. Participants included community representatives, targeted key populations, community leadership structures in their entirety, religious and faith-based leaders, traditional healers and district level key stakeholders.

District focal persons educated communities on pandemics, how to stop the spread of TB and Cholera diseases and raised awareness on simple and effective systems to detect outbreaks, considering how 2024 was riddled with a surge in these diseases intermittently. 838 CBVs and 50 Peer Educators reached 58026 community members in hotspot areas across 11 districts namely Chirumhanzu, Kwekwe, Shurugwi, Zvishavane, Gweru, Mangwe, Bulilima, Umzingwane, Mwenezi, Gwanda, Insiza – some CBVs invited HCWs and local leadership to join the health education and awareness sessions held at ward level. Mangwe Community Cadres, through GF support also educated a total of 518 participants cumulatively on pandemics, how to stop the spread of diseases and how to establish simple and effective systems to detect outbreaks

Figure 14 A session on DRM sensitization during an ISAL training for caregivers in Kadoma (Credit: A. Silver - JHWO)

Through JHWO's Peer-Led Programme, 15 Peer Educators in Shurugwi were trained by the MoHCC Environmental Health Department and operated as treated water point focal persons and assisted first responders at designated areas with case identification, containment, and management in hard-to-reach areas. Management of cholera in artisanal miners or their communities is rather challenging. Through the peer-to-peer approach, prevention and awareness were spearheaded by PEs across ASM sites and reported through community-based surveillance, suspected cases early to deter high mortality rates.

Enhanced pandemic preparedness and disease responses in vulnerable communities.

DRM training session

The training aimed to equip community leaders, members, and cadres with the knowledge and skills to identify, assess, and mitigate disaster risks while strengthening preparedness and response mechanisms. The initiative sought to reduce vulnerabilities and improve disaster management across targeted districts by enhancing coordination, risk mapping, and resilience-building efforts

1,032 leaders & community members trained (577M, 455F) across 8 of 12 districts on disaster preparedness and environmental hazards.

Figure 15 Kwekwe District DEHO (Representative Mrs Chinemaringa) having a discussion on Safe Mining with Village Heads at Senkwasi Clinic. (Credit: Anesu Silver – JHWO)

- WARDCOs drafted district-specific DRM plans, with 6 rural wards in Shurugwi implementing plans.
- 50% of districts with trained communities conducted quarterly ward-level coordination meetings, improving disaster response.
- 2,090 community cadres trained (CCWs, VHWs, CBVs, Peer Educators) – 158% of the annual target (1,320) – to conduct risk assessments and community-based surveillance.
- Enhanced coordination between community groups, authorities, and people at risk for improved disaster management.

The following is an example of what HCC members and leadership were capacitated on;

- Knowing the risks: artisanal mining increases TB risk due to silica dust exposure, poor ventilation, and close living quarters.
- Getting tested: Regular TB screening is crucial for miners and their families.
- Practicing good hygiene: Cover your mouth when coughing, wash hands frequently, and avoid close contact with TB patients.
- Following safety protocols: Adhere to safety guidelines, wear protective gear, and reporting unsafe conditions in artisanal mining sites.

Figure 16 Session on training Shurugwi HCC Chairpersons on DRM and establishment of early warning systems during an advocacy engagement meeting with the DHE and HCCs (Credit: M. Nzwatu)

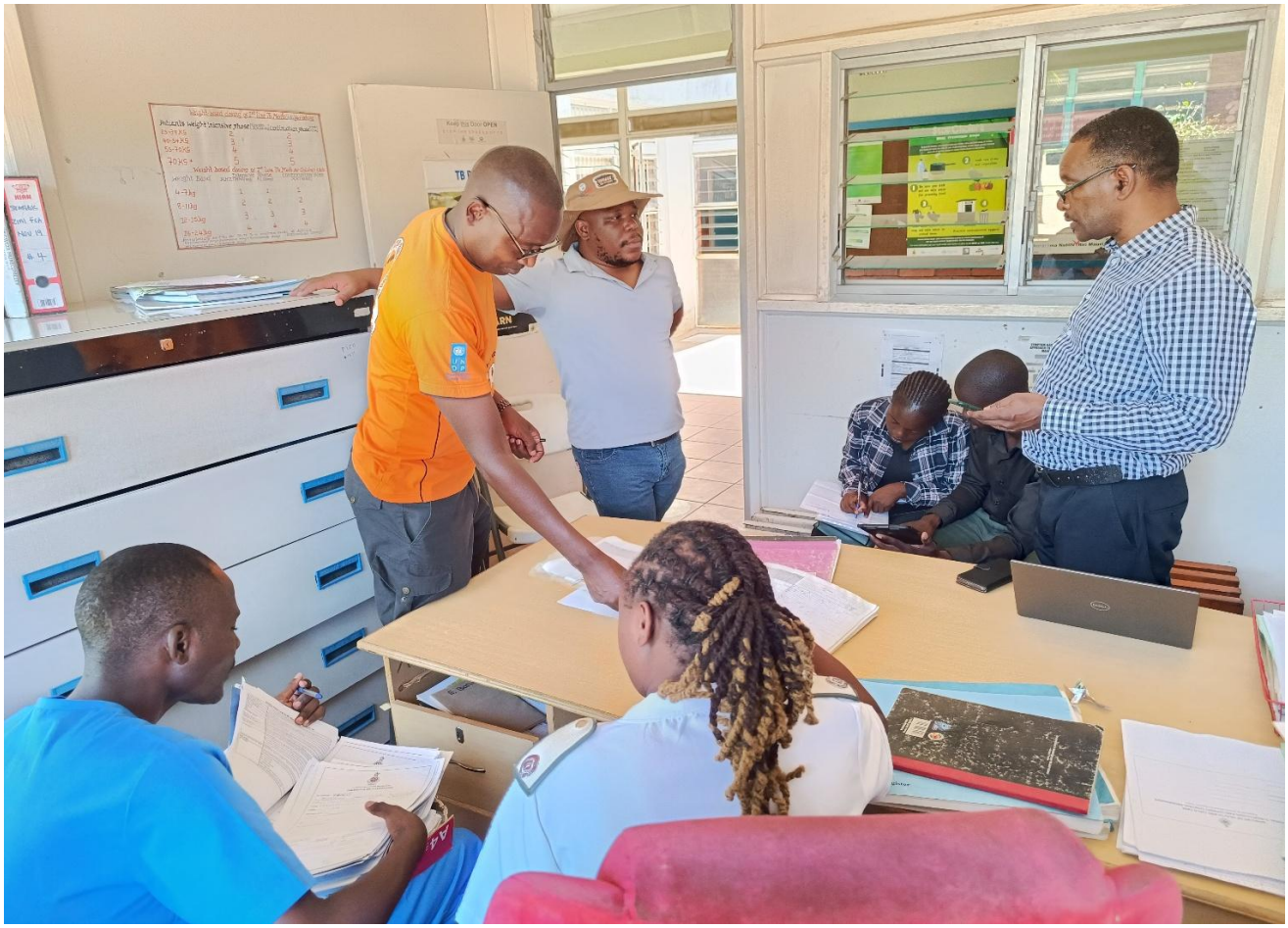
- Wearing protective gear: Use respirators, gloves, and safety glasses to minimize exposure to dust and explosives.
- Staying informed: Attend health and safety training and stay updated on mining operations and potential hazards.
- Prioritizing health: Regular health check-ups can help detect TB, silicosis and other mining-related health issues early.

It is important to remember that disaster awareness and preparedness are key to staying safe in a mining area with high TB and silicosis rates such as the districts JHWO operates in. Participants have been sharing these tips with their communities to promote a culture of safety, prevention of disease, and resilience.

Psychosocial support for families or individuals affected by disasters, diseases and pandemics

JHWO provided psychosocial support and mental health screening to individuals and households affected by disasters, diseases, and pandemics, ensuring their emotional well-being and resilience. Additionally, the initiative aimed to enhance treatment adherence and outcomes for TB and HIV patients through comprehensive care and support services.

- 499 households reached
- 392 patients screened for mental health issues, leading to targeted interventions and counselling.
- Enhanced emotional resilience through psychosocial support for disaster- and disease-affected individuals.
- 960 CBVs trained in comprehensive TB/HIV care, improving patient support and adherence.
- Integration of palliative care services into TB/HIV management for holistic patient care.
- 4 (four) affected households were reached with support, providing food hampers, clothes, sanitary ware in cases of emergencies to disaster-stricken communities.



STRATEGIC INFORMATION AND KNOWLEDGE MANAGEMENT

KNTB end-of-project documentation

The reporting period closed the curtain to the KNTB project with the Strategic Information and Knowledge Management (SIKM) department playing a critical role in terms of documentation of lessons learned during the 5-year project implementation. The documentation captured the most significant change stories and the impact of the project from the recipients of care and stakeholders involved. The stories will be posted on the website for advocacy and demonstration of impact. The detailed report can be accessed here

Website development and going LIVE

The long-awaited organizational website that was being developed by MCE went LIVE and the department played a critical role in the design and development of the site. The staff were trained to enhance their understanding of the site and their ability to update content which will go a long way in enhancing organizational visibility. The site is accessed at https://jointedhands.org

Publications

The SIKMM participated in a writing workshop during the reporting period coordinated by BOHS in the KNTB consortium. The organization representative was key in shaping the write up which was submitted to a journal and culminated in the publication of the article Treatment Outcomes of Tuberculosis Among Artisanal and Small-Scale Miners in Zimbabwe: A Follow-Up Observational Study Using Secondary Data https://doi.org/10.3390/ijerph21101282.

The study focused on treatment outcomes of tuberculosis (TB) among artisanal and small-scale miners (ASMs) in Zimbabwe, a vulnerable group facing a high burden of TB, HIV, and silicosis. Conducted across two occupational health clinics (OHCs) in Gwanda and Gweru, the study aimed to evaluate TB treatment success and the impact of risk factors within this population.

Key Findings:

High Treatment Success Rate: The study reported an 87% treatment success rate among ASMs, comparable to the national average for drug-sensitive TB and to global benchmarks. This success rate indicates the feasibility of achieving favourable treatment outcomes despite challenges associated with the miners' mobility and high-risk work environments.

Unsuccessful Outcomes: Unsuccessful treatment outcomes accounted for 13% of cases, primarily due to deaths (5%) and loss to follow-up (LTFU, 7%). Factors contributing to unsuccessful outcomes included unknown HIV status, smoking, alcohol use, and less than five years of mining experience.

Prevalent Risk Factors: Among the 208 ASMs studied, a significant portion had risk factors for TB, including smoking (57%) and alcohol use (57%). Additionally, over half of the miners had silicosis (58%), a known risk factor for TB, and 93% presented with symptoms such as cough.

HIV Status Gaps: About 27% of the ASMs had an unknown HIV status, raising concerns, as HIV co-infection is a significant risk factor for poor TB treatment outcomes. Improved documentation and encouragement for HIV testing are necessary to bridge this gap.

Impact of Silicosis: Although silicosis increases the risk of TB, this study did not find a statistically significant association between silicosis and unsuccessful TB outcomes. The lack of significant findings may be due to the proactive support provided by the USAID-funded Kunda-Nqob'i TB (KNTB) project, which has implemented extensive TB and silicosis awareness and safety practices among miners.

Role of Occupational Health Clinics (OHCs): The establishment of OHCs under the KNTB project significantly improved access to TB and HIV testing, treatment, and education among ASMs. This access was instrumental in achieving high treatment success rates, even in a population that typically faces challenges with health service access.

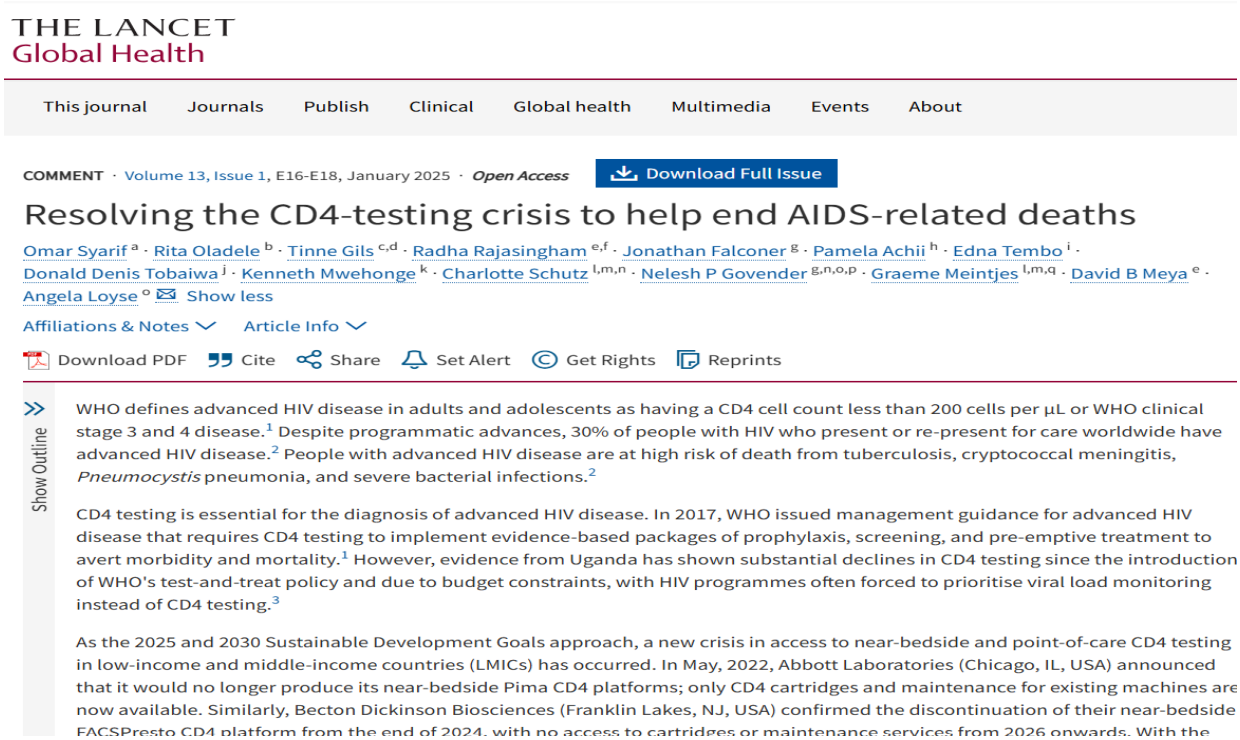
Recommendations:

a. Improve HIV Testing and Documentation: To enhance TB treatment outcomes, there is a need to reduce the high proportion of miners with unknown HIV status by strengthening HIV testing and reporting.

b. Targeted Interventions for Newer Miners: Miners with less experience were at a higher risk of unsuccessful treatment outcomes, likely due to economic instability and challenges accessing healthcare. Targeted support and education for newer miners could help improve outcomes.

c. Enhanced Preventive Measures for Silicosis: Ongoing education on silicosis and the importance of safety practices in mining should be maintained to prevent and reduce the risk of TB.

Overall, the study emphasizes the importance of accessible, targeted health interventions in improving TB outcomes among ASMs and highlights areas for further improvement to reduce the burden of TB in this vulnerable group.



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COMMENT · Volume 13, Issue 1, E16-E18, January 2025 · *Open Access* · Download Full Issue

Resolving the CD4-testing crisis to help end AIDS-related deaths

Omar Syarif [a] · Rita Oladele [b] · Tinne Gils [c,d] · Radha Rajasingham [e,f] · Jonathan Falconer [g] · Pamela Achii [h] · Edna Tembo [i] · Donald Denis Tobaiwa [j] · Kenneth Mwehonge [k] · Charlotte Schutz [l,m,n] · Nelesh P Govender [g,n,o,p] · Graeme Meintjes [l,m,q] · David B Meya [e] · Angela Loyse [o] · Show less

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Show Outline

WHO defines advanced HIV disease in adults and adolescents as having a CD4 cell count less than 200 cells per µL or WHO clinical stage 3 and 4 disease.[1] Despite programmatic advances, 30% of people with HIV who present or re-present for care worldwide have advanced HIV disease.[2] People with advanced HIV disease are at high risk of death from tuberculosis, cryptococcal meningitis, *Pneumocystis* pneumonia, and severe bacterial infections.[2]

CD4 testing is essential for the diagnosis of advanced HIV disease. In 2017, WHO issued management guidance for advanced HIV disease that requires CD4 testing to implement evidence-based packages of prophylaxis, screening, and pre-emptive treatment to avert morbidity and mortality.[1] However, evidence from Uganda has shown substantial declines in CD4 testing since the introduction of WHO's test-and-treat policy and due to budget constraints, with HIV programmes often forced to prioritise viral load monitoring instead of CD4 testing.[3]

As the 2025 and 2030 Sustainable Development Goals approach, a new crisis in access to near-bedside and point-of-care CD4 testing in low-income and middle-income countries (LMICs) has occurred. In May, 2022, Abbott Laboratories (Chicago, IL, USA) announced that it would no longer produce its near-bedside Pima CD4 platforms; only CD4 cartridges and maintenance for existing machines are now available. Similarly, Becton Dickinson Biosciences (Franklin Lakes, NJ, USA) confirmed the discontinuation of their near-bedside FACSPresto CD4 platform from the end of 2024, with no access to cartridges or maintenance services from 2026 onwards. With the

TB Stigma Assessment and TB KVP Size Estimation in Zimbabwe

Jointed Hands facilitated the successful realisation of the first ever TB Stigma Assessment (see abstract below) and TB KVP Size Estimation in Zimbabwe with funding from the Stop TB Partnership working with the National TB Leprosy Program

TB STIGMA ASSESSMENT IN ZIMBABWE

Abstract

Tuberculosis (TB) remains a major public health challenge in Zimbabwe, with stigma posing a significant barrier to accessing and providing TB services. This TB Stigma Assessment, conducted by the National Tuberculosis Programme (NTP) in collaboration with the Jointed Hands Welfare Organization (JHWO), aimed to evaluate the extent and dimensions of TB-related stigma in Zimbabwe and its impact on TB prevention, care, and treatment.

Using a mixed-methods approach, the assessment surveyed 416 people with TB (PWTB), 30 family members, 30 community members, and 30 healthcare workers across 12 districts. The study explored anticipated stigma, self-stigma, enacted stigma, observed stigma, secondary stigma, perceived stigma, and structural stigma.

Key findings indicate that 40.9% of PWTB experienced stigma, with women (44%) facing more stigma than men (38%). Stigma was most reported in community settings (22%), followed by self-stigma (10%), family/home environments (10%), workplaces (6%), and healthcare settings (5%). Community-driven stigma was found to significantly delay diagnosis and treatment, while healthcare worker stigma (33.3%) further deterred patients from seeking care. Additionally, 93% of community members and 43% of healthcare workers exhibited stigmatizing attitudes.

The assessment highlights the urgent need for community education, healthcare worker training, legal protections, and social support systems to mitigate TB stigma. Recommendations include short-term interventions such as awareness campaigns, stigma reduction training, and support group expansion, alongside long-term strategies such as policy reforms, legal protections, and continuous research.

Addressing TB stigma is crucial to improving treatment outcomes, increasing healthcare accessibility, and achieving national and global TB elimination targets. The findings from this assessment will guide evidence-based interventions and policy development to ensure inclusive, stigma-free TB services in Zimbabwe.

Findings of the TB Key and Vulnerable Population (KVP) Size Estimation Report in Zimbabwe

Overview

Zimbabwe continues to face a high TB burden, particularly among key and vulnerable populations (KVPs). This report, commissioned by the Zimbabwe National TB Programme (NTP) and Jointed Hands Welfare Organization, estimates the sizes of high-risk groups and highlights service gaps to improve TB control strategies.

Key Populations and Findings

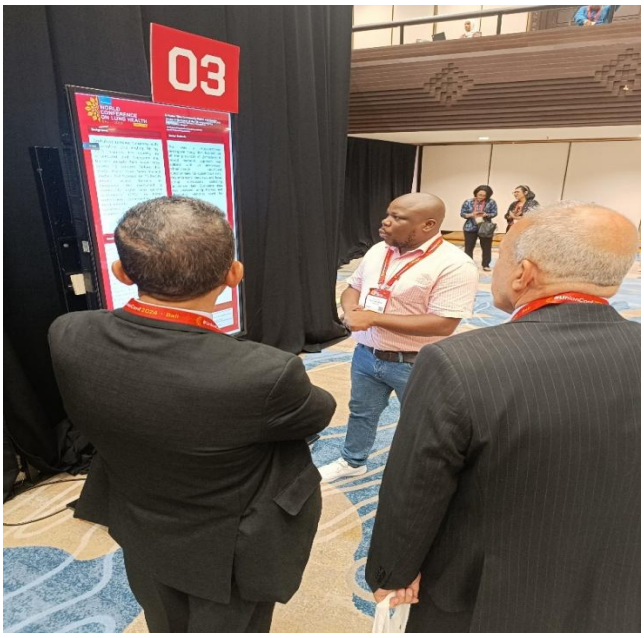
1. People in Congregate Settings (Slums, Refugee Camps)
    - Estimated Population: ~1.25 million in urban slums; ~12,000 refugees in Tongogara Camp.
    - Risks: Overcrowding, poor sanitation, limited healthcare.
    - Gaps: Need for integrated TB/HIV screening, better housing, and health services.
2. Miners & Ex-Miners
    - Estimated Population: ~227,079 formally employed, ~535,000 artisanal miners.
    - Risks: Silica dust exposure, high TB/HIV rates, poor access to healthcare.
    - Gaps: Occupational health services, TB/silicosis screening, and safer mining practices.
3. People Who Use & Inject Drugs
    - Estimated Population: ~450,000 adults with drug/alcohol use disorders.
    - Risks: HIV co-infection, poor immune health, stigma, criminalization.
    - Gaps: Need for harm reduction programs, rehabilitation access, TB screening.
4. Children Under Five
    - Estimated Population: ~2.2 million under five; ~3,500 TB cases annually.
    - Risks: Close contact with TB-infected adults, malnutrition, weak immunity.
    - Gaps: Paediatric TB diagnosis and treatment, low preventive therapy uptake.
5. People Living with HIV (PLHIV)
    - Estimated Population: ~1.3 million PLHIV, 70% of TB cases are co-infected.
    - Risks: Weakened immunity, delayed diagnosis, high mortality rates.
    - Gaps: Poor TB preventive therapy uptake, need for integrated TB/HIV services.
6. People Who Are Malnourished
    - Estimated Population: ~7.6 million (50% of the population) face food insecurity.
    - Risks: Malnutrition weakens immunity, increases TB susceptibility.
    - Gaps: Lack of food support for TB patients, need for food security programs.

Recommendations

- Expand TB case-finding and treatment programs for high-risk groups.
- Improve healthcare access in congregate settings, mining areas, and drug-use communities.
- Integrate nutrition support into TB treatment for malnourished patients.
- Enhance legal protection and reduce stigma for TB/HIV co-infected individuals.
- Increase funding for TB research, prevention, and service delivery.

The Union World Conference on Lung Health 2024 – Abstracts and Knowledge Sharing

The Strategic Information and Knowledge Management unit was key in ensuring that the organization submitted abstracts for the Union World conference to be held in Bali Indonesia. A total of 5 Union abstracts were submitted and two of them were successful which include the Stop TB Country platform enhancing coordination and advocacy efforts in Zimbabwe to be presented by Melody and Community, Rights, and Gender issues at the heart of the TB response in Zimbabwe to be presented by Kudzaishe Mutungamiri.



Melody Mukundwi (left) and Kudzaishe Mutungamiri (Right) presenting at the UNION World Conference in Bali Indonesia

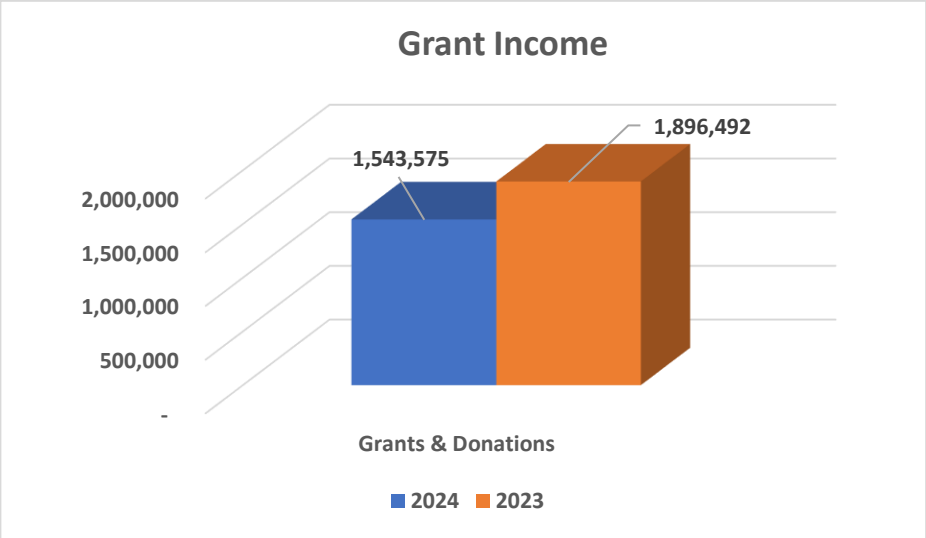
Strategic Plan development

The organization developed the next strategic plan, and the department was key in ensuring that there is stakeholder engagement by developing tools and soliciting for feedback. A workshop with stakeholders was convened in Mwenezi were additional feedback and the development of pillars were made. The Strategic Information Knowledge Management unit supported the Board development of the 5 yr Strategic Plan that can be accessed here

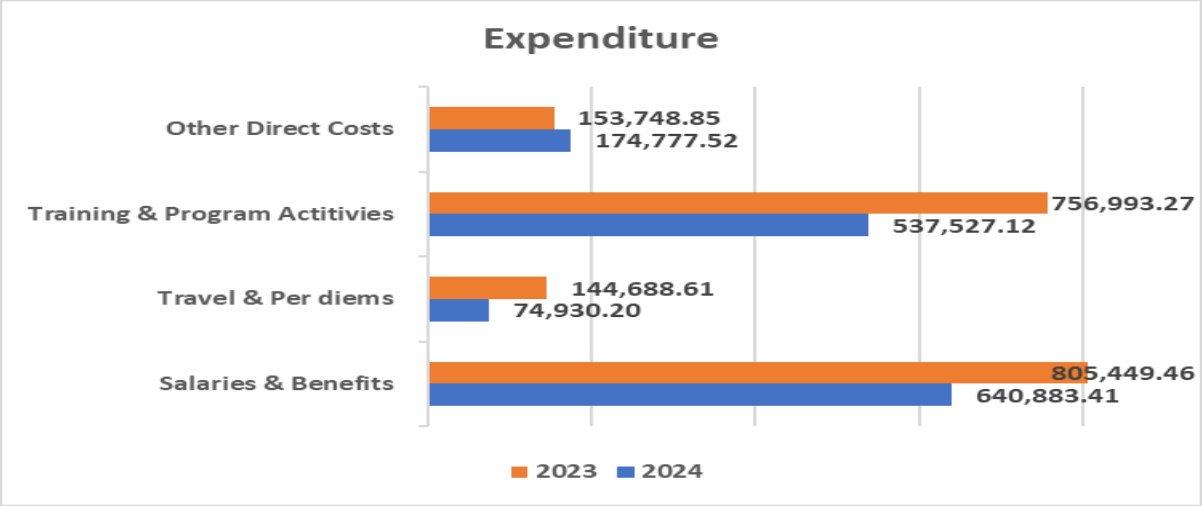
Picture Gallery

FINANCIAL REPORT

01 January to 31 December 2024	
Description	
Income	
Grants & Donations	1,543,575.10
Sundry Income	16,653.20
Total Income	1,357,661.30
	-
Expenditure	-
Salaries & Benefits	640,883.41
Travel & Per diems	74,930.20
Training & Program Activities	537,527.12
Equipment, Materials and Supplies	-
Other Direct Costs	174,777.52
Total Expenditure	1,428,118.24
	-
Surplus or Deficit for the period	(70,456.94)
Balances brought forward	125,586.08
Specific fund written off	
Surplus or Deficit carried forward	55,129.14



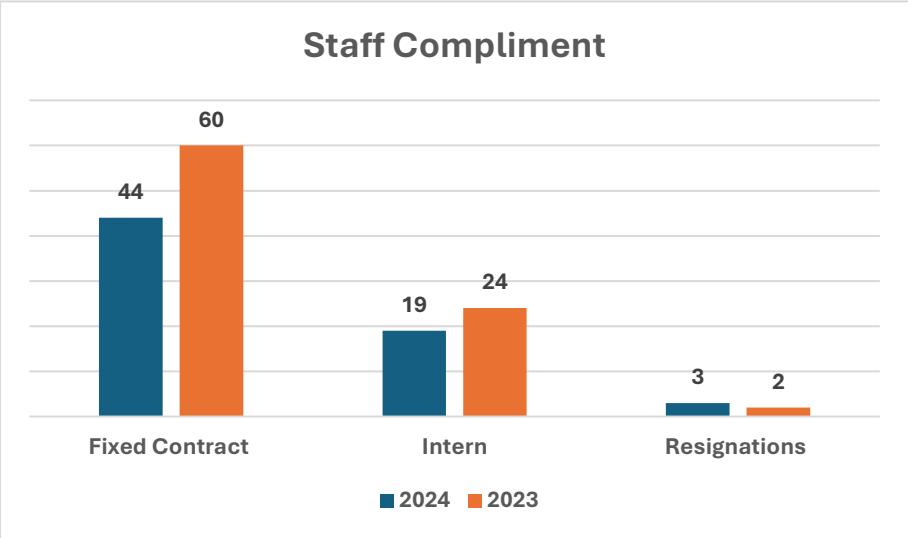
Our Grant income & Expenditure decreased by 19% and 23% respectively. This was due to our KNTB project that came to an end in September 2024.



HUMAN RESOURCES

The year 2024 began with:

- 62 staff members
- 24 interns
- 1% staff growth compared to the previous year



The decrease in staff was mainly attributable to end of KNTB project.

Staff changes throughout the year:

- 4 additional interns placed in Shurugwi, Chirumanzu, Kwekwe, and Harare
- Conclusion of the KNTB project resulted in 20 staff members' contracts ending
- Under Zingane OVC, 12 staff responsible for the Sinovuyo Parenting Program had contracts ended after fulfilling deliverables
- 3 resignations due to employees securing higher opportunities elsewhere
- End of year staff complement: 44 (including interns)

Employee health and well-being initiatives:

- 1st quarter: CIMAS provided health education, mental health support, and free medical check-ups
- 3rd quarter: Legal Resources Centre conducted a session on wills and inheritance
- 4th quarter: Year-end retreat to enhance collaboration, communication, trust, and motivation

Staff development:

- Conducted in-house training sessions
- Several employees graduated with Master's degrees from various colleges and universities

The year concluded with a leaner but well-supported workforce, ensuring continued growth and well-being within the organization.

Figure 17 JHWO team during a team building session in Matabeleland South

PARTNERS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