

Smart Investment in Health: Mining as a Catalyst for Building Sustainable Communities
Sandton International Convention Centre, Johannesburg
26th – 27th July 2017

EXECUTIVE SUMMARY

Objectives of the Smart Investment in Health meeting:

- (i) Assess public and private sector (i.e. mining industry) health service provision for mineworkers and peri-mining communities in Africa;
- (ii) Share innovative interventions of TB in the Mining Sector Program in Southern Africa;
- (iii) Build consensus on investment priorities and strategies for improvement

Key Issues:

- **Mineworker in the Large Scale Mining (LSM) sector** usually benefit from the provision of occupational health services (OH) offered by their companies – which are occasionally extended to the peri-mining communities. However, these services differ in scope and span. Moreover, the LSM sector’s approach to investment in health is fragmented, largely tax-based or dependent of social-corporate responsibility.
- **Mineworkers in the Artisanal and Small Scale (ASM) sector** are neglected and underserved; and much like the peri-mining communities, are heavily dependent on the underfunded and overstretched public health services. Access to OH services by these subpopulations is non-existent. Legislation, where it exists does not adequately address the needs of this sector and in some instances, ASM is considered illegal.
- **Many countries have yet to ratify the ILO conventions** related to mine health and safety and more specifically to OH. The signed policies and legislation are standalone pieces often unaccompanied by time-bound implementation plans and relevant instructions. Inspectorates are ineffective at monitoring and enforcing OH compliance due to lack of funding, inadequate capacity, under-equipment and weak coordination across a number of government agencies.
- **Sustainability and Community Ownership** are insufficiently embedded in policy, program planning and implementation. This in turn affects the effectiveness of Community Development Trust/ Agreement (CDA/T), Social Labor Plan (SLP) and Corporate Social Responsibility (CSR). Solutions to overcoming operational challenges were proposed including recommendations to improve the innovative tools and models initiated by the TB in the Mining Sector Program in Southern Africa (e.g. geospatial mapping, Regional Health Management Information System).
- **Priority investments and strategies** include: the use of country-mining visions to mobilize resources; adoption of a tripartite approach to partnership building; initiation of national-level policy dialogue; investing in occupational and public health for ASM workers and communities, harmonizing legislation and making the Health Impact Assessment (HIA) mandatory and systematic.

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MEETING REPORT

1. BACKGROUND

On 26-27 July 2017, an international meeting entitled ‘*Smart Investment in Health- Mining as a Catalyst for Building Sustainable Communities*’ was convened in Johannesburg by the Southern African Regional Coordinating Mechanism (SARCM) for the TB in the Mining Sector Program. It brought together over 200 senior-level stakeholders from Government and the private sector including civil society, and partners from the African Union (AU) and the Southern African Development Community (SADC), The STOP TB partnership, The Global Fund and The World Bank. Keynote speakers, panelists and participants included: the South-African Minister of Health, high-level government officials, key technical directors in Ministries (of Mining, Health and Labor respectively), occupational and public health experts, academics and researchers; as well as top private sector representatives from mining companies and the chamber of mines; civil society organizations; labor unions, community-based organizations and ex-mineworkers associations. Building on the successes achieved so far in the TB in the Mining Sector Initiative and lessons learnt, the Smart Investment meeting aimed to explore ways of improving Occupational Health (OH) Services for mineworkers and public health care services for the peri-mining communities.

OBJECTIVES OF THE MEETING

The key objectives of this meeting were to:

- Share the evidence generated and lessons learnt from the regional TB in the Mining Sector initiative
- Review the effectiveness of existing mechanisms to improve expansion of access to occupational and public health services in the mining sector
- Identify priority areas for further investments and opportunities resource mobilization for occupational and public health care

2. MEETING PROCEEDINGS: ISSUES AND RECOMMENDATIONS

The meeting proceedings covered three thematic areas : (a) Occupational Health (OH) of mineworkers, (b) public health and peri-mining communities; and (c) Investment priorities for OH and Public Health.

PART 1: OCCUPATIONAL HEALTH OF MINEWORKERS

2.1.1 Opening remarks

The South African Minister for Health officially opened the meeting and key partners from the regional and international community delivered opening remarks. They highlighted the mining industry’s critical role in African economies and emphasized the need to continuously address its negative socio-economic impact on occupational, environmental and public health. In particular, they all underscored the importance of maintaining the current momentum and strengthening commitment on all sides by:

- Sustaining the implementation of several occupational TB initiatives;

- Building on lessons learnt to better inform future innovative interventions;
- Placing communities affected by mining at the center of program planning and implementation;
- Strengthening collaboration between Government ministries (Health, Labor, Mining) and deeply engaging with the private sector;
- Disseminating critical knowledge to countries that are opening up new mines.

2.1.2 Overview of the mining industry and its impact on health

An overview of the size, structure, governance framework, and impact of the mining industry on the socio-economic development in Africa was discussed from a broad perspective with particular reference to the health of mineworkers and peri-mining communities.

Key issues

Africa's footprint in the global mining industry: Africa holds up to 30% of the World's mineral reserves - with minerals and metals contributing to over 20% of Africa's total GDP. Amongst the "top ten" global resource nations in at least one major mineral, eleven are African.

Diversity of the structure of the mining industry: Africa has a diverse mining industry broadly separated into formal and informal sub-sectors. The formal subsector consists of over 2,000 Large Scale local and foreign Mining companies (LSM) including leading multinational mining companies. The semi-formal and informal subsector consists of a number of Artisanal and Small Scale Mining (ASM) operations employing about 8 million people - of which 25% to 50% are women – and indirectly supporting another 30 million livelihoods.

Governance of the mining industry: At global and regional levels, Africa has witnessed a proliferation of governance frameworks that control policy, legal, regulatory and institutional set ups on cross cutting issues. The variety in scope and span of governance frameworks is reflected at country-levels; and national disparities exist in terms of OH practices.

Negative impact of mining on health of mineworkers and peri-mining communities: Key occupational health hazards have resulted from: a) the shift to deep-level mining, b) the opening of new mines in poorly regulated environments; and c) the emergence of zoonotic diseases due to mining in remote and forested areas. Additionally, male mineworkers with disposable incomes are at increased risk of sexually transmitted infections (HIV/STIs) due to associated lifestyle choices. Similarly peri-mining communities are exposed to environmental health hazards and are likewise vulnerable to communicable diseases.

Provision of occupational health services: Several Large Scale Mining (LSM) companies are ensuring health service provision to mineworkers -- with occasional extension to peri-mining communities. However, the services provided vary in scope and span, as do the service delivery arrangements. LSM sector investment in health is largely fragmented and principally tax-based. LSM companies do not have an industry-wide approach to investment in health and do not usually review the effectiveness of their OH interventions - health is not their number one priority. In addition, collaboration between health facilities run by mining companies and the local health authorities are often inadequate due to lack of clear policy guidelines for engaging with each other, no legal requirement for disclosure of data, ill-defined roles and responsibilities, amongst others.

Provision of public health services: Artisanal and Small Scale (ASM) mineworkers are a neglected and underserved subpopulation -- much like the peri-mining communities. They live in dire straits, work under harsh conditions and depend heavily on the overburdened and under-resourced public health services. Yet,

government investments in health have not been commensurate to revenues earned from the mining industry and have not benefited the ASM and peri-mining communities. Disclosure policy on private sector financing is vague, accountability is weak; and grievance and redress mechanisms are non-existent.

Human rights dimension of Occupational Health: Labor Unions could be more proactive in the promotion and protection of mineworker rights in particular: the right to information on protection and prevention; to screening, diagnosis and treatment of OH diseases; to education and training; and to representation.

Limited research on OH of ASM and peri-mining communities: The health impacts of mining operations on ASM mineworkers' and peri-mining communities have received much less attention compared to research and interventions addressing the OH of LSM mineworkers.

Recommendations:

1. Adapt successful global Public-Private partnership models (e.g. from Brazil, Ghana and Mauritania) to the African mining industry;
2. Adopt an integrated approach to OH policy, program design and implementation involving key stakeholders (public, private, mineworkers and community);
3. Strengthen compliance monitoring of OH policies by governments and communities;
4. Step up OH policy harmonization by leveraging Regional Economic Communities;
5. Make 'OH in Mining' *central* to social development, sustainable living and social equity;
6. Catalyze OH reforms via the Africa Mining Vision, regional, and national initiatives;
7. Channel funds to public and community health systems strengthening via partnerships.

2.1.3 Occupational health for Artisanal and Small Scale Mining (ASM)

Following a detailed presentation on the ASM industry, participants extensively discussed OH service delivery challenges for this sector. The African ASM industry employs an estimated 8 million people of which over 50% are in Southern Africa and the Democratic Republic of Congo¹. The sector is characterized by: its informality, scaled-down legal provisions that do not adequately address its challenges; including weak knowledge of occupational health hazards (e.g. use of mercury), inadequate OH implementation capacity, financial constraints, limited political will and lack of institutional capacity to monitor and enforce compliance with good OH practices. The equity gap that drives poor communities to take risks in mining has yet to be bridged.

Key issues

Weak legislation, institutional capacity and incentives: Legal provisions for the ASM industry are largely irrelevant: they are 'watered down' versions of provisions for the LSM sector, ambiguous and outdated. Inspectorate departments have limited capacity to address ASM Occupational Health challenges: the sector comprises of a loosely defined, mobile and flexible group of manual mineworkers who often operate without licenses which makes them vulnerable to punitive action by national and local-level authorities. The political will to address this situation and enforce compliance with good OH practices is wavering since the strict enforcement of health standards could likely trigger mine closures and put many livelihoods at stake.

Absence of OH services for ASM: ASM mineworkers have limited access to basic health care services let alone OH services. They rely primarily on an underfunded and overstretched public health system. They

¹ ASM employs about 2 million people in Democratic Republic of Congo, 1.5 million in Tanzania; 500,000 in Zimbabwe and 200,000 in Mozambique

remain unaware about TB and silicosis risks and are ill-equipped to address OH hazards. Targeting is a challenge due to the often illegal nature of ASM operations including the instability, mobility, high turnover rate and dispersion of its workers. Mineworkers themselves are primarily interested in short term gains and do not see the benefits of OH. They do not have a compensation framework.

Recommendations:

1. Analyze ‘access’ barriers to inform targeted OH service delivery interventions ;
2. Prioritize demand-side interventions tackling OH knowledge, skills gaps, and mineworker rights;
3. Strengthen inspectorate capacity to monitor and aid ASM workers’ adherence to OH standards;
4. Develop outreach OH services that target ASM workers *through the community* (rather than just on mining sites) and are inclusive of women and children;
5. Involve the community in prevention activities and in monitoring of mineworker health;
6. Use mobile clinics and set up OH service centers targeted at ASM mineworkers;
7. Equip and capacitate of health facilities -located in ASM mining areas- to provide low level screening services and refer complicated cases upward.

2.1.4 Mine Health and Safety: Policy and Legislation

Detailed review of Mine Health and Safety legislations in Southern Africa revealed a number of issues/ gaps and implementation challenges.

Key issues

Variations in ratification of ILO conventions: Although most countries do include elements of the ILO conventions in their legislation; many countries have yet to ratify and abide by the ILO conventions related to mine health and safety and more specifically to Occupational Health;

Weak coordination: Responsibilities for legislation - oversight and compliance - are fragmented and dispersed across departments and ministries, thus hampering coordination efforts and resulting in competition for budgets/ resources. The signed policies and legislation are standalone pieces often unaccompanied by time-bound implementation plans.

Generic dust control legislation: Legislative reference to dust control is generic. Specific instructions on systems design and implementation of dust control provisions are rare. For example, up to 50% of countries (South Africa, Tanzania, Namibia, Zambia and Mozambique) have occupational exposure limits for crystalline silica dust but prescriptive instructions on dust monitoring are missing. Most countries do not have a national program for elimination of silicosis.

Ineffectual implementation of Occupational Health surveillance: All countries (except for Malawi and Lesotho) have legal provisions for OH surveillance covering pre-employment, periodic, exit medical and post-work medical examinations. That said, implementation is weak and models for the purposes of replication are uncommon. Pneumoconiosis is considered compensable in all countries while TB is compensable only in South Africa and Zambia.

Inadequate legislative enforcement capacity: Inspection and enforcement systems are under-funded and largely ineffective due to understaffing, under-equipment, low technical capacity. Moreover, standards for inspections are not harmonized across countries.

Recommendations:

1. Develop a “minimum OH standards” at legislative, policy levels; and deploy at programmatic level using Technical Assistance;
2. Improve coordination across implementing agencies, ministries and departments;
3. Strengthen inspectorate department capacity (including training, development of monitoring instruments and skills, clear reporting systems and data management) and turn them into centres of excellence;
4. Analyze systemic barriers to implementation and enforcement of OH measures;
5. Conduct advocacy amongst mineworkers and communities for OH compliance monitoring.

2.1.5 Strategies and Models for Occupational Health Service Provision

Innovations and models for Occupational Health Service delivery implemented in Southern African countries included the following: (1) Establishment of Occupational Health Service Centers providing TB screening and diagnostic services (amongst others) to ex-mineworkers; (2) Assessment of disability among current and ex-mineworkers to inform the expansion of the Occupational Health and Safety package of services; (3) Development of regional databases to identify mineworker location, facilitate access to compensation for occupational lung diseases, and strengthen referral of mineworkers on TB treatment; and (4) Payment of ex-mineworkers for compensable occupational lung diseases including TB.

Key issues

Variations in provision of OH services: Countries vary in their provision of OH services capacity-wise and scope wise (i.e. list of diseases covered). Moreover, TB is not categorized as an occupational health risk/occupational disease - even though mining communities are the most affected compared to the general population – and therefore it remains poorly addressed.

Inadequate Coordination: Legislation for OH is fragmented across ministries and departments making both inter-agency coordination and enforcement of OH standards difficult.

Weak infrastructure and ineffectual surveillance system: Countries have yet to develop the infrastructure and human resource capacity to provide OH services. OH specialists in the Southern African region are few compared to need, specialized resources such as laboratories are lacking and logistical support system is weak. As a result, OH programs do not reach communities in peri-mining and labour-sending areas. In addition, tracking and tracing occupational diseases among current and ex-mineworkers is hampered by inadequate surveillance systems that produce unreliable surveillance data. Ex-mineworkers whose current location is unknown cannot access Benefit Medical Examinations and remain uncompensated.

Recommendations:

1. Review existing OH legislation to ensure occupational lung diseases are adequately covered;
2. Review the governance framework for inter-agency coordination;
3. Develop adequate institutional enforcement capacity and systems for compliance monitoring;
4. Develop a “minimum OH services package” as an initial investment. The minimum package integrating on-going TB and TB/HIV services could include prevention (surveillance, risk assessment, dust control, personal protective equipment, education and training and health promotion and wellbeing programs), medical screening, treatment, post-employment screening, rehabilitation and compensation.
5. Strengthen public and private sector capacity to implement the minimum OH package;
6. Develop and implement standardized protocols supporting provision of minimum OH package;

7. Integrate OH services into public health system for sustainability and to reach ex-mineworkers;
8. Develop a OH database for recording and reporting purposes;
9. Research into OH best practices to generate evidence and lessons learned;
10. Conduct advocacy, communication and social mobilization amongst current and ex-mineworkers to access to OH services.

2.1.6 Technical and information management

Two innovative information management tools were presented during this meeting to demonstrate how information technology can be used to enhance occupational and public health service delivery.

Geospatial mapping database: The geospatial mapping of mines, mineworkers and health facilities provides data to support targeting of health services and strengthening of health systems. It indicates the locations of mines, the density of mineworkers, communities around mines and those in labor-sending areas, hotspots and travel corridors for mineworkers. It also indicates locations of health facilities serving the mining areas and communities.

Regional Health Management Information System (RHMIS) and Cross Border Referral System (CBRS): The RHMIS collects and consolidates specific TB case data related to TB in the mining sector from countries and makes it available at regional-level for decision-making purposes including regional programming. The CBRS makes TB patient data available to clinicians to support effective patient referral from the mine to the labor-sending areas within and outside of the country. The purpose of this system is to strengthen the referral system, to reduce loss to follow up, improve continuity of care, and to increase treatment adherence and treatment completion.

Recommendations

- (i) Geospatial mapping:
 - This tool can be used for health planning purposes and implementation of OH and public health interventions – in particular :
 - Area prioritization for public health intervention e.g.mass screening and contact tracing
 - Diseases surveilllance and response incuding outbreaks investigation
 - Planning for outreach activities (mobile units)
 - Identification of specific sites for establishment of facilities
 - Targeting of customized services for MDR-TB patients amongst mineworkers, ex-mineworkers and peri-mining communities;
 - Tool to support community-level activities carried out by primary healthcare providers and community health workers
- (ii) RHMIS and CBRS – actions required to aid completion of the database development process:
 - Establish a data governance framework for data sharing and protection of confidentiality;
 - Roll out the HMIS in phases starting with countries that have TB data for mineworkers;
 - Establish a system to ensure data quality assurance, integrity and confidentiality;
 - Strengthen Technical and human capacities to use the information management tools;
 - Overcome technical challenges in integration or inter-operability of IT systems;
 - Strengthen data management and utilization capacity at regional and country-levels;
 - Standardize Health definitions and indicators driving data collection.

PART 2: MINING AND HEALTH OF PERI-MINING COMMUNITIES

The role of the private sector in fostering the socio-economic development of peri-mining communities and in addressing their public health needs was discussed extensively

Role of private sector in supporting health programs – Panel Discussion

Mining companies usually invest in public health programs through partnerships with government and as part of their Corporate Social Responsibility (CSR) mandate. For example, in some cases the mining company opens up its health facilities to the public while the Government supplies drugs and other commodities or supports capacity building for local health systems. Several examples of mining companies supporting health programs were explored including private sector contribution to The Global Fund HIV, TB and Malaria initiatives; Malaria programs in Ghana and Swaziland; private sector investment in public health in Zimbabwe and South Africa, amongst others. Evidently mining companies are not just confining their support to OH but are also addressing public health issues in their own way. Nonetheless notable gaps and operational challenges prevail in private sector-supported programs such as:

- Capacity limitations of the mining companies themselves;
- Insufficient attention to the financial sustainability of programs and handover to governments;
- Not allowing the community in the driver-seat affects community ownership and sustainability;
- The absence of an industry-wide approach for private sector investment in health of peri-mining communities: the silo-type mentality hampers knowledge-sharing and ultimately affects the effectiveness and sustainability of private-sector health investments.

The panelists suggested that mining companies should:

1. Develop trustworthy partnerships with communities and place them in the lead position;
2. Co-fund with governments and development partners to scale up of proven innovative interventions at national and regional levels;
3. Engage in program governance and implementation arrangements such as the expansion of occupational TB services to key affected populations, strengthening of cross-sector patient referral mechanisms as well as monitoring and evaluation systems;
4. Support regional efforts to improve TB health services and raise standards by ‘adopting’ health services with revised TB policies, standards and frameworks;
5. Disclose private sector investments in health to the local communities to enable them monitor services provision, improve accountability and become advocates of the mining companies;
6. Adopt an industry-wide approach to “investment in health”, co-design sustainable solutions with all relevant parties and share best practices.

Following the above-mentioned panel discussion, keynote presentations and breakaway groups focused on the various investment mechanisms and instruments used to channel private sector funds towards public health - such as Community Development Trusts and Agreements (CDT/A), Social Labor Plans (SLP) and Corporate Social Responsibility (CSR). During breakaway sessions, discussions centered on: key issues, operational challenges, requirements and solutions for implementation of each mechanism.

3.2.1 Community Development Trusts and Agreements – Breakaway Group No.1

Community Development Trusts and Agreements (CDT/A) are long-term mechanisms for engagement between mining companies and communities that aim at achieving sustainable results. CDT/A are based on partnerships between local communities and mining companies where local communities take leadership in: a) identifying programs addressing their needs; b) establishing vehicles through which mining companies support the programs; and c) identifying the program management and implementation arrangements involving the community. These mechanisms can be used for mining companies to address health needs of the local communities.

3.2.2 Social Labor Plans – Breakaway Group No.2

Social Labour Plans (SLPs) are anchored in South Africa Mining Charter and are used as a vehicle for mining companies to support the socio-economic development of local communities. Local authorities, with participation of local communities develop the Integrated Development Plans (IDPs) which reflect local needs including health. Mining companies derive SLPs from the IDPs by agreeing with local authorities on the IDP priorities they should support. On this basis, mining companies provide financial resources to support local socio-economic development programs. SLPs, therefore, constitute a legal instrument through which mining companies can invest in the public health of peri-mining communities.

3.2.3 Corporate Social Responsibility- Breakaway Group No.3

Corporate Social Responsibility (CSR) is the most common mechanism used by mining companies to support local communities. It is not a legal obligation and depends on the mining company’s willingness or duty of care. The mining company manages and implements programs on behalf of the community, provides financial resources for community-led initiatives and partners with the Government and other development partners to support health programs, among others, as necessary.

Table – Main issues and Cross-Cutting Recommendations for CDT/A, SLP and CSR as identified by breakaway groups

Mechanism	Key Issues	Cross-Cutting Recommendations
CDT/A	<ul style="list-style-type: none"> • CDT/A has a long ‘incubation period’ – it takes time to pull together resources, partners and actions; and to build trust throughout the process; • Requires early recognition and identification of different interests, capabilities, assets, and power inequalities within the community – addressing community representativeness is complex ; • Need to establish a transparent and functional channel for consultations, communication and negotiations – beyond the traditional or local 	<ul style="list-style-type: none"> • Ensure an enabling legislation is in place (e.g. CSR should be declared mandatory and linked to the approval of mining licenses); • Apply guidelines and policies for contracts and license; • Conduct a comprehensive ‘community needs assessment’; • Promote community ownership of the mechanism and its outputs; • Secure a common understanding amongst all stakeholders/parties to the agreement/plan/ intervention;

	<p>authorities – with the community at large;</p> <ul style="list-style-type: none"> • Need to incorporate accountability and sustainability measures into the agreement; • Need to align CDT/A with the country’s policy and regulatory framework; • Process hampered by the absence of benchmarks; • Insufficient attention to gender issues resulting in the under-representation of women. 	<ul style="list-style-type: none"> • Involve relevant multi-stakeholder in all phases and assign clear roles and responsibilities; • Ensure robust stakeholder engagement, participation and representativeness; • Ensure fair engagement of different social groups: women, youth and other minorities; • Set up functional coordination structures and ensure continuous feedback of the progress; • Establish a monitoring and evaluation plan early in the process;
SLP	<ul style="list-style-type: none"> • Weak community ownership - inadequate consultation on community priorities, limited community involvement in planning, implementation and monitoring (e.g. signing of SLP is strictly between company and local authority) • Absence of a structured engagement process; • Complexity of community representativeness; • Misalignment between SLPs and local authority development plans; • Bureaucratic and heavy application and implementation processes. 	<ul style="list-style-type: none"> • Build community capacity in areas of leadership and technical skills; • Establish Literacy programs and continuous capacity building; • Promote multiple modes of communication – e.g. radio and television; • Convene regular stakeholder fora to communicate on implementation progress; • Develop clear accountability and monitoring mechanisms (e.g. social labour forums for SLPs); • Establish independent and community-friendly grievance and redress mechanisms;
CSR	<ul style="list-style-type: none"> • Vagueness of legislation (regarding expectations from companies); • Program continuity– insufficient attention to sustainability; • Disputes on surface rights versus mineral rights; • Ineffective communication, involvement , coordination and representation of communities - resulting in inadequate buy-in and poor community ownership; • Absence of company disclosure on CSR funding; • Lack of involvement and collaboration with local health authorities; • Misalignment between CSR and local authority plans; • Assessment of community needs not compulsory; • Communities lack implementation and monitoring capacity; • Company and government roles and responsibilities ill-defined; • Absence of community-friendly and independent ‘grievance and redress’ mechanisms. 	<ul style="list-style-type: none"> • Ensure internalization of costs for the development of the mechanism; • Align community plans to local, provincial and national plans; • Integrate community health and mining health services; • Develop a clear operational plan including: establishment of office infrastructure, regular reporting mechanisms, institutionalization of activities and provision of required resources; • Integrate and communicate on sustainability development measures for continuity beyond the life of the mining operations; • Learn from best practice cases in other settings.

PART3: CONCLUSION- INVESTMENT STRATEGIES AND MODELS FOR OCCUPATIONAL AND PUBLIC HEALTH

3.1 Proposed strategies

The concluding sessions of the Smart Investments in Health meeting focused on the necessary strategies and models to be developed in order to best address the occupational and public health issues discussed. The strategies proposed are as follows:

1. **Use of country-mining visions to mobilize resources:** The Africa Mining Vision’s main agenda is human development. Within this context, countries are developing mining visions to enhance the contribution of mining to their economies. The proposed strategy consists in embedding occupational and public health needs of mineworkers and peri-mining communities into the country mining visions.
2. **Adopt a tripartite approach:** The proposed strategy consists in using existing tripartite structures (or setting them up as required) to effectively engage with governments, employers and employees; and to phase in communities. Donor partners should support the process throughout.
3. **Initiate national-level policy dialogue:** The proposed strategy consists in initiating national-level policy dialogue on Occupational Health Services - for mineworkers and peri-mining communities – with focus on:
 - Community ownership and Sustainability (i.e. placing the community at the heart of policy, program planning and implementation; and agreeing on sustainability measures);
 - Transparency and Accountability (e.g. reference to financial disclosure policy and establishment of accountability mechanisms for the benefit of the community);
 - Public Private Partnership (PPP) approaches using a combination of existing relevant financing and service provision models; and taking into account the respective roles, responsibilities, comparative advantages of Government, the Private Sector and Beneficiaries. Examples include: (i) accreditation of private parties to provide OH services open to all people in the catchment area; (ii) co-investments by mining companies and governments to improve access to OH by mineworkers and ex-mineworkers via public health systems strengthening.
4. **Mandatory Health Impact Assessment:** Environmental Impact Assessments (EIA) are habitually mandatory and systematic – this is not the case for Health Impact Assessments (HIA). The strategy consists in elevating HIA to the level of EIA and making it mandatory, systematic and binding.

3.2 Next steps

The next steps after the Smart Investment Meeting are as follows:

- (i) *Supporting selected recommendations through the Global Fund Funding Request 2018-2020:* Selected recommendations of the Smart Investments Meeting will be implemented through Global Fund support. The regional TB Initiative is developing a Funding Request to the Global

Fund for 2018-2020 period. Recommendations that address TB, TB/HIV and silicosis among mineworkers will inform the design of the Funding Request.

- (ii) *Using Smart Investment Meeting recommendations to inform World Bank regional project implementation:* Recommendations from the Smart Investment Meeting will inform the implementation strategies of the on-going World Bank regional TB initiative covering 4 countries.
- (iii) *Implementing Smart Investment Meeting recommendations through national TB programs:* The Smart Investment Meeting recommendations will be disseminated to countries through various fora to enable national programs to implement recommendations most relevant to their context. A key forum for disseminating these recommendations is the Project Implementation Committee (PIC) meeting which is a partnership forum that takes place annually. The second opportunity is the upcoming SADC Health Ministers' meeting in October 2017.