STOCKHOLM EVALUATION UNIT

MEDECINS SANS FRONTIERES LÄKARE UTAN GRÄNSER

EVALUATION OF

THE BASIC HEALTHCARE PROJECT FOR ARTISANAL AND SMALL-SCALE GOLD MINERS IN GWANDA, ZIMBABWE

December 2025

This publication was produced at the request of Médecins Sans Frontières (MSF) – Operational Centre Brussels (OCB) under the management of the Stockholm Evaluation Unit (SEU).

All evaluators contracted by the SEU adhere to the SEU Ethical Guidelines for Evaluations.

It was prepared independently by HWÉFA Consulting

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ACRONYMS

ASM	Artisanal and Small-Scale Gold Miners
CBO	Community Based Organization
CeSSHAR	Centre for Sexual Health and HIV AIDS Research Zimbabwe
CG	Consultation Group
DHIS2	District Health Information System
DSD	Differentiated Service Delivery
EH	Environmental Health
EPI	Expanded Programme on Immunization
EPREP	Emergency Preparedness and Response
EQ	Evaluation Question
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IMNCI	Integrated Management of Neonatal and Childhood Illness
KII	Key Informant Interview
LM	Logic Model
MH	Mental Health
MOU	Memorandum of Understanding
MoHCC	Ministry of Health and Child Care
MSC	Most Significant Change
MSF	Médecins Sans Frontières
NCD	Non communicable disease
OCB	Operational Centre Brussels
OECD	Organization for Economic Co-operation and Development
STI	Sexually Transmitted Infection
SEU	Stockholm Evaluation Unit
SGD	Small Group Discussions
SRH	Sexual Reproductive Health
TB	Tuberculosis
ToR	Terms of Reference

EXECUTIVE SUMMARY

This formative evaluation assessed Médecins Sans Frontières–Operational Centre Brussels (MSF OCB)'s *Basic Healthcare Project for Artisanal and Small-Scale Gold Miners (ASM)* in Gwanda, Zimbabwe. Commissioned by the Stockholm Evaluation Unit (SEU), the evaluation examined the project's relevance, effectiveness, efficiency, and sustainability midway through its three-year implementation (December 2023–2026). It aimed to generate practical learning to inform adaptation and transition planning for the remainder of the project cycle.

PROJECT OVERVIEW

The Gwanda project seeks to reduce morbidity and mortality among artisanal miners, sex workers, and surrounding host communities by expanding access to integrated basic healthcare through mobile clinics, outreach, and health promotion. The intervention addresses a broad burden of disease, including HIV, TB, STIs, NCDs, SRH, silicosis, and mental health, while tackling environmental and occupational risks through water, sanitation, and hygiene initiatives and advocacy for safer mining practices. It also serves as a learning and innovation model within MSF's broader public health programming.

METHODOLOGY

The evaluation used a mixed-methods, participatory approach combining document review, analysis of routine medical data, key informant interviews, small group discussions, clinic observations, and participatory tools such as the Most Significant Change and "battery" methods. Fieldwork covered four outreach sites and included 221 participants representing service users, non-users, MSF and Ministry of Health staff, community-based organizations, peer educators, technical specialists, and traditional leaders. Data were analysed thematically using the OECD/DAC evaluation criteria.

Limitations included the absence of baseline data and targets, lack of unique patient identifiers, and incomplete integration of monitoring systems, which restricted quantitative assessment of progress and continuity of care.

KEY FINDINGS

Relevance

The project design is well aligned with the needs of miners and host communities. The mobile clinic and differentiated service delivery model effectively overcomes barriers of distance, cost, and stigma, providing essential care where static services are inaccessible. Health promotion activities are locally resonant and accessible through vernacular communication. However, sex workers and remote miners remain underserved, and mental health integration is still limited.

Effectiveness

The project has achieved notable improvements in access and service utilization, with a 55–60% increase in health services delivered across 39 sites. Quantitative analysis showed significant gains in PrEP uptake, syphilis testing, and new STI clients. Beneficiaries reported improved knowledge and behaviour change related to HIV prevention, family planning, and occupational health. However, continuity of care for chronic conditions is weak due to long outreach intervals and absence of patient tracking. Advocacy and operational research are promising but remain nascent, with limited evidence of policy influence so far.

Efficiency

Human resource shortages, long travel times for some locations (see Annex 3 for distance and travel times), and inefficient communication about clinic schedules (in some sites where peer educators are not present) which reduce patient attendance. Stockouts, logistical delays, and safety risks at mining sites occasionally interrupt service delivery. Nonetheless, MSF's adaptability, staff training, and investment in mobile technology (e.g., portable X-ray) have enhanced efficiency and reduced unnecessary referrals.

Sustainability

Sustainability efforts have focused on community ownership rather than institutional handover. The peer educator and health promotion models show strong potential for continuity beyond MSF, but they require structured incentives and support. Physical infrastructure (e.g., incinerators, waste zones) will likely endure, while the full mobile clinic model is financially unsustainable without external funding. Integration with the Ministry of Health and Child Care (MoHCC) remains symbolic, constrained by resource shortages and limited capacity for uptake.

CONCLUSIONS

The Gwanda project is a relevant and adaptive model that has expanded healthcare access and improved health literacy among marginalized populations. Its participatory, context-sensitive approach and flexibility are strong assets. However, systemic weaknesses in data systems, follow-up mechanisms, and transition planning limit the project's efficiency and sustainability. Continued learning and advocacy could position Gwanda as a valuable reference model for MSF's work with mobile and informal labour populations in stable but underserved settings.

KEY RECOMMENDATIONS

1. Formalize and resource the peer educator model with clear roles, incentives, and supervision.
2. Prioritize a knowledge and evidence-driven handover to the Ministry of Health and Child Care rather than transferring activities not yet ready for absorption.
3. Expand partnerships with traditional leaders, mining associations, and CBOs to diversify support and co-funding.
4. Address the lingering stigma associated with mobile clinics from earlier NGO programs that hosted local clinics for HIV care.

5. Consolidate advocacy and research outputs into practical, shareable tools for policy engagement.
6. Pilot and optimize delivery models to prepare for a realistic transition.

INTRODUCTION

This final report presents the findings of the formative evaluation of the Basic Healthcare Project for Artisanal and Small-Scale Gold Miners (ASM) in Gwanda, Zimbabwe (hereafter referred to as the GWANDA project), implemented by Médecins Sans Frontières–Operational Centre Brussels (MSF OCB). The evaluation, managed by the Stockholm Evaluation Unit (SEU), assessed the relevance, effectiveness, efficiency, and sustainability of the project.

It reflects the evaluation team's analysis of the project, drawing on stakeholder consultations, a review of relevant documentation, and analysis of contextual and operational dynamics. The report synthesizes evidence gathered through data collection and engagement activities, presents conclusions in relation to the evaluation questions, and offers practical recommendations to inform future programming.

PROJECT BACKGROUND

The GWANDA project is a three-year initiative launched in December 2023 to address persistent gaps in healthcare access for artisanal and small-scale gold mining (ASM) communities, associated sex workers, and surrounding host populations. These groups face significant yet often overlooked health risks, including Human Immunodeficiency Virus (HIV), tuberculosis (TB), silicosis, and other occupational and environmental health issues. Their vulnerability is compounded by high mobility, limited access to formal healthcare, economic insecurity, and social stigmatization.

In response, Médecins Sans Frontières–Operational Centre Brussels (MSF OCB) is implementing a multi-component basic healthcare intervention that combines mobile clinics, community outreach, and health promotion to expand access.

PROJECT CONCEPTUALIZATION

According to the consultation group[1] (CG), the GWANDA project represents an intentional shift by MSF to extend healthcare to ASM and surrounding communities in a relatively stable setting, contrasting with its typical emergency-driven programming. Internally described as a "choice" project, it is designed both as a service delivery model and as a platform for learning, innovation, and advocacy.

According to our understanding of the project, the primary objective of the project is to contribute to the reduction of the morbidity and mortality of ASM and host communities. To do this, the project is structured around seven expected results that seek to address a complex and overlapping burden of

[1] A consultation group is a group of stakeholders selected by the SEU and project implementation team members to work with the evaluation team and guide the evaluation.

disease, particularly TB, HIV, Sexual Reproductive Health (SRH), sexually transmitted infections (STIs), immunization, childhood nutrition and illness[2], non-communicable disease (NCDs), mental health (MH), and silicosis, while also tackling broader determinants of health such as stigma, environmental hazards, and legal precarity. Key innovations include AI-supported portable x-ray technology and targeted operational research (e.g., water contamination studies). Community outreach and advocacy are central to ensuring relevance and building the public health case for government adoption of successful elements.

However, the project's conceptualization is not uniform across stakeholders. Some CG members frame it primarily as a public health intervention, others as a learning and advocacy pilot, and some as a humanitarian response adapted to hard-to-reach populations. These differing perspectives reflect both the project's multidimensional nature and ongoing internal discussions about its strategic focus and long-term vision.

PROJECT EXPECTED RESULTS

The project is organized around seven expected results:

1. Differentiated Service Delivery models of care providing an integrated package of basic healthcare (HIV, TB, STIs, NCDs, MH, SRH, Expanded Programme on Immunization (EPI), and Integrated Management of Neonatal and Childhood Illness (IMNCI)) are available for the target population.
2. Occupational health services (TB, silicosis, and heavy metal and chemical related illnesses screening, treatment and referral) are available for the target population.
3. The target population is directly or indirectly identified, evaluated, mobilized, informed and trained on knowledge about attitudes and practices to be applied in terms of self-care and access to care.
4. The target population has access to clean water, hygiene and sanitation facilities and poor Environmental Health (EH) conditions and practices including intoxication linked to the use of heavy metals are addressed through rollout of innovative EH interventions.
5. Advocate and communicate for improved access to health services and safer and healthier mining practices for artisanal and small-scale miners and host communities
6. MSF EPREP Monitoring & Response is available for communities in Matabeleland South Province.

[2]Child nutrition was included in the logframe because of national concerns about malnutrition after two decades of drought. Once implementation began, however, the program encountered very few cases of malnutrition, therefore, this was no longer a priority need.

7. The project activities are regularly monitored and evaluated, and improvement and reinforcement measures are taken to support the project and the partners in providing quality medical care to the target population.

The project is deploying a differentiated service delivery (DSD) model to adapt health services to the specific needs of ASM and nearby communities. DSD is a person-centred approach that shifts away from one-size-fits-all models by tailoring care to the realities of different population groups, while also making better use of health system resources. In the Gwanda context, DSD is understood as a flexible model that prioritizes accessibility, integration, and self-care. It moves beyond static, facility-based care to meet people where they are. This is operationalized through mobile and decentralized clinics that deliver essential services (such as STI screening and services, TB and silicosis screening, HIV testing, SRH services, and mental health care) directly at mining sites. The model is designed in response to the specific barriers ASM face, including mobility, isolation, and stigma. It promotes peer support and reduces reliance on distant health facilities. Ultimately, the DSD approach in this context supports MSF's broader goal of strengthening patient autonomy and promoting sustainable, community-driven health outcomes.

PROJECT IMPLEMENTATION TO DATE

The GWANDA project is implementing a phased, context-adapted response across seven interconnected expected results. While some components have been operational since the start of implementation, others remain in early stages or are awaiting full rollout due to staffing, logistical, or regulatory constraints. The following section summarizes progress and key details for each of the seven result areas described above.

EXPECTED RESULT 1: BASIC HEALTH SERVICES (DSD MODEL)

Two MSF outreach teams currently serve 32 active and 4 seasonal sites, operating three weeks per month with one week reserved for reporting[3]. Services provided include integrated basic healthcare using a DSD model. This includes HIV testing and linkage to antiretroviral therapy, STI screening and treatment, and general primary care. Additional components such as mental health, SRH, and non-communicable disease (NCDs) are integrated into the basic healthcare package. A Mental Health Supervisor was recently hired, and with the support of a visiting Mental Health Activity Manager, a draft mental health strategy has been submitted for internal review. Sex workers are not currently targeted through tailored interventions, given the difficulty of being about to target them and the stigma associated with this work preventing individuals from self-identifying, especially considering the reduction of the Centre for Sexual Health and HIV/AIDS

[3] The MSF team was only able to operate three weeks per month due to constraints imposed by the MOH, which did not allow their staff to be in the field for 4 weeks, and not allowing MSF to operate without their staff.

Research's (CeSHHAR)[4]'s local activities. However, discussions are underway to develop appropriate indicators and tracking mechanisms and potentially collaborating with local CBOs that work with sex workers. Night-time outreach was piloted but discontinued due to high cost and minimal additional reach.

EXPECTED RESULT 2: OCCUPATIONAL HEALTH SERVICES (TB, SILICOSIS, HEAVY METALS)

TB and silicosis are key foci of occupational health interventions. With the exit of TB partner Baines due to grant closure, MSF has procured a mobile x-ray unit to strengthen in-house screening capacity. As of July 2025, the x-ray unit screening for TB and silicosis has been registered with the Ministry of Health and x-ray screening has begun. Due to the high cost of blood sample testing, MSF is targeting screening of water sources for drinking water quality (including heavy metal contamination) as part of its broader occupational health strategy.

EXPECTED RESULT 3: HEALTH PROMOTION AND COMMUNITY ENGAGEMENT

Seventeen peer educators have been identified and received training on the Friendship Bench model for mental health and other health promotion topics. This peer-to-peer model will be piloted before being scaled up to additional sites. Health promotion sessions are conducted at outreach sites while clients wait for clinical services, though participation can be limited by the mobility of ASM and sometimes by alcohol use at sites. Focus group discussions have been challenging in ASM contexts due to the low numbers and brief presence of miners but are more feasible among host communities. Three dedicated Health Promotion Officers are involved in implementation.

EXPECTED RESULT 4: EH AND WASH

EH interventions are integrated into all outreach activities. Core EH services include daily waste collection and incineration, provision of safe water, water quality testing, and IPC materials. A new incinerator built at Phakama clinic now serves the entire district. Future improvements at the clinic include construction of waste management infrastructure (ash pit, sharps pit, organic pit) and installation of a bottle crusher. Collaboration with MOHCC facilities has been slower due to bureaucratic delays in donation approvals, however construction of 4 other waste zones is planned. In addition to these activities, MSF is conducting an operational research project on drinking water quality testing to examine water contamination due to mining activities. Follow-up measures (depending on findings) may include borehole drilling, well decontamination, and water trucking if needed.

[4] The Centre for Sexual Health and HIV/AIDS Research is a research organization in Zimbabwe that works with sex workers on HIV prevention and care. As a result of international funding cuts, CeSHHAR has significantly cut its activities in Gwanda.

EXPECTED RESULT 5: ADVOCACY AND COMMUNICATIONS

Implementation under this result is still in early stages. A national communications framework is nearing completion and will inform both internal and external advocacy strategies. The Project Operations Responsible is currently leading efforts in this area, including the finalization of the advocacy strategy by the advocacy team. There is recognition that advocacy has lagged behind other result areas and will require dedicated focus in the next implementation phase.

EXPECTED RESULT 6: EMERGENCY PREPAREDNESS AND RESPONSE (EPREP)

The project has fully stocked EPREP supplies on-site, ready to respond to cholera outbreaks, mass casualty events, and vaccine-preventable diseases. Preparedness includes a 20-bed Cholera Treatment Unit, multiple community water points and latrines, Oral Rehydration Points, and trauma kits. The team is also equipped to provide logistical support (e.g., vehicle access) and health promotion during emergencies.

EXPECTED RESULT 7: MONITORING, EVALUATION, AND LEARNING (MEAL)

Routine medical monitoring is ongoing, coordinated by the medical team. However, challenges in data quality, completeness, and alignment across systems (DHIS2, MOHCC registers, and Activity Info) persist. The team has started developing disaggregated tracking and improving internal systems, but several gaps remain, especially in registration-based tracking for chronic conditions and repeat visits. External evaluation, including this consultancy, is seen as an opportunity to strengthen learning and inform future strategy.

EVALUATION PURPOSE, SCOPE, CRITERIA

PURPOSE

This formative evaluation assessed the appropriateness, effectiveness, efficiency, and sustainability of the GWANDA project model in its current state of implementation. Conducted at the halfway mark of the project's three-year duration, it examined how well the intervention was meeting the needs of its target populations and identified areas for adaptation ahead of the strategic planning phase (scheduled between July and October 2025). The evaluation aimed to inform real-time improvements, support MSF's internal learning, and guide transition planning by identifying gaps, highlighting opportunities for adaptation, and offering practical recommendations to strengthen the design and delivery of services for the remainder of the project timeline.

SCOPE

The evaluation focused primarily on activities carried out between the project's launch in December 2023 and July 2025, while also considering activities planned for the remainder of the project duration. Although centred on the GWANDA project, the evaluation also generated insights relevant to MSF's broader health programming with mobile and informal labour populations in comparable settings.

EVALUAND AND INTENDED USERS

The primary evaluand is the GWANDA project model as a whole, with particular attention to how it delivers differentiated service components tailored to the needs of ASM and surrounding host communities. While the evaluation considers individual activities and operational performance, its core focus is on how effectively the model functions in practice, assessing its relevance, effectiveness, efficiency, and sustainability.

The intended users of this evaluation are the Gwanda project team, the Zimbabwe country team, MSF Southern Africa Medical Unit, and relevant departments at MSF headquarters that are supporting or exploring the broader application of this model. Findings may also be of interest to external stakeholders, including national health authorities and community-based partners, particularly in discussions on sustainability and handover.

The evaluation is framed around the OECD/DAC evaluation criteria to ensure rigor, relevance, and alignment with international best practices. This approach provides evidence-based insights to support MSF's efforts to strengthen health service delivery for vulnerable populations.

EVALUATION CRITERIA

The evaluation framework, data collection instruments and analysis process were structured around the OECD Development Assistance Criteria[5]. These criteria are defined below:

OECD/DAC Criteria	Definition
Relevance/ Appropriateness	The extent to which the intervention objectives and design respond to beneficiaries, global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.
Effectiveness	The extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups.
Efficiency	The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way.
Sustainability	The extent to which the net benefits of the intervention continue, or are likely to continue.

Table 1: OECD/DAC Criteria

[5] More information can be found at www.OECD.org

EVALUATION QUESTIONS

The table below outlines the key evaluation questions that guided this assessment, aligned with the OECD/DAC evaluation criteria.

OECD/DAC Criteria	Evaluation Questions
Relevance/ Appropriateness	1. To what extent is the project design and delivery model appropriate to the needs of the target populations and local context? • Are project activities well aligned with the socio-cultural, economic, and political realities of the affected communities? • How appropriate are the project's operational research and advocacy components in advancing its health-related goals? • What changes to the healthcare service delivery model could enhance its relevance and responsiveness to community needs?
Effectiveness	2. To what extent is the project on track to achieve its intended objectives? • How effectively are project activities contributing to the project's overall outcomes? • What opportunities exist for the project to influence occupational health policy for artisanal miners and associated groups?
Efficiency	3. How efficiently are healthcare services being delivered under the current healthcare service delivery model? • What inefficiencies, if any, are evident in the current healthcare service delivery model? • What opportunities exist to improve efficiency in the healthcare service delivery approach?
Sustainability	4. To what extent are the project's outcomes and service delivery mechanisms likely to be sustained after MSF's exit? • How are sustainability considerations integrated into current project activities, and what challenges or barriers affect this integration? • How have key stakeholders been engaged in the project to date, and what forms of collaboration have emerged? • What adaptations could strengthen the continuity of health services beyond MSF's direct support?

Table 2: Evaluation Questions and OECD/DAC Criteria

EVALUATION METHODOLOGY

METHODS

This formative evaluation used a mixed-methods approach to examine the relevance, effectiveness, efficiency, and sustainability of the GWANDA project. The methodology integrated document review, qualitative and participatory data collection methods6, and descriptive analysis of routine and operational data. It was grounded in MSF's commitment to continuous learning and ethical, context-sensitive engagement with communities. Data collection activities were designed to align with each evaluation question and were carried out using purposive sampling to ensure representation across key groups, including ASM, health workers, community-based organizations (CBOs), other health facilities in Gwanda, and local leaders. Methods included:

DOCUMENT REVIEW

The ET conducted a targeted review of key external and internal project documents to inform the evaluation framework, including project proposals, logframes, medical reports, operational research outputs, monitoring data, and relevant national policies. This provided essential context on project design, implementation status, intended outcomes, and data availability. Documents were collected during the Inception Phase into a password-protected library, with additional materials (such as partner reports and external publications) added throughout the evaluation based on stakeholder recommendations and targeted searches.

Using a document review matrix, the team systematically recorded and analysed each source, capturing key details, summarizing findings, identifying challenges and gaps, linking content to OECD-DAC criteria, and noting follow-up questions to guide primary data collection. The main documents reviewed included project design materials, MSF internal reports, technical and environmental assessments, community outreach resources, and relevant government and sectoral publications. This structured approach ensured comprehensive coverage of available documentation, supported triangulation with field data, and provided a strong evidence base for assessing appropriateness, effectiveness, efficiency, and sustainability.

[6] The evaluation integrates participatory principles across multiple methods. SGDs, KIIs, and health promotion debriefs are explicitly participatory, using storytelling and open-ended, activity-based prompts to surface participants' own interpretations of change, value, and barriers. These methods prioritize local voices and center lived experience as evidence. Participation is further supported through purposive sampling strategies that amplify underrepresented groups, including ASM (by gender and age), sex workers, and community-based actors. Additionally, informal feedback loops during data collection (e.g. Learning Board) helps ensure that reflections inform both data collection and analysis. The overall approach aims to create space for meaningful engagement, not just data extraction.

ROUTINE AND OPERATIONAL MEDICAL DATA REVIEW

Existing quantitative service delivery and medical data was analysed to measure the target-output compliance. Data were drawn from multiple sources, including MSF Daily utilization records (3,176 encounters), comparative facility data (42 Facility records), MSF beneficiary feedback (111 records), and the 2025 Client Satisfaction Survey (192 respondents). This ensured that the analysis was both comprehensive and representative of the program's reach.

KEY INFORMANT INTERVIEWS - PARTICIPATORY METHOD

Semi-structured interviews were used to collect primary data at multiple levels. At the national and district levels, interviews were conducted with representatives from the government (e.g. MoHCC, rural district committee), along with interviews with other key stakeholders, such as MSF teams, CBOs, peer educators, service users, non-service users,7 and mining associations. These interviews provided contextual depth on the enabling environment, implementation realities, and opportunities to strengthen care quality. A purposive sample of all stakeholder types were contacted, and representatives were invited to participate in one-hour interviews. Interview protocols, linked to the evaluation questions, were tailored to each stakeholder type to ensure relevance. KIIs with national and district stakeholders were conducted both in person and remotely, depending on availability and location. Community-level KIIs were conducted in person in Gwanda District.

SMALL GROUP DISCUSSIONS (SGD) - PARTICIPATORY METHOD

Age and sex-disaggregated SGDs were held with service users and non-service users. With the former group, participants were invited to share stories that reflect the most meaningful changes they have experienced as a result of the GWANDA project. With the latter group, participants were invited to share stories of challenges in accessing MSF services. These discussions helped define the "why" and "how" behind observed results, particularly in relation to perceived value, barriers, and unintended effects.

CLINIC AND OUTREACH OBSERVATIONS

Structured observations were conducted at MSF mobile clinics and outreach activities to assess healthcare service delivery. The evaluation team focused on five key domains: patient flow, communication, privacy, referral processes, and responsiveness to the specific needs of mobile and marginalized populations. These key domains were chosen in consultation with the CG. This method allowed for direct assessment of the quality, inclusivity, and accessibility of services.

[7] Community participants are categorized as "service users" and "non-service users," rather than by fixed identity groupings (e.g., ASM, sex workers). See Section 3.4 for rationale.

HEALTH PROMOTION DEBRIEFS

Informal, semi-structured, debriefs were held with service users following their attendance of a health promotion session. These short discussions were set up to capture real-time feedback on the clarity, relevance, and resonance of messaging, as well as any suggestions for improving community outreach.

Sites[8]	Number of KIIs	Number of SGDs	Debriefs	Observations	Total
Geelong	25	5 (16 individuals)	4	6	**51**
Zindere	22	2 (5 individuals)	4	6	**37**
Bena Mina	26	4 (14 individuals)	5	6	**51**
Five Mine	24	4 (12 individuals)	4	5	**45**
Gwanda	23	N/A	N/A	N/A	**23**
Virtual	15	N/A	N/A	N/A	**14**
Total					**221 (95 female; 126 male)**

Table 3: Evaluation Sample

[8] These sites were chosen by the implementation team. The criteria for choosing the sites included high-volume locations, so that the evaluation team could speak to a diversity of people.

DATA ANALYSIS

The qualitative data analysis followed a structured, team-based approach aligned with the evaluation matrix and OECD/DAC criteria. This approach ensured analysis across stakeholder groups while allowing space for emergent findings and reflective insights.

FRAMEWORK-BASED THEMATIC ANALYSIS

Qualitative data (including interviews, SGDs, observation notes, and participatory tools) were analysed using a coding framework structured around the four evaluation questions and corresponding judgement criteria from the evaluation matrix (Annex 1). Each excerpt of data was reviewed and tagged according to:

- **Evaluation Question**
- **Evaluation Matrix Indicator Criteria** (e.g., contextual fit, policy engagement, inputs vs outputs)
- **Stakeholder Group**
- **Emergent Theme or Sub-theme** (e.g., outreach timing, stigma, collaboration)
- **Type of Evidence**, using four categories:
    - Confirming evidence (supports what's working)
    - Divergent or disconfirming views (shows gaps or alternative perspectives)
    - Illustrative quotes or stories (compelling examples of change or experience)
    - Suggested adaptations or actions (recommendations from participants)

A collaborative coding process was used, relying on shared spreadsheets instead of software tools. Team members extracted quotes and summaries from transcripts and notes into a common coding matrix, assigning the relevant evaluation question and judgement criteria to each row. This approach allowed the team to systematically surface patterns across data sources and stakeholder types, while maintaining consistency in interpretation and tagging.

Team debriefs and synthesis sessions were held regularly during and after data collection to compare interpretations, validate patterns, and surface cross-cutting insights. These discussions informed the structure of the final findings and ensured that voices from structurally excluded groups were not lost in the aggregation process.

DESCRIPTIVE ANALYSIS OF ROUTINE DATA

A difference-in-difference analysis was used to comparing trends at intervention versus control sites before and after the intervention. The treatment sites are those health facilities which MSF provided the outreach services to and the control sites are health facilities which MSF did not provide the outreach

services to. It should be noted that MSF worked with the health facilities that are nearest to the ASM mining sites, and the patients were referred to those health facilities for routine care and follow-up services after they were seen at the outreach sites. The 22 indicators9 used in the quantitative analysis are listed in the footnote and their full description can be found in Annex 2, 4, and 5. The MoHCC and MSF co-facilitated and jointly selected these indicators based on their understanding that these indicators demonstrated the strongest programmatic impact. This statistical approach allowed for attribution of observed changes to the program, with 77% of indicators showing significant positive effects. Complementing this, descriptive statistical analysis was used to track service volumes, demographic reach, and trends in utilization, while forecasting techniques (Prophet model) projected short-term service trajectories to flag areas requiring immediate attention, such as the decline in TB screening (see Annex 4 and 5 for fuller description).

PARTICIPATORY TOOLS SYNTHESIS

Participatory methods such as MSC and the "battery tool" were analysed thematically. MSC stories were clustered by types of change (e.g., health outcomes, trust, knowledge, service access), while battery responses supported interpretation of perceived progress or gaps in service relevance and delivery.

LEARNING ROADMAP BOARD

To support real-time reflection and collaborative analysis with the CG, the evaluation team established a Learning Roadmap board in Miro. This tool served as a live space to capture and organize emerging

[9] HIV - Self-test kits distributed (Secondary distribution, excluding for partners) COMMUNITY
HIV - Self-test kits distributed (Secondary distribution, for partner) COMMUNITY
HIV - Self-test kits distributed (excluding for partners, Secondary distribution)
HIV - Self-test kits distributed (for partner, Secondary distribution)
HIV - Self-test kits distributed (Primary Distribution) COMMUNITY
HIV - Results shared COMMUNITY
HIV - Self-test kits distributed (Primary Distribution)
HIV - Clients with reactive results
HIV - Clients with reactive results COMMUNITY
HIV - Total reactive tests confirmed HIV positive
HIV - Total reactive tests confirmed HIV positive COMMUNITY
HIV - PLHIV in care on ART who had a sample collected for Viral Load testing
HIV - PLHIV in care on ART who had high second Viral Load test results >1,000 copies/ml
HIV - PLHIV in care on ART who received Viral Load test results
HIV - PLHIV in care on ART who received Viral Load test results >1,000 copies/ml
HIV - New STI clients
HIV - Repeat STI clients
HIV - STI clients who were tested for Syphilis
HIV - STI clients who tested positive for Syphilis
HIV - STI clients who were treated for Syphilis
HIV - HIV-positive women on ART screened for cervical cancer
HIV - PrEP indicators (screened, eligible, received, newly enrolled)

insights throughout data collection and synthesis. Structured around reflective prompts, the board enabled the evaluation team and CG to:

- Identify patterns or tensions early
- Document CG feedback on emerging findings
- Surface blind spots, surprises, and missing perspectives
- Guide internal reflection and validation discussions

The Learning Board was updated iteratively and was used to support real-time sensemaking, identify areas for deeper inquiry, and prepare for validation sessions. It helped ensure the analysis process was adaptive, inclusive, and grounded in collective interpretation rather than static coding alone.

TRIANGULATION AND SYNTHESIS

Findings were triangulated across data sources (interviews, SGDs, observations, service data, and participatory tools) and stakeholder perspectives (community, implementer, system). The evaluation team documented areas of convergence and divergence and used validation sessions and Learning Board reviews to test and refine interpretations. This process informed both the structure and content of findings and recommendations.

SAMPLING STRATEGY

The sampling strategy for this formative evaluation was designed to ensure representation across key stakeholder groups within the limited data collection period. It drew from the stakeholder mapping conducted during the inception phase and reflected the evaluation's focus on the Gwanda project model, with attention to differentiated service delivery, access, effectiveness, and sustainability across ASM, sex workers, host communities, health workers, implementing staff, and relevant system actors.

APPROACH

Our approach was grounded in purposive sampling, aimed at generating depth and diversity of insight rather than statistical representation. Participants were selected based on their relationship to the project: whether direct (e.g., service users, MSF staff) or indirect (e.g., community members not currently accessing services, government officials). Sampling was also guided by practical considerations such as mobility, accessibility, safety, and language. Sampling remained flexible during fieldwork to allow for iterative adjustments based on emerging insights and feasibility constraints.

The team intentionally considered diversity and power dynamics in the selection process to ensure that voices across gender, age, and occupational hierarchies were represented. This included balancing

perspectives from women and men in artisanal mining communities, ensuring inclusion of women and youth, and capturing the views of frontline health workers alongside decision-makers.

To support equitable participation, data collection methods were adapted for varying literacy levels and comfort with formal interviews. For example, participatory tools such as the "battery method" using images and visual scales were applied to help illiterate participants express their perceptions of service quality, satisfaction, and trust. These methods created space for participants with lower literacy or institutional power to contribute meaningfully. Sampling was also guided by practical considerations such as mobility, accessibility, safety, and language, and remained flexible during fieldwork to allow for iterative adjustments based on emerging insights and feasibility constraints.

"SERVICE USERS" VS "NON-SERVICE USERS"

Rather than categorizing community participants strictly by occupation (e.g., ASM, sex workers, host community), this evaluation used "service users" and "non-service users" as the primary sampling categories, with participant occupation/role being a secondary category of identification. This reflected both ethical and analytical considerations:

- Engagement status is more observable than identity: Many participants do not explicitly identify by occupation, and some groups (e.g. sex workers) may be under-disclosed due to stigma or limited targeting by the project.
- Focus on access and inclusion: Organizing by service enables the evaluation to explore who is being reached, who is not, and why, without making assumptions or requiring disclosure of sensitive information.

Demographic and contextual characteristics (e.g., age, gender, livelihood) were still captured during data collection to support analysis of equity and differentiated outcomes.

SAMPLE OVERVIEW

The table below outlines the stakeholder groups, sample size, and rationale for inclusion.

Table 4: Sampling Overview

Stakeholder Group	Method	Purpose	Estimated	Actual
Service Users (people who have accessed MSF services)	In-person interviews, SGDs, health promotion debriefs, sensemaking	Understand experiences with service access, delivery, and impact	30 - 40	127
Non-Service Users (people living in project areas who have not accessed services)	In-person participatory interviews, SGDs	Identify awareness gaps, access barriers, and perceptions of exclusion	8–12	52
MSF Health Workers (nurses, CHWs, health promoters)	In-person Interviews, observation, participatory validation sessions	Assess quality, efficiency, challenges, and responsiveness in service delivery	6–8 staff	6
CBOs and Peer Educators	In-person and remote interviews	Explore collaboration/sustainability roles	3–5	12
Traditional Leaders / Mining Association Reps	In-person interviews	Understand support for the model, and community dynamics	4–6 individuals	7
MoHCC Officials (District and Provincial levels)	In-person and remote Interviews, participatory validation session, learning brief engagement and dissemination	Examine alignment with government health systems and transition planning	3 - 5 officials	8
MSF Coordination and Project Staff	Remote and in-person interviews, validation sessions, sensemaking through the ongoing Learning Board	Explore model design, rationale, learning, and adaptation	4-6 staff	5
SAMU / Regional / Thematic Advisors	Remote interviews, validation sessions, sensemaking through Learning Board	Capture broader technical learning and links to organizational strategy	2-4 staff	4
Total				221

ETHICAL CONSIDERATIONS

The evaluation team was committed to ethical, inclusive, and context-sensitive engagement with all stakeholders, in line with SEU's Ethical Guidelines. The team remained attentive to the rights and safety of all participants, particularly given the sensitivity of identities (e.g., sex workers, undocumented miners) and the inequitable power dynamics present in the project context. The following measures were put in place to mitigate risks and uphold participant safety, dignity, and agency:

- **Access to Target Groups:** Engagement with target groups was facilitated through trusted entry points, including MSF outreach staff and community health workers already known to the community. These intermediaries supported introductions, provided initial information about the evaluation, and helped ensure that participation was voluntary and based on informed understanding. All data collection took place in locations and formats that respected participants' preferences for safety, anonymity, and comfort.

- **Involvement of Minors:** The evaluation did not involve minors. Preliminary fieldwork and MSF monitoring data confirmed that adolescents under 18 were not a primary or visible group among those accessing project services. If a minor was incidentally present during outreach or observed activities, they were not invited to participate in any data collection, in line with both ethical and safeguarding protocols.

- **Informed Consent:** Verbal informed consent was obtained prior to all interviews and SGDs. Participants were clearly informed about the purpose of the evaluation, how their information would be used, and their right to withdraw at any time.

- **Confidentiality and Data Management:** All participant data were anonymized at the point of transcription or summary. No identifying information was retained or published. Audio recordings were stored securely and deleted after transcription. Notes and transcripts were stored on encrypted, access-controlled folders available only to the evaluation team. All data were handled in accordance with SEU's data protection protocols and national data privacy regulations.

- **Trauma-Informed and Respectful Facilitation:** All members of the data collection team received training in trauma-aware, inclusive facilitation approaches led by the team leader. Interview guides were designed using accessible language and adapted for use with structurally excluded groups, including sex workers and mobile ASM.

- **Language Accessibility:** Tools and guides were translated into Ndebele and Shona as needed to ensure clarity and comfort during data collection.

- **Power Dynamics and Inclusion:** The evaluation prioritized engagement with structurally excluded groups, including sex workers and mobile ASM. Interview guides were tailored with accessible language, and national-based data collectors were trained in respectful, trauma-aware facilitation.

- **Inclusive Sampling:** Purposive sampling was used to ensure fair representation across stakeholder types, with a particular focus on reaching less visible or historically excluded groups.
- **Do No Harm:** Project visit activities were scheduled to avoid disruption of essential services or participant fatigue. Safety considerations related to mining environments guided site selection and timing.
- **Transparency and Reciprocity:** Preliminary findings were shared with participants through informal small-group validation sessions to ensure their voices were reflected accurately and to support reciprocal learning. These sessions were not a review of individual interviews but a space for participants to reflect on early interpretations, offer corrections, and contribute to shared meaning-making.

LIMITATIONS

This formative evaluation was conducted under several limitations that should be considered when interpreting the findings.

Data and Monitoring Gaps: The project's monitoring and evaluation framework did not include targets or baseline data, which limited the evaluation team's ability to assess progress against intended outcomes or determine whether objectives were achieved. In the absence of benchmarks, the evaluation focused on observed trends, qualitative perceptions of change, and analysis across sites rather than quantitative measurement of progress.

Tracking of Service Users: The project team did not allocate unique patient identifiers, making it impossible to distinguish between new and repeat users in service data. As a result, utilization figures may overestimate actual reach and do not allow for analysis of continuity of care, treatment adherence, or long-term outcomes for chronic conditions such as HIV, TB, and hypertension.

Data Quality and Integration: Fragmentation across data systems (DHIS2, MOHCC registers, and Activity Info) also constrained the ability to triangulate results and produce consolidated performance trends. Incomplete or inconsistent data entry further limited the reliability of some indicators.

Interpretive Scope: Given these constraints, findings should be understood as indicative rather than exhaustive. They reflect perceived changes and plausible contributions of the Gwanda model to improved access and service delivery but cannot quantify the extent of impact or longer-term health outcomes.

FINDINGS

EQ 1: TO WHAT EXTENT IS THE PROJECT DESIGN AND DELIVERY MODEL APPROPRIATE TO THE NEEDS OF THE TARGET POPULATIONS AND LOCAL CONTEXT?[10]

The findings of this EQ will be organized by the seven expected results of the project to allow the reader to clearly distinguish how appropriateness and responsiveness relate directly to what the project set out to achieve.

EXPECTED RESULT 1: BASIC HEALTH SERVICES

Finding 1: The mobile clinic model is appropriate and addresses access barriers for ASM and host communities.

Interviews with miners and host community members, service user debriefs, and MSF monitoring data converge in showing that the mobile clinic model is a practical and often the only accessible way to reach key populations in mining areas. Eighty percent of respondents described the mobile clinics as their only reliable source of healthcare. One miner explained: *"If MSF did not come, we would not test or get medicines; the clinics are too far."*

Project data confirm the model's reach: two mobile teams cover 32 active and four seasonal sites three weeks each month, and attendance improved when visit schedules were aligned with mining cycles. MSF staff noted that static clinics are often inaccessible, with "*clinics often charging user fees miners can't afford*." Service users highlighted how the model reduces major barriers such as transport costs, distance, access to medications which are often out of stock at clinics and occupation-related systemic exclusion from formal health systems. Communities described the services as "*life-changing"* and especially valuable in the context of poverty and economic instability. Free care was viewed as essential: *"Here we don't have money to pay for clinics; if MSF comes, we can be tested and treated."*

The majority of the participants also found locations and hours convenient, and they appreciated the two-day model, which offered flexibility when mining work was unpredictable. However, stakeholders at two different sites noted that the clinics are perceived as "*HIV clinics*," discouraging attendance among those who fear being labelled HIV-positive. Many (mentioned 18 times) male miners, particularly at Zindere and Geelong, when asked why they did not attend the MSF clinics reported avoiding services because they

[10] The sub questions supporting this evaluation question are: Are project activities well aligned with the socio-cultural, economic, and political realities of the affected communities? How appropriate are the project's operational research and advocacy components in advancing its health-related goals? What changes to the healthcare service delivery model could enhance its relevance and responsiveness to community needs?

thought it was an HIV clinic, which limits the model's reach despite its overall appropriateness and effectiveness.

Finding 2: The DSD model matches key health needs, including HIV testing and linkage to ART, STI screening and treatment, family planning, NCDs, and some mental health support.

Triangulated data from health session debriefs, service uptake statistics, and staff interviews show that the DSD package responds well to perceived health needs in communities. Participants praised the integrated services: "*I was really excited about the PrEP session that taught us about pills that can prevent HIV,*" said a young woman from the host community. Others valued family planning and NCD support: "*The part that really stood out to me was the discussion on managing high blood pressure… It gave me practical tips to stay healthy*." Miners highlighted sessions on occupational diseases: "*I enjoyed the session about the invisible dust that causes silicosis and TB*." MSF staff reported adapting services over time by adding cervical cancer screening, long-acting contraceptives, and a portable X-ray after the exit of TB partner, Baines. This alignment between user priorities, service statistics, and implementer adjustments confirms that the DSD package is well suited to the needs of key populations. However, mental health remains underdeveloped: while a mental health supervisor is in place and a strategy is being drafted, uptake and user experience are not well documented.

Finding 3: Outreach services have substantially improved access but remain uneven, with persistent transport and scheduling barriers for some groups.

Interviews and debriefs show that many miners and host community members now receive care closer to where they live and at no cost. One participant described the mobile clinic as *"a one stop shop… we now get HIV tests, cancer screening and health education right where we are*." Another called the model "*the most perfect for ASM and host communities because it reduces the distance and teaches people to seek care*." Yet access is not universal. Some estimated that only about half of residents actually reach services, citing transport costs, distance, and mistrust as continuing obstacles: "*Transport is still a big problem, especially for the elderly*," one informant from the host community explained. This was apparent in locations where mining sites are distant from villages/host community settlements such as Bena and Geelong. While many praised the locations and service times, "*the clinic has a perfect location and service times*," others said schedules do not align with mining work: "*Some underground miners knock off at 14:00 so they end up not accessing services; hours should be extended*." Data that were routinely collected by the MSF project team, referred to as monitoring data, were analysed and similarly showed strong uptake, confirming that access has improved.

Finding 4: Project flexibility and rapid adaptation have been defining strengths.

Stakeholders consistently praised MSF's ability to adjust to emerging needs. Project staff described mapping hotspots, expanding from a miner-only focus to include host community members when they began attending, and adjusting service packages (e.g., cervical cancer screening, mental health, portable X-ray). This adaptability has kept the model relevant and responsive in a changing and politically sensitive

ASM context. This adaptability was also observed during the evaluation. Monthly insights provided by the evaluation team to the CG based on iterative analysis of data was immediately taken by the project team and integrated into service activities. For example, the evaluation team identified the lack of indicators that target sex workers and raised this issue in the Learning Board. This resulted in the project team immediately creating an indicator to target this key population. However, some adaptive measures proved unfeasible long term: night clinics, piloted to reach sex workers and late-shift miners, were discontinued due to high cost and minimal added reach.

EXPECTED RESULT 2: OCCUPATIONAL HEALTH SERVICES

Finding 5: The occupational health package (TB, silicosis, and related risks) is appropriate but awareness and systemic uptake remain uneven.

Evidence from service user interviews, staff perspectives, and monitoring data indicates that the occupational health focus is well-suited to miners' exposures. Many miners described understanding dust-related illness: *"I enjoyed the session about the invisible dust that causes silicosis and TB."* Others linked their work to chest problems: *"Dust and gases from explosives lead to TB and pneumonia."* However, divergence exists: several miners denied risk, *"There is no dust in our mining area; it doesn't affect us,"* while some host community members admitted, "I have no idea if mining work can affect one's health." These mixed views suggest persistent gaps in risk perception despite health education. The project responded to partner withdrawal by procuring and registering a mobile X-ray unit for TB and silicosis screening, keeping services available despite Baines' exit. Staff noted expanding environmental testing, shifting from costly blood tests to water source screening for heavy metals. This adaptation shows responsiveness to both cost and context. There were early efforts to promote prevention and linkage to care, particularly around HIV and TB. Several participants described increased confidence in accessing testing and treatment, for example noting that a positive TB or HIV test "*is not the end of it all*" and that treatment allows them to live well. Others mentioned increased use of condoms or better understanding of PrEP and family planning. These perceptions point to progress in general prevention awareness, although they remain uneven across conditions.

It is also important to interpret the uneven uptake in light of timing. The mobile CAD/X-ray unit and the expanded occupational health package were only recently operational. Limited community familiarity with silicosis screening, the absence of earlier preventive services for dust-related illness, and the short period for consistent messaging mean that awareness and demand would not yet be expected to be widespread. Some of the remaining gaps may reflect the natural lag between introducing new diagnostic capacity and full community uptake, especially in a mobile, highly seasonal mining context.

That said, community knowledge on TB prevention and silicosis risk reduction was still limited. Many respondents felt informed about HIV but expressed gaps related to dust exposure, silicosis, and how prevention works in practice, such as the use of protective measures or reducing exposure in shafts. There was no clear community understanding that silicosis has no curative treatment, or of the importance of preventive interventions such as minimizing dust exposure, early TB preventive therapy for people with HIV or silicosis, or consistent use of masks or wet drilling techniques. These gaps were reinforced by low

male participation in health promotion sessions and limited opportunities to discuss occupational exposure risks before clinical services began.

However, the package remains narrower than the full range of occupational hazards raised by miners during interviews, such as mercury exposure, injuries from unsafe shafts, and harm during police raids. Awareness campaigns appear effective for some but not all miners, and there is no evidence yet of policy adoption or systemic integration of occupational health interventions into government services despite MSF's advocacy. Data on screening uptake and long-term follow-up for silicosis or heavy metal exposure are incomplete, limiting confidence in sustained impact. The lack of consistent community understanding of prevention measures, especially for silicosis and TB, suggests that strengthening prevention-oriented messaging and expanding tailored engagement with miners could help close remaining gaps as the new diagnostic tools become more established.

EXPECTED RESULT 3: HEALTH PROMOTION AND COMMUNITY ENGAGEMENT

Finding 6: Health promotion is culturally resonant, accessible, and builds knowledge, but engagement is uneven due to ASM mobility.

Health promotion sessions were consistently described as "*relevant, practical, and easy to understand*" by all service users interviewed. The use of vernacular language was repeatedly cited as key to inclusion, particularly for people with limited literacy: "*It made me feel part of the discussion; I didn't feel left behind*," said one participant. Topics resonated strongly: silicosis and TB prevention (*12 mentions*), family planning and reproductive health (especially among younger women, 8 mentions), PrEP and HIV prevention (6 mentions), and managing hypertension (*5 mentions*). Staff confirmed that holding sessions while people wait for clinical care increases participation. However, several noted that "*miners move a lot; if they are busy or drinking, they don't stay for the whole talk."* Likewise, recognizing the limited time available to ASM, MSF staff often prioritize them by moving them to the front of the queue. However, this practice results in their absence from the health promotion sessions. Participants who did attend these sessions also noted that they would benefit from take-home materials, explaining that without pamphlets or similar resources, the knowledge shared is less likely to be reinforced. At the time of writing the report MSF was developing materials to address this barrier.

EXPECTED RESULT 4: EH AND WASH

Finding 7: Environmental health and WASH interventions respond to urgent risks but remain partial and poorly internalized by communities.

Interviews with MSF staff and field observations reveal widespread environmental health risks in ASM areas. Overcrowding, lack of sanitation, and use of contaminated water are common. One staff member noted, "*In most of these areas there is poor sanitation… they use bush toilets… people drink dirty river water. We've seen diarrhea, bilharzia, worms, and skin diseases."* Another added that "*most health issues from the environment include upper respiratory infections, silicosis, diarrheal diseases and TB because of their squatter living."* MSF has invested in mitigating these risks: building an incinerator at Phakama clinic,

planning four additional waste zones, and conducting operational research on water quality. These actions directly respond to observed hazards, and staff confirm their relevance to the local context. However, most evidence came from implementers rather than community members themselves; only limited first-hand user voices described WASH practices or perceptions. There is little monitoring data linking these investments to improved health outcomes. Planned follow-up measures (borehole drilling, well decontamination) remain incomplete, and some residents continue to underestimate risks or lack alternatives to unsafe water, weakening the long-term impact of current actions.

EXPECTED RESULT 5: ADVOCACY AND COMMUNICATIONS

Finding 8: Advocacy efforts seek to be evidence-driven but remain nascent and have yet to achieve visible policy influence.

MSF has developed draft advocacy and communication strategies to address key barriers miners face, such as transport, cost, and stigma, and to humanize miners in a context where they are often marginalized. As one HQ informant explained, "*there is this very strong stigma [against ASM] … the communication strategy is really around humanizing ASM*." Likewise, the draft communication strategy takes a community-based approach to advocacy and is designed to be replicable, using miners' lived experiences to shape key messages. Operational research underpins these efforts. Studies on TB and silicosis, including the use of computer-aided detection (CAD) for silicosis, directly respond to miners' expressed needs and to evidence gaps identified by MSF. Emerging research on environmental contamination, while still developing, is viewed as a promising area for future advocacy once results are consolidated. MSF staff believe the growing evidence base could inform a national and potentially global advocacy toolkit on occupational health, safer mining practices, and climate impacts.

EXPECTED RESULT 6: EMERGENCY PREPAREDNESS AND RESPONSE

Finding 9: Emergency preparedness and rapid response are appropriate and valued.

Stakeholders consistently described a responsive, flexible emergency posture. One district informant explained, "*the project supported us with an incinerator in our clinic during an outbreak*…" another stakeholder stated "*MSF has provided support in road traffic accidents where MSF helped with first aid and transporting the injured… the project is flexible and very quick to adapt to the needs that are pressing at that time*." Community and health staff accounts also referenced cholera as a recurrent threat in the area, confirming the relevance of outbreak readiness. Local authorities described concrete actions by MSF during a recent cholera episode in Manama, including pumping out and chlorinating contaminated wells, decontaminating wells, and planning to solarize them, as well as support to MOHCC with borehole decontamination. Taken together with the project's broader flexibility narrative and the documented investments in waste management, these examples triangulate across stakeholder testimony and project adaptation records to substantiate an emergency response capacity that is appropriate to context and needs.

EXPECTED RESULT 7: MONITORING, EVALUATION, AND LEARNING

Finding 10: Monitoring and learning systems enable adaptation but are fragmented, exclude key groups, and limit meaningful community feedback.

Routine monitoring has allowed MSF to adjust service delivery over time. For example, outreach schedules were shifted and new services, including long-acting contraceptives, cervical cancer screening, and a mobile X-ray unit, were added when uptake patterns and mapping data indicated demand. As one staff member explained, "*we adjust services when we see where people come from and what they ask for*." These adaptive practices show that the project uses available data to respond to evolving needs on the ground.

However, the systems supporting this learning remain uneven and only partially inclusive. While feedback mechanisms such as suggestion boxes, satisfaction surveys, and health promotion officers exist in principle, many non-literate service users reported feeling that they "*have no options to give feedback*" because the anonymous options require one to be able to read and write. Moreover, while sex workers were included in the original project design as a key target population, with the expectation that CBOs such as CESHHAR would deliver services directly and MSF would provide support and referrals, this referral pathway never materialized. As a result, sex workers are now largely absent from project documentation and reporting. One of the reasons for this is that the logframe has no indicator that directly targets sex workers which means their participation, access to services, and specific outcomes are neither tracked nor reported, making it difficult to assess whether the project is meeting their needs or contributing to improved health and protection outcomes for this group. Secondly, the work of CESSHAR has been significantly cut because of funding changes. In addition, given the strong stigma surrounding sex work, many do not self-identify as sex workers, and the project team has not made intentional efforts to reach or engage them specifically. As a result, this group remains largely invisible in implementation and monitoring.

Fragmentation in data systems also limits the project's ability to learn and adapt systematically. MSF's funding model, which relies very little on government funding, gives MSF flexibility to adapt services without donor-driven RBM requirements. Yet, this autonomy also has trade-offs. For example, given the lack of government funding, there is no centralized performance system or reporting mechanisms. Responsibility for data gathering is spread across teams, resulting in no single view of project results. The evaluation team never received any results matrix to track which indicators were achieved, which were on track to being achieved, and which targets were behind.

In addition, data systems remain fragmented (DHIS2, MOHCC registers, and Activity Info are used in parallel) without a unified platform to consolidate and analyse findings. These gaps raise concerns about data validity, inclusiveness, and accountability.

Tracking of service users is another major gap. The project does not use unique patient identifiers, which makes it impossible to distinguish between new and repeat users in service data. Utilization figures may therefore overestimate actual reach and prevent any analysis of continuity of care, adherence, or long-term outcomes for chronic conditions such as HIV, TB, and hypertension.

The monitoring framework also lacked baseline data or targets. This limited the evaluation team's ability to assess progress against intended outcomes or determine whether objectives were achieved. In the absence of benchmarks, the evaluation relied on observed trends, qualitative perspectives on change, and comparative analysis across sites rather than quantitative measurement of results.

EQ 2: TO WHAT EXTENT IS THE PROJECT ON TRACK TO ACHIEVE ITS INTENDED OBJECTIVES?[11]

Finding 11: The project is largely on track to achieve its intended service delivery objectives, having expanded health care access and utilization among ASM and host communities.

Routine service records show that from March 2024 to May 2025 the project reached 39 mining sites and delivered 24 814 health services, resulting in a 55–60 % increase in critical services at outreach sites. Nearly half of all encounters were general consultations (11 846; 47.7 %), with uptake of TB screening (9 927; 40 %), family planning (1 164; 4.7 %), STI care (788; 3.2 %) and hypertension management (564; 2.3 %). An increase of less than 5% is still meaningful in the context of family planning and contraceptive access, particularly among ASM populations who face limited availability and barriers to uptake. This modest gain is significant given the broader challenges adolescents and young women face in using modern contraceptives due to stigma and social expectations.

The figure below presents MSF health service utilization across the six most frequently reported indicators. There was insufficient data to calculate or estimate continuity of care. Both MSF routine monitoring data and MoHCC records show no evidence indicating whether patients seen during one outreach were the same individuals who returned for subsequent outreaches, or whether they sought follow-up care at nearby static facilities. Each outreach cycle recorded all consultations as new cases. Moreover, the intervals between outreach cycles were long, meaning that many patients would have been due for review at least two or more weeks before the next outreach visit. Given the high mobility of clients, it is also possible that some sought care at facilities in other regions during this period.

[11] The sub questions supporting this evaluation question are: How effectively are project activities contributing to the project's overall outcomes? What opportunities exist for the project to influence occupational health policy for artisanal miners and associated groups?

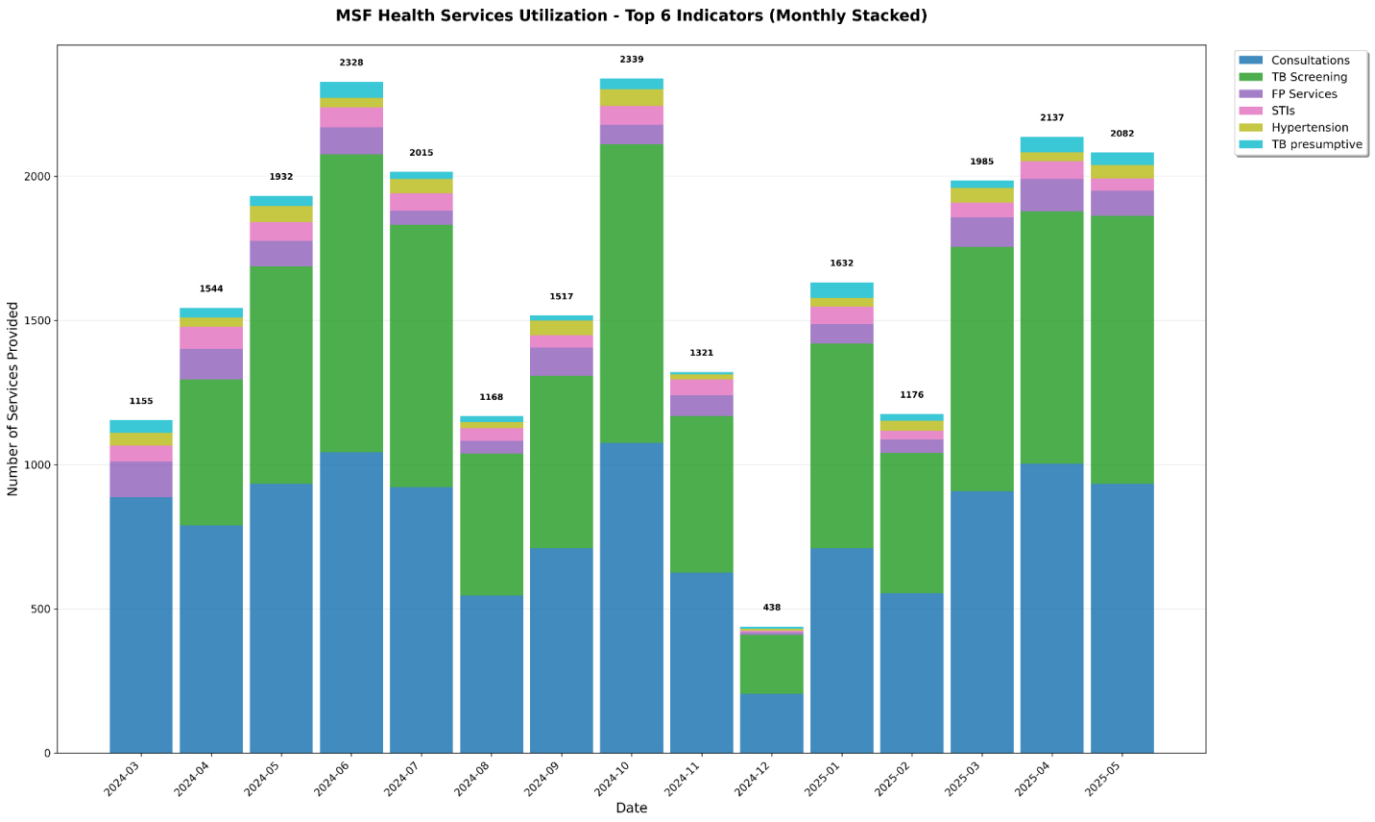

Figure 1: MSF Health Service Utilization

These findings align with results from MSF's client satisfaction survey of 192 respondents and 111 beneficiary feedback records, both indicating high levels of approval and perceived accessibility. Users frequently described the mobile clinics as "*the only way we can see a nurse"* and *"a one-stop shop where you can test and get medicine without paying*." The availability of free medicines and on-site consultations reduced financial barriers, while the geographic reach of the clinics extended services to previously unreached ASM clusters. Together, these data suggest that the project is achieving its core objectives of improving access and coverage.

Finding 12: Project activities are effectively improving priority service uptake and utilization but continuity of care for chronic conditions is limited.

A difference-in-difference analysis of 22 health service indicators (see annex 2 for descriptions) found 77 % statistically significant positive effects, with especially strong gains in PrEP uptake (+23.4 per quarter), syphilis testing (+14.6), new STI clients (+13), and HIV self-testing (+4.5). These trends also point to early signs of self-care. Community members described increased awareness of their health needs and a stronger ability to act on them independently. Several reported that when the outreach clinic is not present, they now go to their local clinic to access services such as HIV testing, STI treatment, and PrEP refills. This shift suggests that MSF's outreach activities have not only improved service uptake during clinic visits but have also strengthened health-seeking behaviour more broadly. While the systems needed for sustained self-care are not yet fully in place, these patterns indicate that the project is beginning to

influence how communities manage their own health.

Beneficiaries described the tangible impact: "*Those who were not able to walk are now walking… had MSF not started offering services, they might have gotten worse*." Others reported improved blood pressure control, TB recovery, and pain relief. Health promotion on PrEP, PEP, family planning, and silicosis created demand for prevention and early treatment. Triangulation of routine indicators, forecasting trends, and user accounts provides robust evidence of improved infectious-disease and SRH outcomes. However, long intervals between mobile visits interrupt follow-up for chronic conditions such as hypertension and musculoskeletal disorders. Patients described losing contact due to transport cost or work schedules, and there is no longitudinal data on TB treatment completion or NCD control, reducing confidence that early gains translate into sustained improvement.

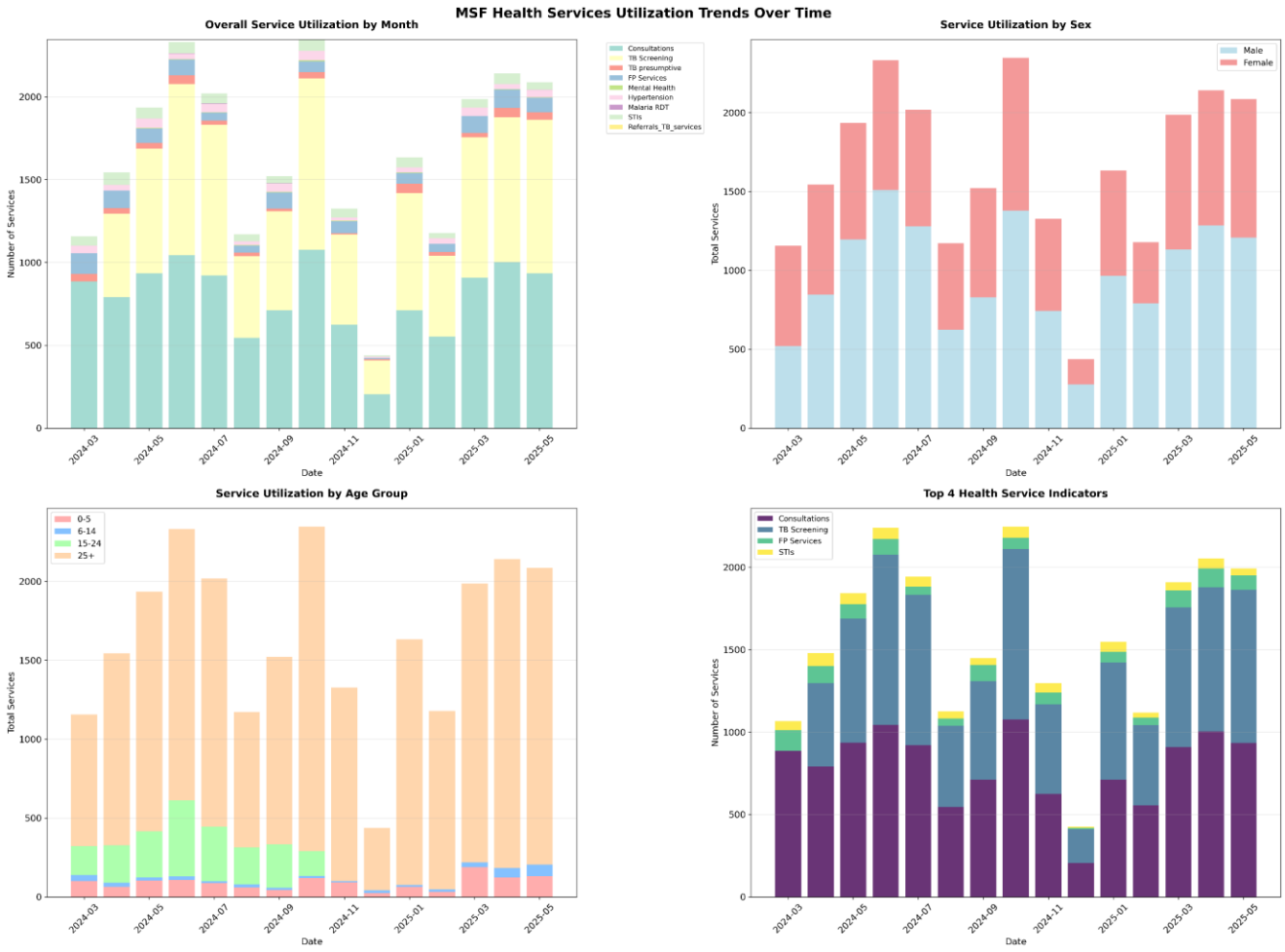

Figure 2: MSF Health Service Utilization Trends

These charts show monthly trends in service utilization across several indicators, disaggregated by type of service (e.g., TB screening, family planning), sex, and age group. They highlight seasonal fluctuations, periods of decline, and demographic shifts in health service uptake.

Finding 13: Early signs of self-care are emerging in specific sites, but the project is unlikely to achieve its broader self-care objectives within the current timeframe.

Self-care was identified as one of the project's intended outcomes, defined as the ability of individuals, families, and communities to promote health, prevent disease, maintain health, and cope with illness with or without direct support from a healthcare provider. While the evaluation observed some promising behaviour shifts, these remain limited in scope and uneven across sites.

The most visible progress appeared in Geelong and Zindere, where health promotion activities prompted households to begin siting land for toilet construction and to organize basic waste-management practices, including systematic burning and pit disposal. These actions suggest that, where conditions permit, communities can adopt self-directed practices that reduce environmental health risks.

Despite these examples, the broader self-care objective is unlikely to be reached during the current implementation period. Achieving meaningful self-care requires two foundational elements that are not yet in place. First, it depends on a functioning system of supply and access, especially for preventive tools and chronic-care commodities. That system remains incomplete and under development. Second, self-care practices take time to internalize and sustain, and typically emerge only through consistent reinforcement, reliable access to resources, and supportive social norms. Given these realities, the project would require a significantly longer timeline to translate early behaviour change into durable self-care habits.

While the project has laid groundwork in several sites, future efforts should align self-care ambitions with realistic timelines, predictable supply systems, and behaviour-change strategies designed for gradual uptake.

Finding 14: Health promotion activities improve self-reported knowledge for many service users, yet gaps in inclusiveness and follow-up measurement limit their overall effectiveness.

Service users widely credited sessions with new knowledge on HIV prevention, family planning, and occupational risks: "*Learning about silicosis was really eye-opening… I had no idea about the severity of the disease*." Several women reported starting contraception; miners described increased condom use and interest in PrEP. Seventy-five per cent of feedback entries praised the usefulness and clarity of talks. Sessions in vernacular languages and on-site delivery reduced barriers and were valued for practical tips (e.g., managing high blood pressure). These findings triangulate user testimony, feedback analysis, and survey ratings to show self-reported increases in knowledge. However, some participants found the talks repetitive or felt uncomfortable asking personal questions in groups. Non-literate users said they "have no options" for feedback or deeper dialogue. Highly mobile miners often miss sessions, and there is no systematic measurement of knowledge retention or behaviour change.

Finding 15: The project is generating policy-relevant evidence on occupational health and safer mining but has not yet leveraged it assertively; opportunities for greater influence remain.

Operational research on TB and silicosis (including pilots of computer-aided detection for silicosis) directly reflects miners' stated concerns about dust and respiratory disease. New environmental health studies (e.g., water contamination mapping, waste management) are considered valuable for policy dialogue. The communication strategy deliberately seeks to reduce stigma and "*humanize why people are there*." Communities self-reported that they now recognise silicosis as a serious disease, and now seek health services to address concerns: "*Learning about silicosis was really eye-opening… I had no idea about the severity of the disease*." Stakeholders identified potential to integrate the outreach model into Zimbabwe's primary health care and to scale peer educator networks as community-based advocacy structures. However, advocacy remains cautious and politically risk-averse: "*It's very difficult to challenge the government or change their thinking*…." Environmental research has been narrowly framed to avoid backlash and to avoid repercussions for miners who could face punitive actions from the government. Likewise, policy engagement is poorly documented, with no system to track influence or uptake. Sustainability planning for advocacy after MSF's exit is unclear, risking loss of momentum once external support ends.

Finding 16: High client satisfaction and trust underpin effectiveness, but irregular service frequency and unclear transition planning threaten long-term outcomes.

The 2025 client satisfaction survey shows strong approval for service quality and accessibility across gender and age groups. Beneficiaries praised free medicines, respectful care, and convenience: "*MSF is a game-changer; we don't have to travel far or pay*." Positive sentiment dominated feedback logs (75.5 % positive; 68.8 % from miners). Sustained attendance over 15 months signals trust and reliance on the model. However, respondents voiced frustration with long gaps between mobile visits and uncertainty about continuity: "*Sometimes they don't come for a while; we are left not knowing where to go*." Staff noted the absence of a costed handover or sustainability plan. Without a clear transition strategy, effectiveness achieved during MSF's tenure may not endure.

EQ 3: HOW EFFICIENTLY ARE HEALTHCARE SERVICES BEING DELIVERED UNDER THE CURRENT HEALTHCARE SERVICE DELIVERY MODEL? [12]

Finding 17: Limited human resources and long intervals between site visits interrupt continuity of care, leading to treatment disruptions and in some cases drop-outs among mobile miners.

Long gaps between return visits further disrupt care. The team is described as "*too small and the cycle takes too long before returning to sites*." Miners shared, "*You start getting better but if they don't come back on time for refills, you have to stop treatment or pay somewhere else*." Evidence from key informant interviews, routine monitoring, and patient debriefs consistently shows that high mobility combined with limited human resources makes long-term care difficult and drives treatment drop-out. In practice, follow-up intervals of up to 6–8 weeks make it hard to maintain adherence NCD treatment protocols that require regular monitoring and medication refills. Human resource shortages further compound the issue, with a small clinical team covering a wide geographic area. As a result, continuity of care is weakened, and drop-out rates remain high, particularly among miners who migrate seasonally or change sites frequently.

Finding 18: Inconsistent communication about clinic schedules lowers turnout and wastes outreach resources, but digital and community-led mobilization could improve efficiency.

Many miners lack phones, internet, or fixed addresses, making it difficult to advertise schedules or send reminders. Staff noted that "*attendance at planned outreach events can be highly variable; miners frequently prioritize work over health services, leading to low turnout and wasted resources*." Community members echoed this: "*Sometimes we don't hear the announcement*." This unpredictability leads to days where teams travel and set up but see fewer clients than planned. Attendance often improves on the second day of an outreach visit, as word spreads through physical presence and peer-to-peer communication among miners after the first day. This was directly observed at the Zindere and Bena sites where attendance improved on the Day 2. When this effect is not factored into planning, first-day underutilization can reduce overall efficiency, with resources committed to low-volume service delivery before demand builds.

Finding 19: Logistical delays from travel, tent set-up, and early closure reduce clinical time and patient throughput, but clear options exist to improve efficiency.

Although outreach sites are generally well chosen, both patients and staff described late starts and short operating hours. "*They mobilise for 08:00, but end up coming later… service delivery ends at 13:00*," said

[12] The sub questions supporting this evaluation question are: What inefficiencies, if any, are evident in the current healthcare service delivery model? What opportunities exist to improve efficiency in the healthcare service delivery approach?

one ASM. Night-shift miners requested earlier openings: "*They should come as early as 08:00 to cater for those coming from the night shift*." Patients sometimes queued but left unserved: "*Sometimes people are still waiting in line when it's time to close, and they might not get the services they need*." Staff pointed to long travel to remote clusters such as Jayivela and Zindere, poor roads, and rainy-season mud slowing tent pitching and set-up. These logistical burdens shorten the proportion of each day spent on care. Practical improvements are already visible: clustering sites geographically, pre-positioning supplies, using digital schedule tracking, and mobilizing local helpers or peer educators to speed set-up. Making these adaptations systematic and data-driven could turn reactive work-arounds into predictable, cost-efficient delivery.

Finding 20: Stockouts and delayed resupply interrupt care and reduce efficiency, but better supply planning and pre-positioning could address this.

Despite MSF's generally reliable provisioning, several users reported arriving to find medicines unavailable: "*Some pills become out of stock before everyone has been assisted*.". Others said they were asked to purchase drugs or wait: "*It was unfortunate that I did not get the painkillers as they were out of stock… MSF prescribed tablets to purchase but they brought them later*." Staff acknowledged dependence on MoHCC supply chains for certain commodities. Each stock-out means clinical time is spent without delivering full treatment, requiring repeat visits or forcing out-of-pocket spending, both reducing efficiency. However, while the program systematically tracks the stock through the isystock system and regular pharmacy report, it does not cost impact of stockouts, making it difficult to quantify the scale of the problem or target improvements.

Finding 21: Staff training and upgraded equipment (portable X-ray, privacy tents) enhance field efficiency and reduce unnecessary referrals.

MSF has invested in targeted training (e.g., HIV guideline updates, TB in children, emergency response) and better equipment such as portable X-ray and privacy-friendly tents. MohCC staff said, "*The HIV training… was very useful in my service delivery*," and praised the X-ray: "*It's covering a lot of issues we would have had to refer to Gwanda*." These investments allow more care to be completed on-site, shorten consultations, and avoid costly referrals, a clear efficiency gain corroborated by both staff and service data.

EQ 4: TO WHAT EXTENT ARE THE PROJECT'S OUTCOMES AND SERVICE DELIVERY MECHANISMS LIKELY TO BE SUSTAINED AFTER MSF'S EXIT?[13]

Finding 22: Sustainability planning has focused on community ownership and norm change.

MSF has deliberately framed sustainability as strengthening community knowledge, peer support, and behavior change rather than solely focusing on embedding services into government systems. MSF staff explained that "*I am not convinced… we can really embark on sustainability at the government level… that is the reason why we have deliberately chosen to go to the community level*". This choice reflects recognition of the fragile health system and scarce government resources as well as the significant resources required to run the outreach clinics. The peer educator program, health promoters, and community-led mobilization are seen as the most likely elements to survive MSF's exit. Evidence from staff and stakeholders converges on the idea that community-cantered sustainability is more realistic than expecting the MOHCC to absorb the mobile clinic model.

Finding 23: Physical infrastructure and some service components are likely to endure, but the mobile clinic model is viewed as unsustainable without external support.

Stakeholders consistently praised MSF's infrastructure investments, such as the Phakama incinerator and WASH systems, as lasting assets: "*The incinerator will be maintained… it will be able to continue in service and that's a good thing*". However, the structured mobile clinic model is widely seen as too costly and human-resource intensive for the government to maintain: "*Everything about this project will be hard to continue… this model is very expensive and judging by what is at the government clinics, there is no money to spare for these mobile clinic activities*." Withdrawal of donors like USAID has already weakened local continuity. Triangulation across staff, local authorities, and CBOs indicates that infrastructure may remain, but mobile clinics would likely diminish without another dedicated funding.

Finding 24: Integration efforts with MOHCC (use of registers, co-delivery of services) promote ownership.

MSF has established formal relationships and operational agreements with key public and local authorities, including the MOHCC, the Rural District Council, Gwanda Municipality, and mining associations. MSF teams described working closely with MOHCC: "*We are already trying to make our work sustainable by integrating MOHCC from supporting clinics into our outreaches. We use their registers and connect clients to them because it is their data and their duty*." MOHCC Environmental Health Technicians

[13] The subquestions that support this evaluation question are: How are sustainability considerations integrated into current project activities, and what challenges or barriers affect this integration? How have key stakeholders been engaged in the project to date, and what forms of collaboration have emerged? What adaptations could strengthen the continuity of health services beyond MSF's direct support?

also mobilize communities and support outreach. Yet stakeholders repeatedly doubted the ministry's capacity to maintain this model: "*They don't have the medicines… they want us to go to them when we get sick, but we are deep in the bush*." There is no clear transition plan, budget, or staffing pathway, and the ministry's chronic resource shortages threaten continuity. Evidence is strong across KIIs and stakeholder debriefs that integration is symbolic rather than fully institutionalized.

Finding 25: The peer educator model shows the strongest potential for continuity beyond MSF, but long-term support structures are unclear.

Peer educators now handle most mobilization: "*We just reach out to the peer educators… and they partner with the committees to mobilise*". This reduces MSF's pre-visit workload and builds local health literacy. Community members described mobilizing peers after positive clinic experiences. However, the program's sustainability depends on incentives, supervision, and resources: "*There will be a need for MSF to donate a few vehicles to support these cadres and to continue with the honorarium*".

Finding 26: Limited engagement with informal/traditional authorities and the private mining sector leaves untapped sustainability potential.

While MSF has built strong ties with MOHCC and formal mining associations, traditional leaders and informal community influencers are largely absent: "*We have not really been deliberate [about] traditional leaders… we did visit one traditional healer at one point*.". At the same time, mine managers have shown willingness to release workers for clinics and even provide transport. The private sector's potential to co-fund or host services has not been fully explored. This gap suggests missed opportunities to diversify support and reduce reliance on overstretched public funding.

RECOMMENDATIONS

The evaluation found that MSF's Gwanda project has actively adapted in response to learning and stakeholder feedback throughout implementation. Many of the following recommendations build on steps that MSF has already initiated based on the feedback we have provided, such as piloting hybrid static–mobile linkages, developing an advocacy strategy, and supporting MoHCC capacity building. The recommendations are intended to consolidate and systematize these efforts, address persistent gaps, and guide a realistic transition plan as MSF prepares for exit.

→ Formalize and resource the peer educator model

Define clear roles, provide refresher training, and establish predictable incentives (e.g., modest honoraria, airtime, transport). Link peer educators to ward health committees, mining committees, and traditional leaders so that mobilization, health promotion, and basic follow-up can continue without MSF. Equip peers with simple referral tools to track and support miners who relocate, ensuring continuity of care for HIV, TB, and chronic conditions.

→ Prioritize a knowledge and evidence handover to MoHCC rather than transferring activities

Given the current gaps in data systems, continuity of care, cost of outreach, and service pathways, the existing evidence does not yet support handing over MSF's outreach activities in their current form. The most significant contribution of the project has been generating visibility on the health needs of miners and host communities and demonstrating how flexible and adaptive outreach can reach groups that are otherwise missed by the formal health system. A more appropriate transition would focus on transferring this knowledge to MoHCC rather than attempting to transfer activities that are not yet ready for absorption.

This handover should centre on the evidence MSF has gathered about population needs, service-use patterns, and barriers to care, along with practical insights on how these groups can be reached through adaptive and community-oriented models. It should also document MSF's learning on what flexible service delivery looks like in practice, including the adjustments made in response to uptake and demand. Finally, MSF should share guidance on the systems improvements required for any future programming to function effectively, such as the use of unique patient identifiers, integrated reporting, and reliable supply chains for chronic care.

A knowledge-driven handover aligns more closely with the project's achievements to date and positions MoHCC to design future services based on evidence rather than inheriting activities that cannot be sustained under current conditions.

→ Expand partnerships beyond MSF and MoHCC

Engage traditional leaders and informal mine owners more systematically to mobilize miners and enable small cost-sharing. Explore collaboration with private mining operators (transport support, hosting outreach, co-funding occupational health interventions). Broker partnerships with local NGOs/CBOs (e.g CeSHARR) already active in health and rights-based advocacy to maintain health promotion and influence after MSF leaves.

→ Address stigma to maintain and grow service uptake

Involve respected community influencers and satisfied service users in public storytelling to normalize care-seeking and to discuss how these clinics are basic health services clinics. Equip peer educators and health promoters with anti-stigma messaging and talking points to reach miners worried about being labeled HIV positive.

→ Consolidate and hand over advocacy and research outputs

Finalize and operationalize the advocacy and communications strategy before exit, with clear contacts and action steps for national engagement. Package operational research (silicosis, TB, water contamination) into briefs, toolkits, and case studies for use by civil society, mining unions, and health authorities to influence occupational health policy.

→ Pilot and optimize service delivery models to prepare for a realistic transition

Use upcoming outreach cycles to test mixed delivery models that place more responsibility on peer educators and local structures, with MSF providing limited technical support. Reducing MSF's direct input in these pilots can free staff time and resources that could then be redirected toward strengthening service availability in priority sites. This includes extending clinic operating hours where miners work long or irregular shifts, rotating late-day or weekend sessions, and increasing visit frequency to every 3–4 weeks in high-density mining areas. In parallel, pilot efficiency measures such as fast-track refills for family planning and chronic medication, community medicine depots managed by trained peer educators, and selective, cost-contained night outreach where unmet need is documented. Collecting cost, workload, and service-continuity data during these pilots will help refine the transition plan and build an evidence base for future funders.

ANNEX 1: EVALUATION MATRIX

Criteria	Evaluation question	Judgement criteria	Indicators	Data sources
Relevance	1. To what extent is the project design and delivery model appropriate to the needs of the target populations and local context?	Extent to which the strategies and activities adopted are contextually appropriate over time	Stakeholders' perceptions of whether strategies and activities adopted are contextually appropriate over time	Document review; interviews Debrief Sessions; SGDs, Outreach Activity Observations
	1.a Are project activities well aligned with the socio-cultural, economic, and political realities of the affected communities?	Perceptions of cultural and contextual fit of project services	Evidence of context-specific adaptations	Document review; interviews; Debrief sessions; Observations
	1.b. How relevant and strategic are the project's operational research and advocacy components in advancing its health-related goals?	Presence of research/ advocacy outputs aligned with project goals	Stakeholder views on usefulness of research; influence on strategy	Project staff, SAMU technical advisors, Community feedback; SGD transcripts; Observation notes
	1.c What changes to the healthcare service delivery model could enhance its relevance and responsiveness to community needs?	Suggestions from staff and community on adapting the model	Observed service gaps; community and staff suggestions	Document review; Interviews; Research documents
Effectiveness	2.To what extent is the project on track to achieve its intended objectives?	Alignment of project activities with expected outcomes	Stakeholder perceptions of observed changes/results	Community SGDs; interviews; Clinic observation
	2.a. How effectively are project activities contributing to the project's overall outcomes?	Evidence of positive health outcomes or improved access	Reported changes in health-seeking behaviour	document review; interviews

Criteria	Evaluation question	Judgement criteria	Indicators	Data sources
	2.b. What opportunities exist for the project to influence occupational health policy for artisanal miners and associated groups?	Evidence of policy engagement activities	Stakeholder views on MSF's influence or role	Document review; Client and health worker feedback
Efficiency	3. How efficiently are healthcare services being delivered under the current healthcare service delivery model?	Ratio of inputs to outputs (staff, time, reach, outcomes)	Observed bottlenecks; service reach vs. input	Interviews; Policy documents, medical data
	3.a. What inefficiencies, if any, are evident in the current healthcare service delivery model?	Delays, duplication, or resource constraints reported by staff	Service user feedback on inefficiencies (e.g., wait times)	Service data analysis; Clinic observations; Interviews
	3.b. What opportunities exist to improve efficiency in the healthcare service delivery approach?	Suggestions for workflow or coordination improvements	Examples of adaptive strategies being used locally	interviews; Observations; Validation sessions
Sustainability	4. To what extent are the project's outcomes and service delivery mechanisms likely to be sustained after MSF's exit?	Existence of sustainability planning	Stakeholder confidence in service continuation	Document review; interviews
	4.a. How are sustainability considerations integrated into current project activities, and what challenges or barriers affect this integration?	Level of collaboration with MoHCC and local actors	Inclusion of exit/transition plans in current activities	Project reports; interviews; Observations
	4.b. How have key stakeholders been engaged in the project to date, and what forms of collaboration have emerged?	Evidence of shared responsibilities and information exchange	Perceived value of partnerships; joint activity records	Stakeholder mapping; Meeting notes; Interviews
	4.c What adaptations could strengthen the continuity of health services beyond MSF's direct support?	Ideas from MSF staff, government, and communities	Examples from other contexts or local initiatives	Validation session notes; Key informant interviews; Literature review

ANNEX 2: HEALTH SERVICE INDICATORS

This annex provides a description of the 22 health service indicators included in the quantitative impact analysis. The indicators span across HIV self-testing, STI management, viral load monitoring, cervical cancer screening, and pre-exposure prophylaxis (PrEP) services.

Indicator Name	Description
HIV - Self-test kits distributed (Secondary distribution, excluding for partners) COMMUNITY	HIV self-test kits distributed to the community for secondary use, excluding partner testing.
HIV - Self-test kits distributed (Secondary distribution, for partner) COMMUNITY	HIV self-test kits distributed for partner testing within community-based secondary distribution.
HIV - Self-test kits distributed (excluding for partners, Secondary distribution)	Secondary distribution of self-test kits excluding partner testing, not community-specific.
HIV - Self-test kits distributed (for partner, Secondary distribution)	Self-test kits distributed for partner use through secondary distribution, general population.
HIV - Self-test kits distributed (Primary Distribution) COMMUNITY	Primary community-level distribution of HIV self-test kits.
HIV - Results shared COMMUNITY	Community members who shared their HIV self-test results.
HIV - Self-test kits distributed (Primary Distribution)	General primary distribution of HIV self-test kits.
HIV - Clients with reactive results	Clients who obtained reactive results from HIV self-testing.
HIV - Clients with reactive results COMMUNITY	Community-based clients with reactive HIV self-test results.
HIV - Total reactive tests confirmed HIV positive	Confirmatory testing results verifying HIV-positive diagnosis among reactive cases.
HIV - Total reactive tests confirmed HIV positive COMMUNITY	Community-level confirmatory positive HIV diagnoses.

HIV - PLHIV in care on ART who had a sample collected for Viral Load testing	People living with HIV (PLHIV) on ART with a sample collected for viral load testing.
HIV - PLHIV in care on ART who had high second Viral Load test results >1,000 copies/ml	PLHIV on ART with repeat viral load >1000 copies/ml, suggesting treatment failure.
HIV - PLHIV in care on ART who received Viral Load test results	PLHIV who received viral load results after testing.
HIV - PLHIV in care on ART who received Viral Load test results >1,000 copies/ml	PLHIV who received high viral load results (>1000 copies/ml).
HIV - New STI clients	Number of new clients presenting with sexually transmitted infections (STIs).
HIV - Repeat STI clients	Clients returning for follow-up or recurrent STI management.
HIV - STI clients who were tested for Syphilis	STI clients who received syphilis testing.
HIV - STI clients who tested positive for Syphilis	STI clients with positive syphilis test results.
HIV - STI clients who were treated for Syphilis	Syphilis-positive clients who received appropriate treatment.
HIV - HIV-positive women on ART screened for cervical cancer	HIV-positive women on ART screened for cervical cancer (including first-time and follow-up screenings).
HIV - PrEP indicators (screened, eligible, received, newly enrolled)	Indicators capturing PrEP screening, eligibility, initiation, and ongoing use among clients.

ANNEX 3: DISTANCE TO SITES

The table below outlines the time it takes to get to the site from the MSF office. The highlighted sites are dormant and/or seasonal sites.

Name	Total_TravelTime (Minutes)	Total_Kilometers
Gwanda Office - KOMAHUBA	1.21708443	0.602988018
Gwanda Office - GREENLANDS (KODAYIZA)/IMANI	10.97174192	3.806910758
Gwanda Office - MAPANI	5.758194664	6.472869889
Gwanda Office - BAR 20	5.782949045	6.481122345
Gwanda Office - BENA	11.38017766	7.11978954
Gwanda Office - FM-EZIKWAKWENI	21.24613667	7.1622059
Gwanda Office - DANSLUCK	20.21034652	8.893371156
Gwanda Office - BIG BEN	28.5365382	9.592419325
Gwanda Office - WILLIS MINE	17.15391495	11.03375479
Gwanda Office - UDUBAKITHI	36.02953699	12.89510843
Gwanda Office - VUBACHIKWE	38.14082362	13.59875486
Gwanda Office - DUBANE	12.11763571	15.13766212
Gwanda Office - WHITE MINE	45.10762907	15.92108857
Gwanda Office - SIRKURB(KNOWLEDGE MINE)	13.23957643	16.63358951
Gwanda Office - STOMPY	13.66988684	17.20739577
Gwanda Office - SIGODO	58.70462064	20.58809826
Gwanda Office - VOVA 1	32.47746475	22.26227123

Gwanda Office - VOVA 2	32.47746475	22.26227123
Gwanda Office - KAMELA	69.50045176	24.05153057
Gwanda Office - MAGUNDELA	70.50268147	24.38558118
Gwanda Office - MUTEMA	72.25185669	24.96972679
Gwanda Office - FREDA MINE	72.96421523	25.20705073
Gwanda Office - MAQETHUKANE	74.52057041	25.72594638
Gwanda Office - 5 MINE	78.7693309	27.14225486
Gwanda Office - 3 STAMP	23.09443559	27.24243873
Gwanda Office - MAI ZVENYIKA	30.66071052	28.85096138
Gwanda Office - TSHEBETSHEBE	29.14605482	29.48972129
Gwanda Office - MARVE MINE	25.93128868	32.25871125
Gwanda Office - KOCOSTER	99.5422159	34.06652401
Gwanda Office - GEELONG MINE	33.97458196	34.93971953
Gwanda Office - MAKHAWULAZI	35.77054424	35.53842101
Gwanda Office - NHLANGANO	59.87865809	43.5742962
Gwanda Office - B MINE (EMAYOUTHINI)	35.79547279	45.22956451
Gwanda Office - JAYIVELA	71.31367862	60.82556544
Gwanda Office - ZINDERE MINE	172.6428478	69.33138063
Gwanda Office - TANKWA (FORET BRONCHE)	232.6131877	84.93463976
Gwanda Office - MANDIHONGOLA	232.6131877	84.93463976

ANNEX 4: MSF QUANTITATIVE ANALYSIS

This analysis outlines the impact of MSF's basic health model in Gwanda District, Zimbabwe, on healthcare access and utilization among ASM communities and host populations. The program has successfully delivered 24,814 health services across 39 mining sites, with robust quantitative evidence showing 55-60% relative increases in critical health services at intervention facilities, complemented by overwhelmingly positive beneficiary feedback (75.5% positive sentiment).

Key Achievements

- 24,814 total health services delivered across 39 mining sites
- 77% of health indicators show positive intervention effects
- 55-60% relative increases in critical STI services
- 75.5% positive sentiment in beneficiary feedback
- Comprehensive geographic coverage across Gwanda District
- Successful engagement of both mining workforce and families (41.3% female utilization)

Methodology for quantitative analysis

Data Sources

- MSF Daily utilization data: 3,176 service records across 39 mining sites
- MSF ITS comparative data: 42 facility records (7 intervention + 7 control facilities)
- MSF Beneficiary Feedback: 111 feedback records with sentiment analysis
- Client Satisfaction Survey (CSS 2025): 192 survey responses

Analytical Approaches

- Descriptive analysis of service utilization trends
- Prophet forecasting for 3-month service projections
- Difference-in-Difference analysis across 22 health indicators
- Geospatial analysis with utilization indices
- Sentiment analysis and topic modeling of beneficiary feedback
- Client satisfaction survey analysis

Program scale and reach

Geographic

- reach 39 mining sites across Gwanda District with geographic coverage from 28.73°S to 29.37°S latitude and -21.44°E to -20.82°E longitude.

Service Delivery Volume

- Total health services: 24,814 services delivered over 15 months

- Individual service records: 3,176 documented encounters
- Average monthly services: 1,654 services per month
- Target population: 10,000 individuals associated with ASM and host communities

Demographic Reach

- Male patients: 14,579 services (58.8% of total)
- Female patients: 10,235 services (41.3% of total)

Service Utilization by Age Group

- Adults 25+: 20,889 services (84.2%)
- Youth 15-24: 2,210 services (8.9%)
- Children 0-5: 1,342 services (5.4%)
- Children 6-14: 373 services (1.5%)

Daily utilization trend analysis

Analysis of daily service utilization data reveals consistent service delivery patterns with strong performance across multiple health service categories.

Overall Monthly Service Delivery

Figure 1 shows the monthly distribution of all health services delivered across the 15-month program period. The stacked bar chart demonstrates comprehensive service delivery across nine key health service categories.

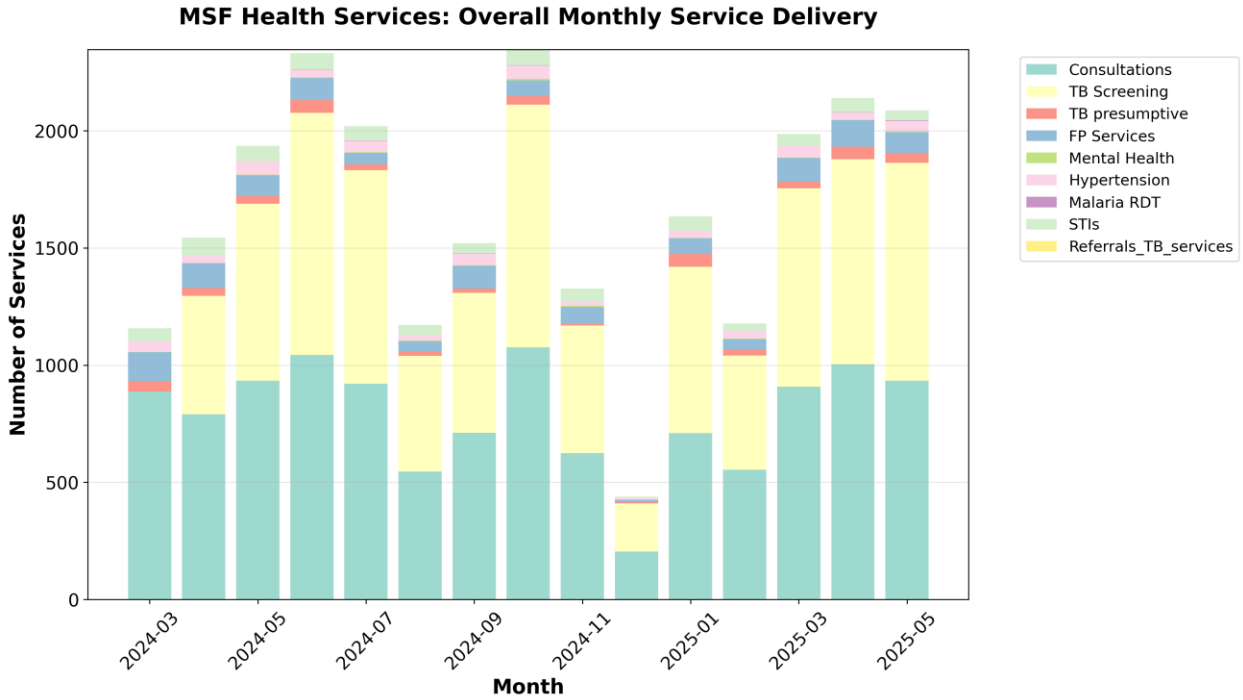

Figure 1 Overall Monthly Service Delivery

Service Delivery by Sex

Figure 2 illustrates the distribution of services by sex, demonstrating successful engagement of both male mining workforce (58.8%) and female family members (41.3%).

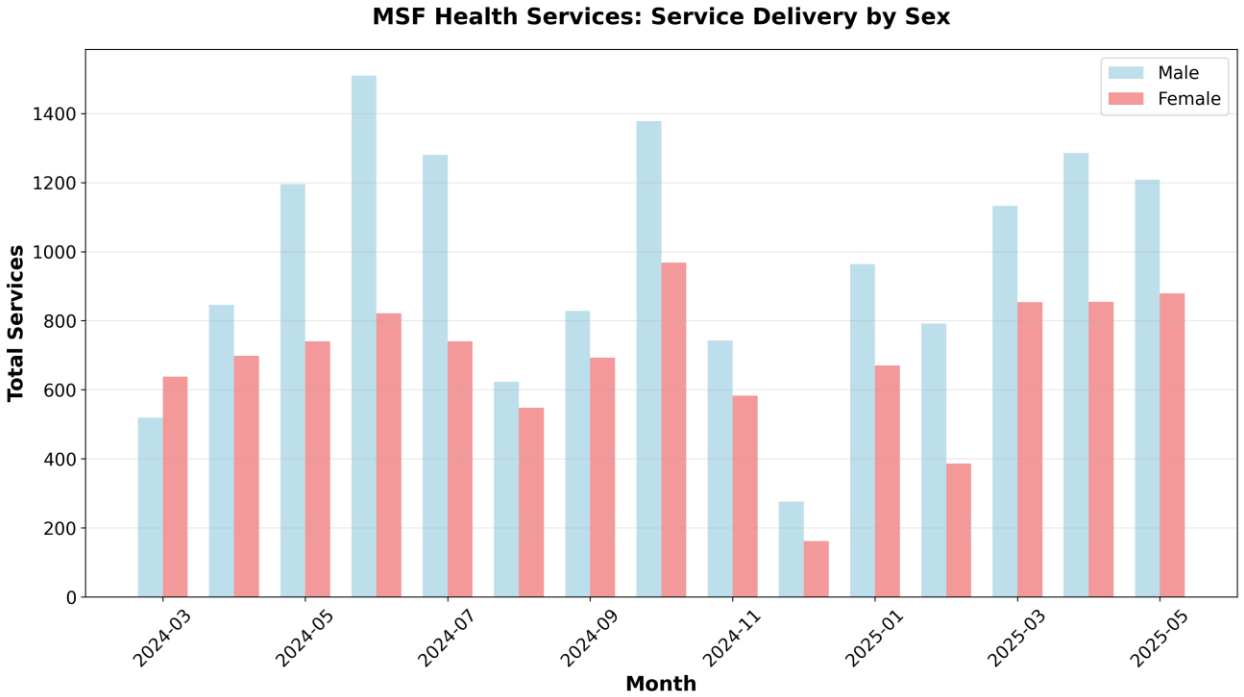

Figure 2: Service Delivery by Sex

Service Delivery by Age Group

Figure 3 shows service utilization across age groups, with adults 25+ comprising the majority (84.2%), reflecting the primary target population of mining workforce, while demonstrating meaningful reach to youth and children.

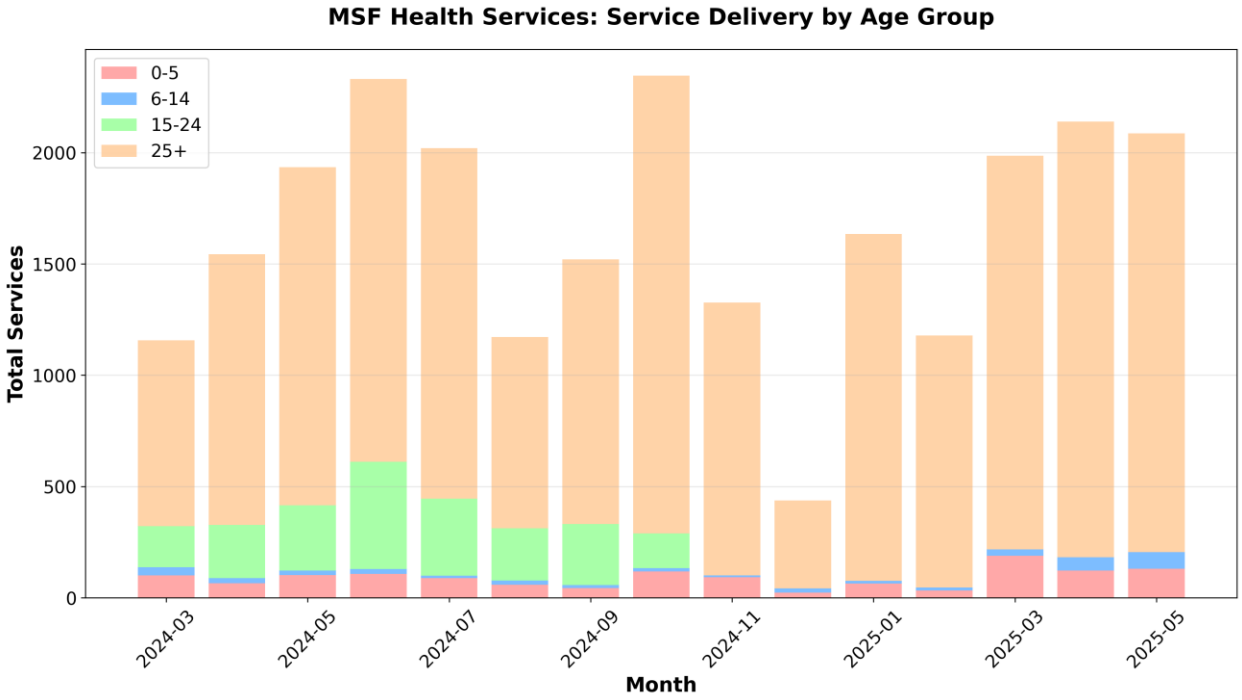

Figure 3: Service Delivery by Age Group

Top Service Indicator Trends

Figure 4 presents the trend lines for the top four service indicators: Consultations (47.7%), TB Screening (40.0%), Family Planning (4.7%), and STI Services (3.2%).

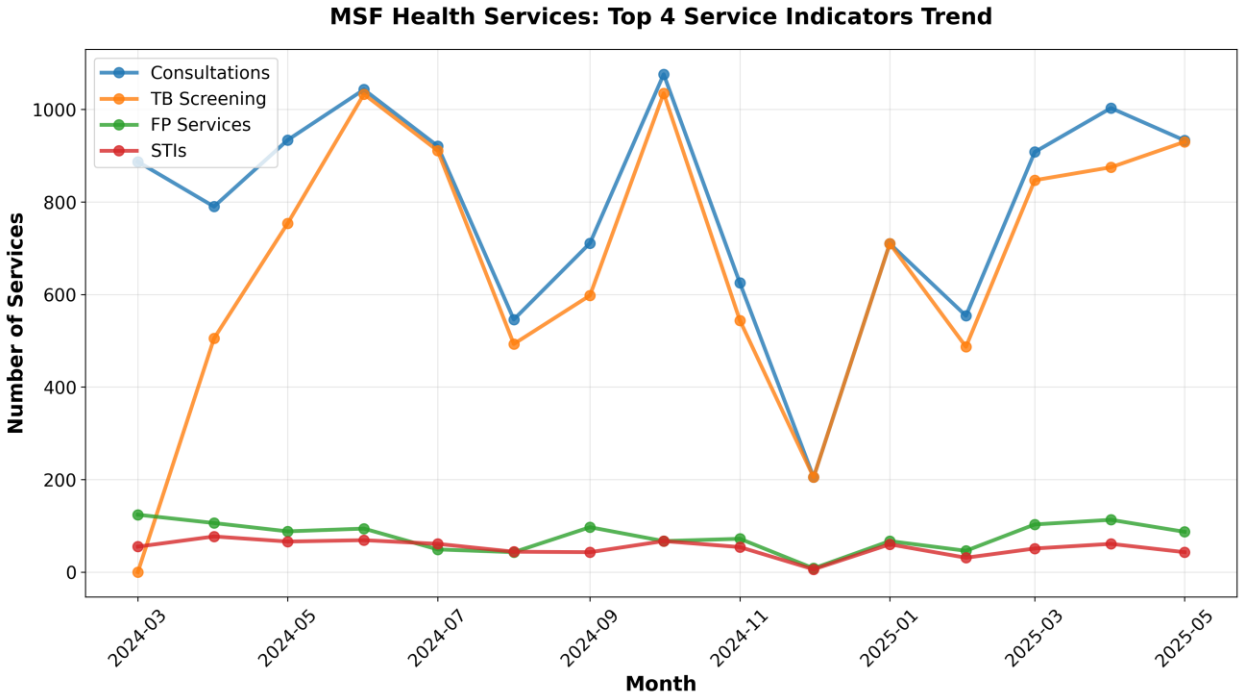

Figure 4: Top 4 Service Indicator Trend

Forecasting Analysis

Prophet forecasting models were applied to project service utilization for the next 3 months (June-August 2025). The analysis reveals mixed projections requiring strategic attention.

Consultation Forecast

Figure 5 shows a slight projected decline in consultations (-5.9%), which is manageable with continued community engagement efforts.

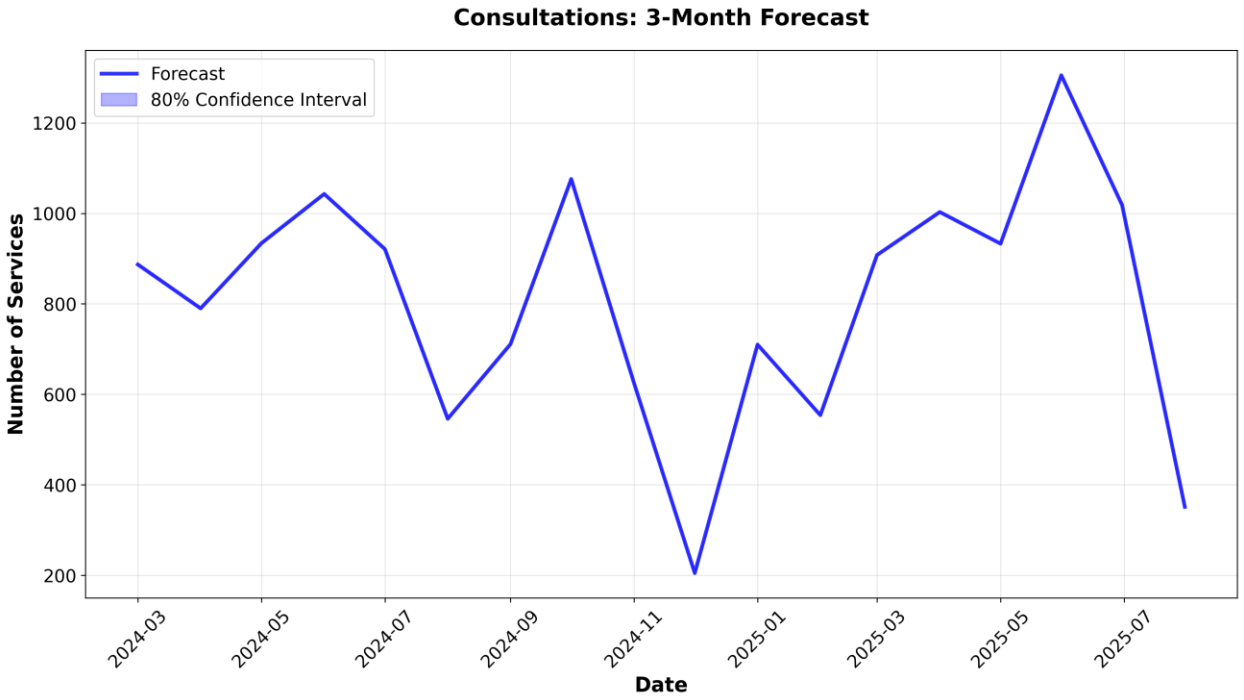

Figure 5: Consultation 3-month forecast

TB Screening Forecast

Figure 6 reveals a concerning projected decline in TB screening services (-56.5%), requiring immediate intervention through enhanced screening campaigns and community education.

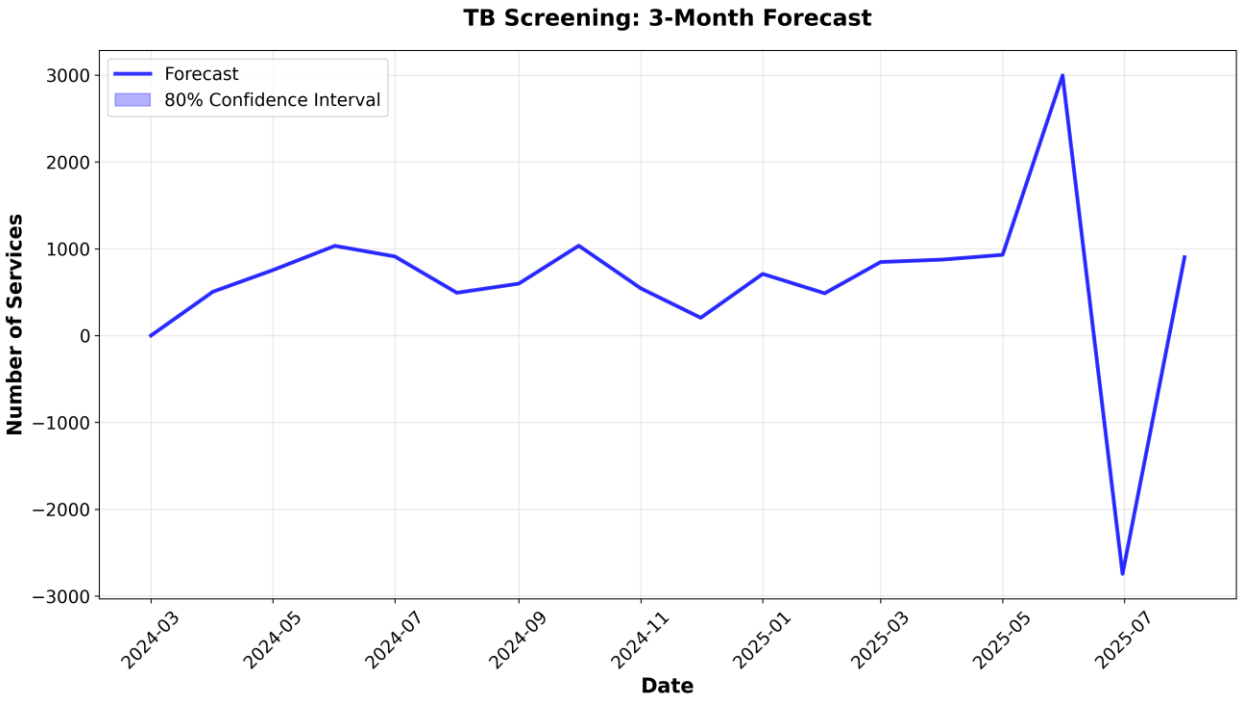

Figure 6: TB Screening 3-month forecast

Family Planning Services Forecast

Figure 7 demonstrates stable growth in family planning services (+4.8%), indicating sustained demand and successful program integration.

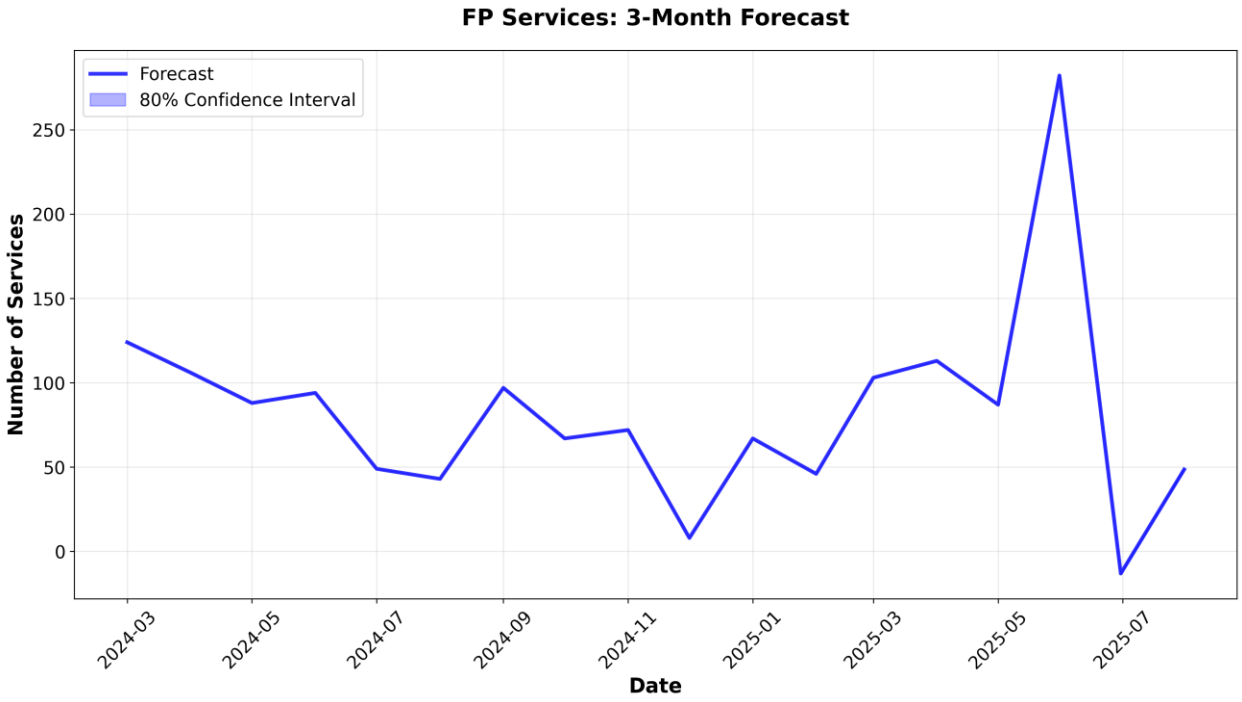

Figure 7: Family Planning Services 3-month forecast

STI Services Forecast

Figure 8 shows modest growth in STI services (+10.6%), reflecting continued community awareness and service uptake.

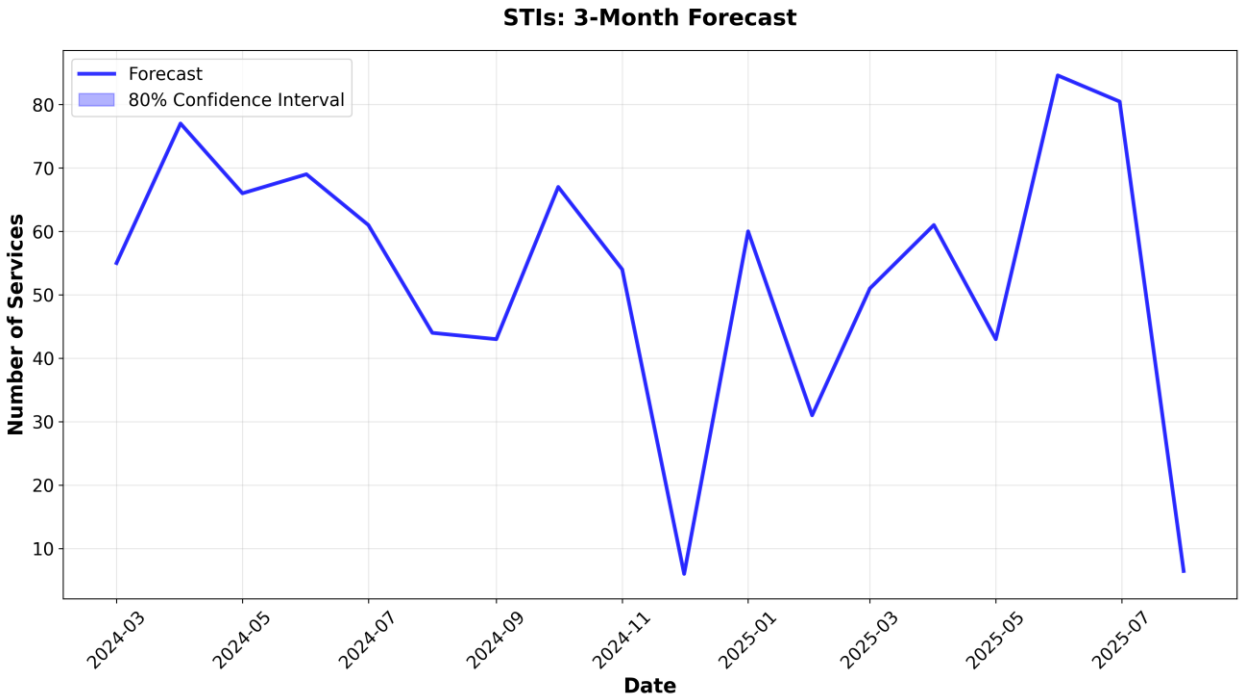

Figure 8 STI Services 3-month forecast

Difference-in-Difference (DiD) Analysis

DiD analysis was conducted across all 22 health service indicators, comparing 7 intervention facilities against 7 control facilities. The intervention start date was January 1, 2024.

Overall Results:

- Total indicators analyzed: 22 health service indicators
- Significant positive effects: 17 indicators (77% of all indicators)
- Significant effects (effect > 1): 13 indicators (59% of all indicators)
- Top 5 Strongest Intervention Effects:
- PrEP Recipients: +23.43 additional per quarter (massive impact)
- Syphilis Testing: +14.61 additional tests per quarter
- New STI Clients: +12.98 additional clients per quarter
- New PrEP Enrollment: +8.05 additional enrollments per quarter
- HIV Self-Test Kits (Primary): +4.46 additional distributions per quarter

Significant DiD Effects

Figure 9 presents all 13 indicators with significant intervention effects (absolute effect > 1). The lollipop chart clearly demonstrates the magnitude and direction of program impact.

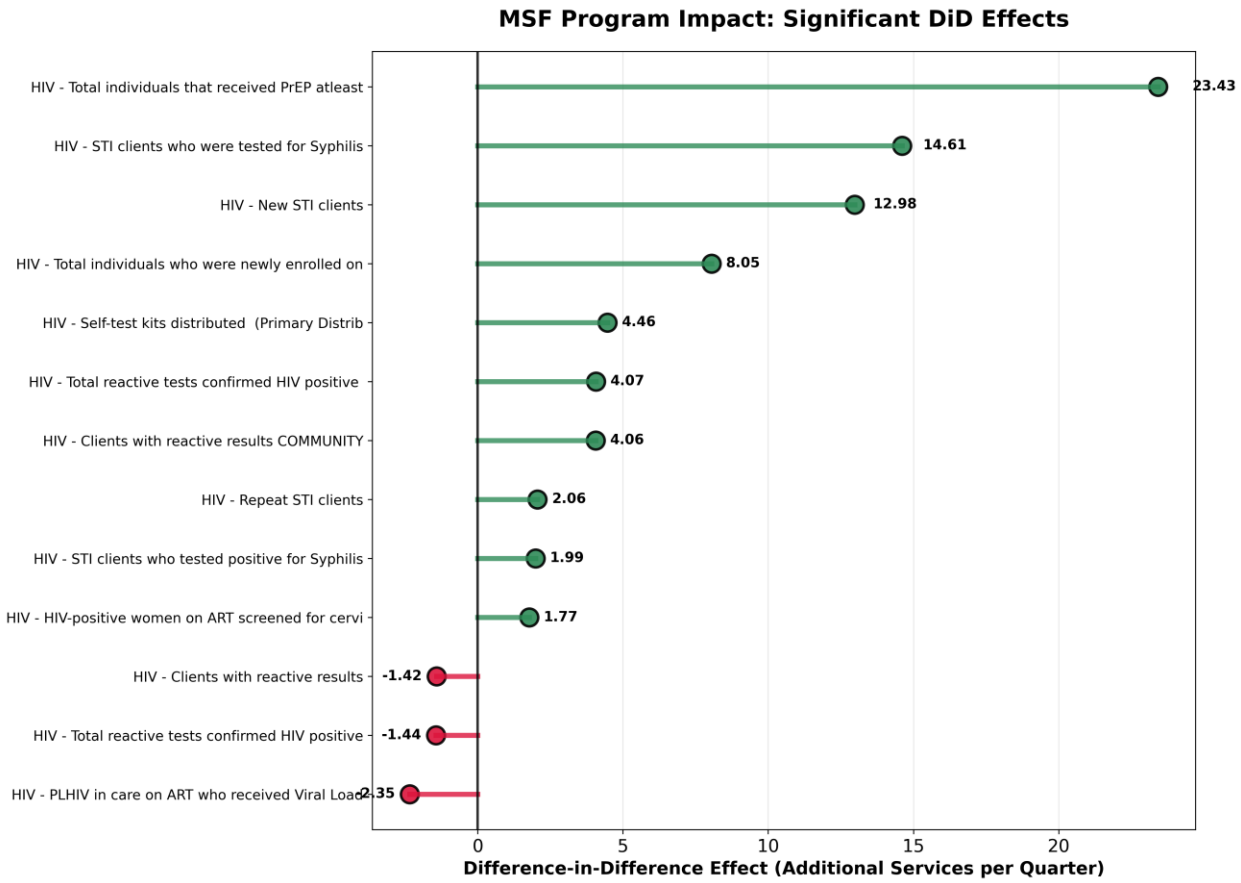

Figure 9: Significant DiD Effects

Top Positive Intervention Effects

Figure 10 highlights the top 10 positive intervention effects, with PrEP services showing exceptional growth (+23.43 recipients, +8.05 new enrolments per quarter).

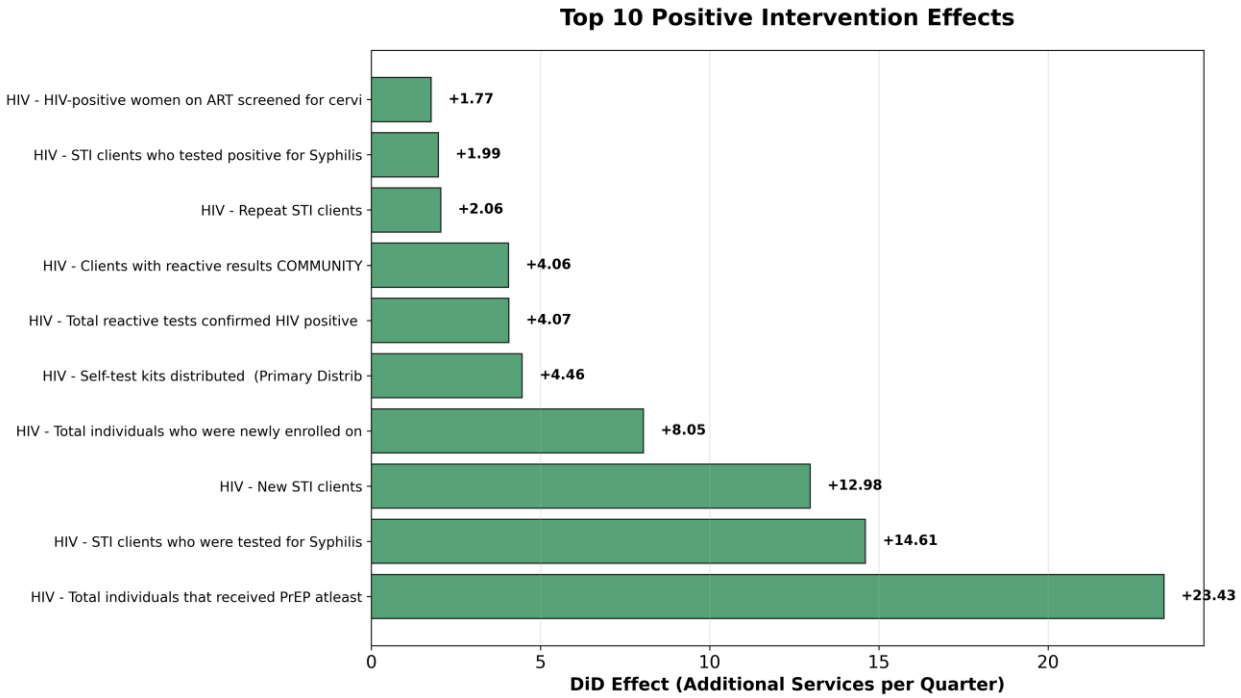

Figure 10: Positive DiD Effects

Geospatial Performance Analysis

Geospatial analysis mapped all 39 mining sites with utilization indices (0-100 scale) to identify performance patterns and optimization opportunities.

Site Performance Distribution

- Utilization index range: 0-100 scale (normalized)
- Average utilization: 33.8 across all sites
- Top performer: GEELONG MINE (100.0 index, 1,842 services)
- Performance quartiles: Clear differentiation enabling targeted improvements

Figure 11 displays the geographic distribution of all mining sites with utilization performance indicated by dot size and colour intensity.

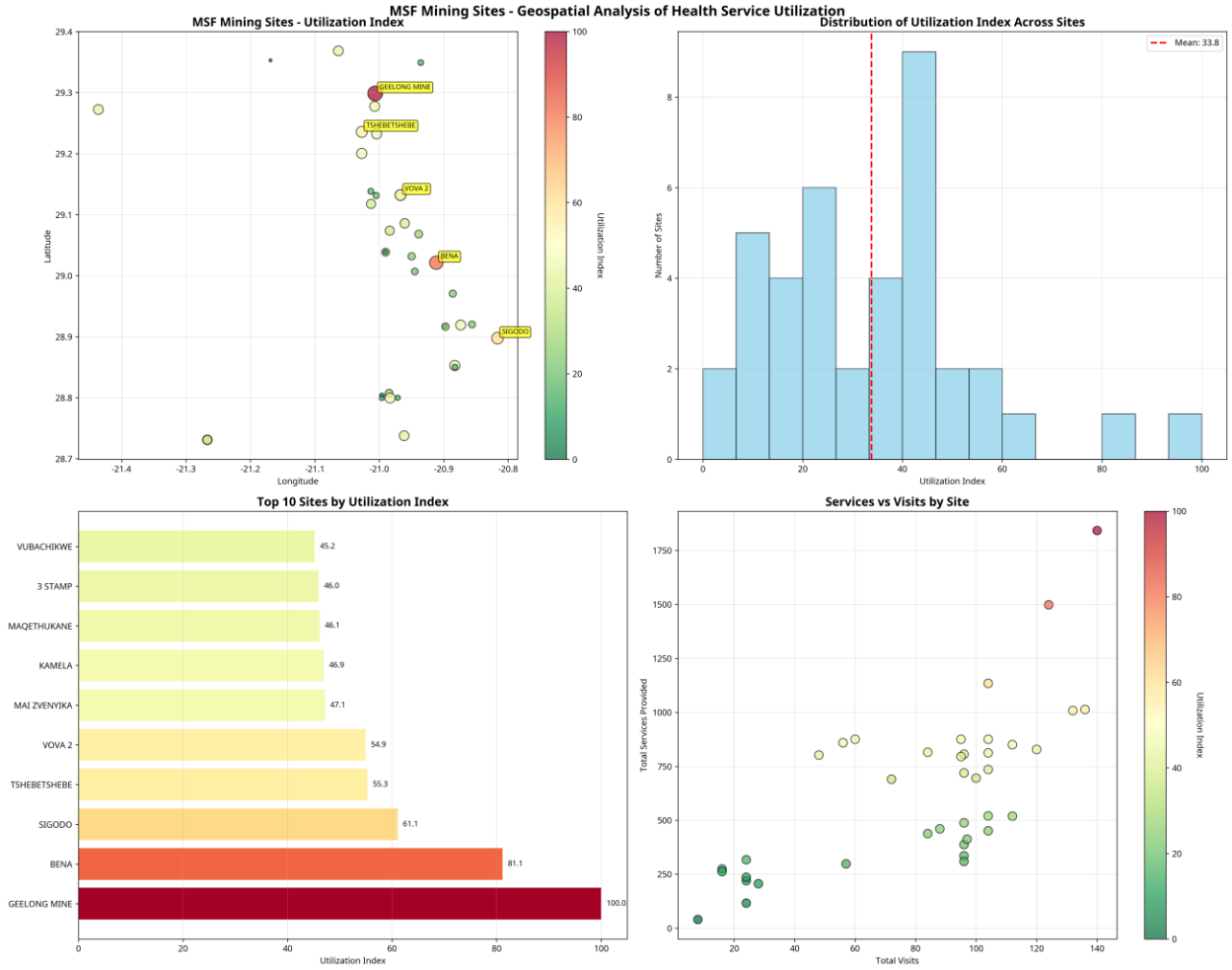

Figure 11: Geospatial Performance Analysis

Beneficiary Feedback Mechanism

Sentiment analysis was conducted on 110 beneficiary feedback records to assess community perceptions and satisfaction with MSF health services.

Overall Sentiment Analysis

Figure 12 shows the distribution of sentiment categories, with 75.5% positive sentiment demonstrating strong community appreciation for MSF services.

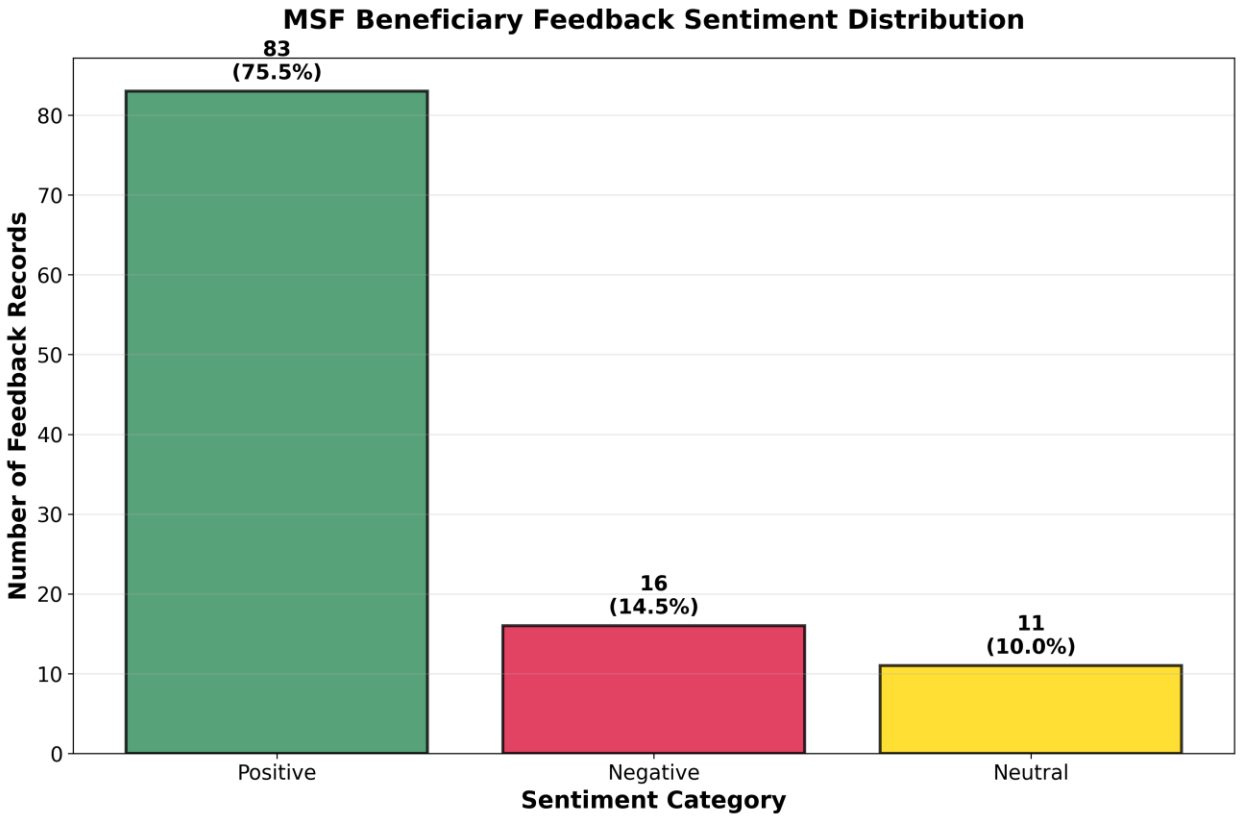

Figure 12: Beneficiary Sentiment Distribution

Feedback by Sources

Figure 13 illustrates the distribution of feedback sources: Artisanal Miners (68.8%), Mine Managers (13.8%), Host Community (12.8%), and Stakeholders (4.6%).

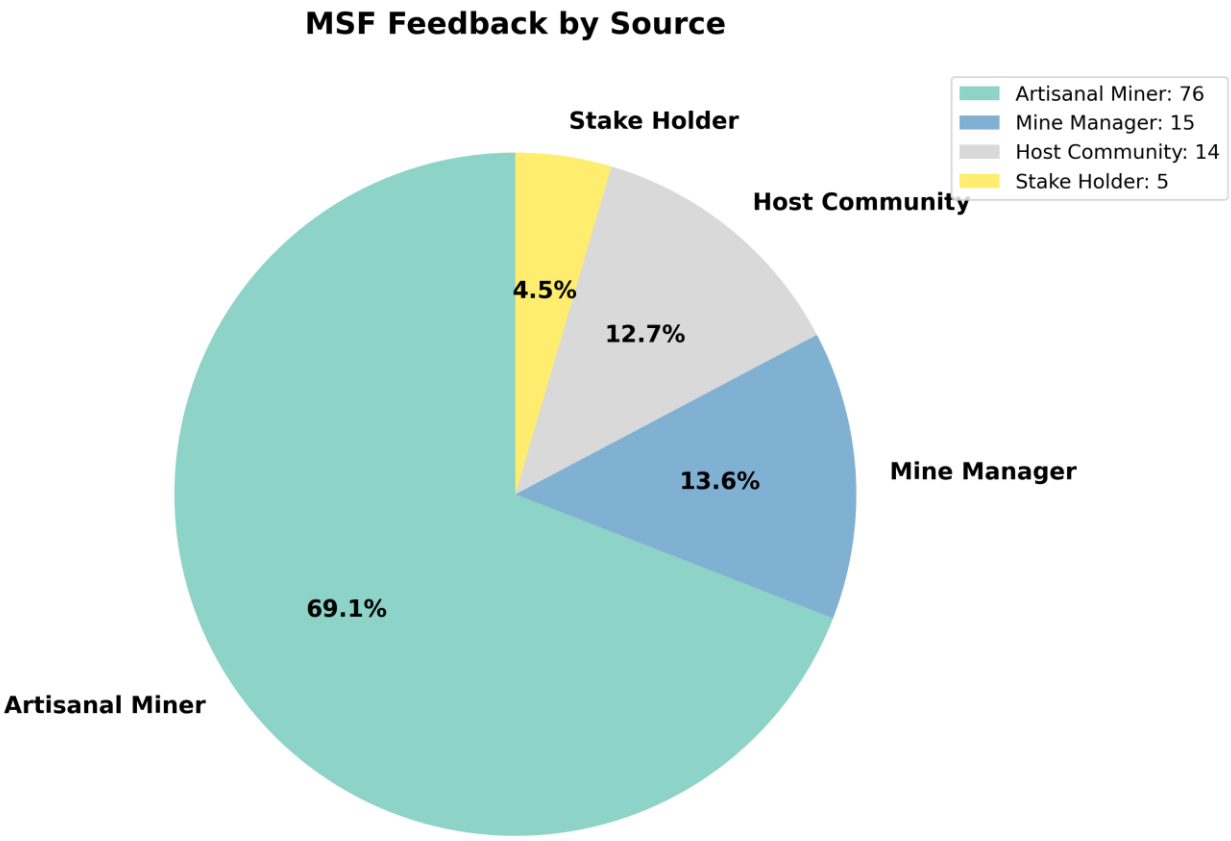

Figure 13: Feedback by Source

Sentiment Score Distribution

Figure 14 presents the distribution of sentiment scores with an average of 0.423, indicating overall positive community sentiment.

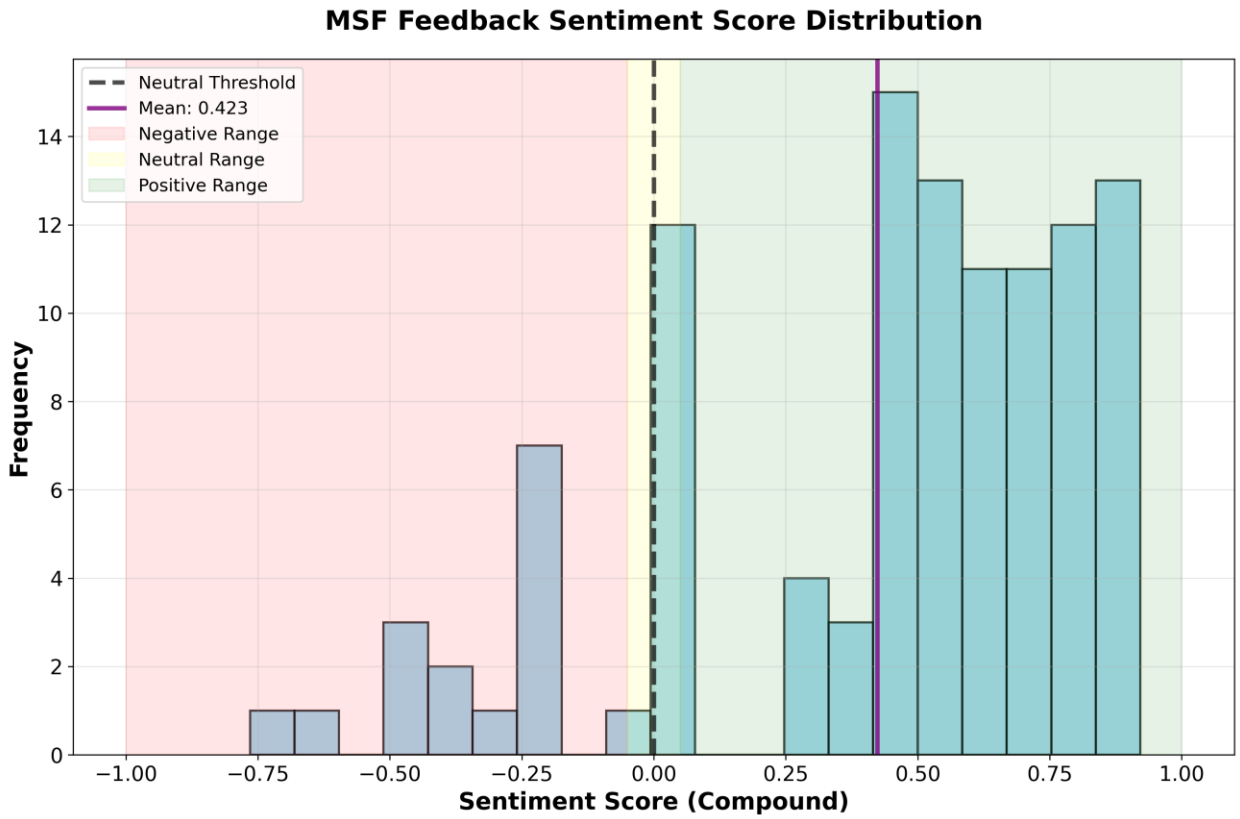

Figure 15: Sentiment Score Distribution

Sentiment by Feedback Source

Figure 16 shows sentiment distribution across different feedback sources, with consistently positive sentiment across all stakeholder groups.

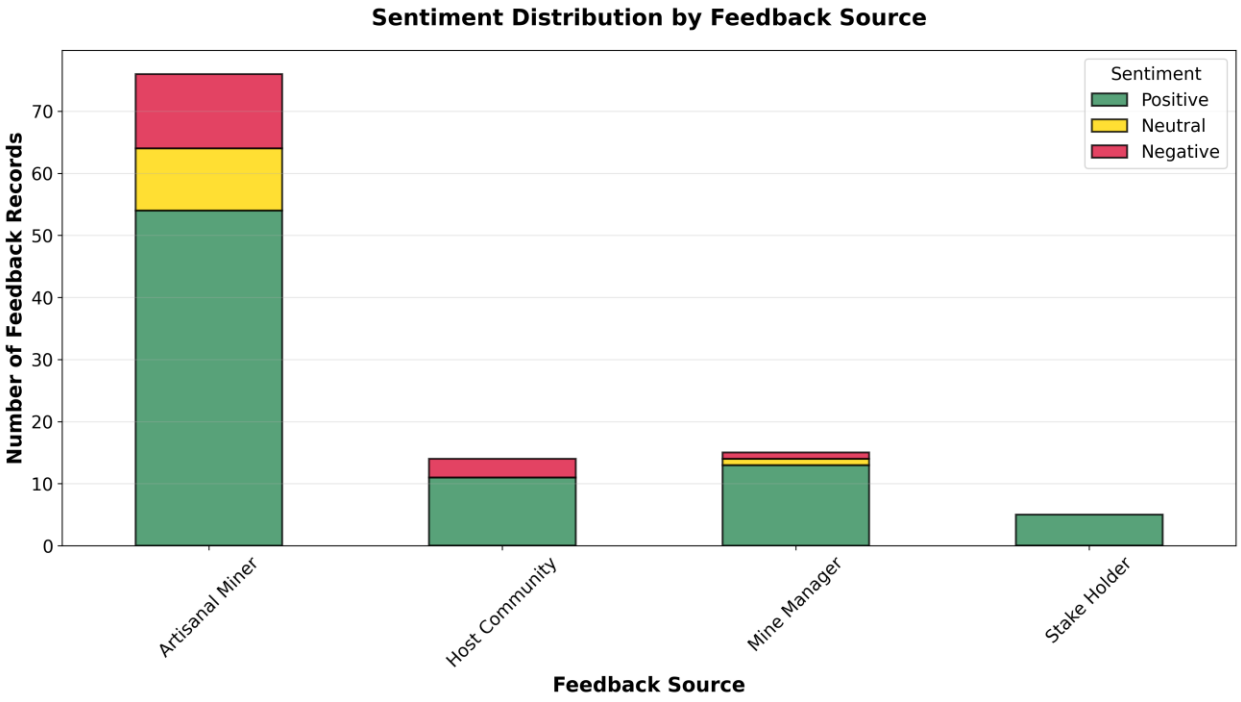

Figure 16: Sentiment by Feedback Score

Key Themes from Beneficiary Feedback

Figure 17 presents a word cloud highlighting the most frequently mentioned terms in beneficiary feedback, revealing key themes and concerns.

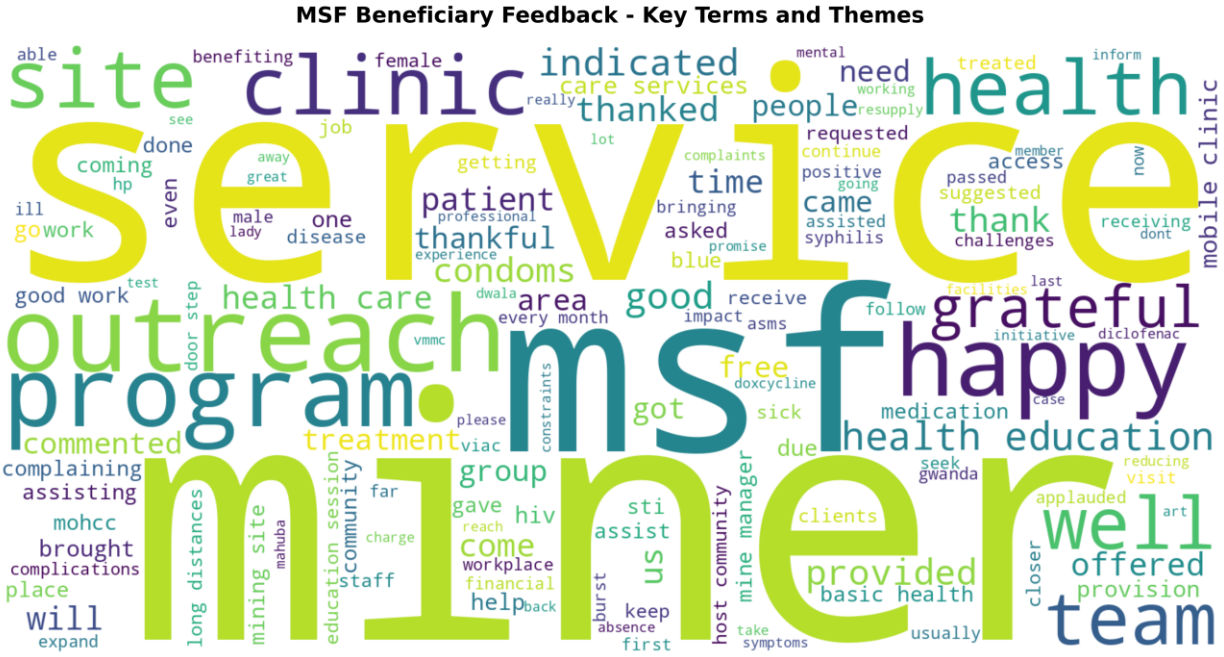

Figure 17: Beneficiary Feedback Word Cloud

Representative Beneficiary Voices

The following quotes from the MSF Beneficiary Feedback Mechanism demonstrate the range of community sentiments regarding the health services provided:

"She is grateful and gave thanks to MSF for the great work in proving basic health care services to the miners."

— Stakeholder from Mining Site (Female)

Sentiment: Positive, Score: 0.922

"There is an STI called blue sick and there is treatment being sold in mining sites (small containers labelled 'blue sick treatment')."

— Artisanal Miner from Mining Site (Male)

Sentiment: Negative, Score: -0.765

"We drink unsafe water thus why we have diarrhea. Management not doing anything for us."

— Artisanal Miner from Community (Male)

Sentiment: Neutral, Score: 0.000

Feedback
Conclusion

ANNEX 5: QUANTITATIVE OUTPUTS INTERPRETATION

Methods Summary

Difference-in-Difference (DiD) Analysis

Purpose: To estimate the causal impact of the MSF intervention on key health service indicators by comparing trends at intervention versus control sites before and after the intervention.

Approach:

- Pre-intervention and post-intervention data were collected from both groups.
- The DiD estimator captures the additional change attributable to the intervention, removing background trends.

Interpretation:

- Positive DiD values indicate that intervention sites experienced greater improvements than control sites.
- Negative values indicate that control sites improved more than intervention sites.
- The magnitude (e.g., +12.98) reflects the additional services per quarter attributable to the intervention.

Disaggregated Trend Analysis

Data were analyzed by:

- Month: To identify seasonality or temporal patterns in service utilization.
- Sex: To examine male versus female service uptake trends.
- Age Groups: Service utilization was stratified by age (e.g., 0–5, 6–14, 15–24, 25+).
- Service Type: Focused on identifying the most utilized services (e.g., TB screening, STI treatment).

What the Outputs Mean

A. DiD Bar Graphs

These show the net effect of the MSF program on service delivery across indicators. For example:

- Syphilis Testing: +14.61 indicates that intervention sites had approximately 15 more tests per quarter than control sites.
- HIV Clients with Reactive Results: −1.42 indicates a relative decline in the outcome at intervention sites.

B. Stacked Bar Charts

These charts display trends in monthly service utilization across multiple indicators, disaggregated by:

- Type of service (e.g., TB screening, family planning)
- Sex (male and female)
- Age group

They reveal seasonal peaks, declines, and demographic shifts in health service uptake.

C. Summary Plots

- Top Panels: Show ranked DiD effects and an overview of all indicators by effect size.
- Bottom Panels: Present a histogram of DiD effects and a summary of their direction.
- 17 indicators showed positive effects.
- 4 indicators showed negative effects.
- 1 indicator showed no measurable effect.

Conclusion

The methods applied provide a robust evaluation of the MSF program's effect on health service delivery. The DiD methodology helps isolate the intervention's impact from background changes, and the disaggregated analyses offer practical insights for planning and improving service delivery.

ANNEX 6: DATA COLLECTION TOOLS

This section outlines the data collection tools that will be used in the evaluation. All tools are aligned with the four overarching evaluation questions and are designed to capture diverse perspectives across stakeholder groups. In addition, they are mapped to the project's seven expected results, such as access to basic and occupational health services, strengthened health promotion, environmental health, community engagement, and advocacy. This dual alignment ensures the evaluation can speak meaningfully to both MSF's core learning needs and the intended results of the intervention.

To support inclusive and meaningful participation, each tool uses a narrative-based, open-ended format that avoids technical or formal language. This approach encourages openness, reduces the risk of leading responses, and creates space for participants to share experience-based insights in their own words. Interview guides are tailored to each stakeholder group based on their role and connection to the project. The tools are also iterative and adaptive: questions may be added, adjusted, or skipped during data collection to reflect emerging themes, respondent comfort, and contextual relevance. Not all questions will be used in every interview. Consent forms are included in Annex 4.

INTERVIEW GUIDE: MSF STAFF

Section 1: Role and Involvement

1. Can you tell us about your role in the GWANDA project and how long you've been involved?
2. What are your main responsibilities within the project?

Section 2: Project Relevance and Design

3. From your perspective, how well do the project activities (like mobile clinics, outreach, health promotion) meet the needs and realities of artisanal miners, sex workers, and host communities?
4. Are there any parts that feel like they don't quite fit or need adjustment?
5. Have any activities or strategies been adapted to better fit the context since the project began? Can you give an example?
6. How do people in the community respond to the services? Are there any barriers or enablers to access?
7. How was the collaboration between health service providers, mining associations, community leaders, and other stakeholders conceptualised in this model?

Section 3: Implementation and Results

8. Looking back over the last year or so, what parts of the project seem to be making the biggest difference on the ground?

9. Have there been any challenges or surprises that shaped the way the team works or how they implement activities, even small ones?

10. Have there been moments when the team had to shift plans or do things differently than expected? What led to those changes?

Section 4: Service Delivery Model

11. When you think about a typical clinic day or outreach visit, where do things usually run smoothly, and where do you find yourselves stretched or under pressure?

12. If the team had a bit more room to breathe, more time, more hands, or more flexibility, what would you improve?

Section 5: Community Engagement and Collaboration

13. Who have been the most helpful people or groups outside of MSF in getting the work done? What kind of support have they offered?

14. How have you engaged with local stakeholders like the Ministry of Health, CBOs, mining associations or traditional leaders?

15. Have there been challenges in working with local actors, partners, leaders, or communities?

Section 6: Emergency Response and Coordination

16. Were there any emergency events during the project (e.g., outbreaks, flooding)? How did MSF respond?

17. How does MSF coordinate with MoHCC or others during emergencies?

Section 7: Sustainability and Continuity

18. If MSF were to slowly step back, what parts of the project do you think would keep going? And what might fall through the cracks?

19. What would need to be in place to make sure target groups still get the support they need if MSF is no longer here?

20. What risks do you see to the long-term sustainability of the project's outcomes?

21. What steps are being taken (if any) to ensure that services or benefits from the project continue after MSF leaves?

Section 8: Looking Ahead

22. When you think about what you've learned from this project so far, what stands out, maybe something you'd keep in mind for future work?
23. If you could tweak one thing to make the work easier or more impactful, what would you change?
24. Are there any additional comments, recommendations, or reflections you'd like to share?

Additional Questions for Specific Stakeholders on Coordination and Policy

Policy Alignment and Influence

25. From your perspective, has the project aimed to support or influence any national or district-level health policies, strategies, or guidelines? If so, how?

Collaboration with Health Authorities

26. What kinds of formal or informal engagement have taken place between MSF and the government actors?

Emergency Readiness and Coordination

27. Were any preparedness or response mechanisms in place for emergencies like outbreaks or floods? How did MSF coordinate with others for these?

Potential for Uptake by Others

28. Are there aspects of the project you think MoHCC, or other partners might be interested in adopting or adapting?

INTERVIEW GUIDE - MOHCC STAFF

Section 1: Role and Collaboration

1. Can you tell us a bit about your current role and how you've interacted with the MSF Gwanda project?
2. What kinds of collaboration have taken place between the Ministry and MSF on this project, whether formal or informal?
3. Have there been any challenges or misunderstandings along the way?

Section 2: Relevance and Fit with Health System

4. From what you've seen or heard, does this project respond to health concerns that are important for the communities it targets?
5. How well does the project fit with the Ministry's priorities or strategies, especially in hard-to-reach or informal areas like mining zones?
6. Are there any gaps in services for these populations that the project is helping to address?

Section 3: Implementation and Delivery Approach

7. What stands out to you about how MSF has gone about delivering services through this project, including mobile clinics, outreach, environmental health, WASH?
8. Are there parts of this delivery model that you think work particularly well? Are there any aspects that seem difficult to maintain or expand?
9. Have you observed any challenges, gaps, or unintended effects in how the project has been delivered, especially for people who move around a lot, like those working in ASM?
10. In your view, how does this approach compare with other efforts you've seen to reach underserved populations?
11. Can you tell us about any emergency planning or response work MSF has been involved in within this province or district?
12. In what ways, if any, does MSF engage in emergency preparedness or coordination efforts, such as contributing to trainings, supplying materials, or developing protocols?
13. What role does MSF play when unexpected health events happen, like disease outbreaks or extreme weather?

Section 4: Integration and Sustainability

14. Are there any parts of the project that already connect well with government systems or that could be picked up by public services in the future?
15. What kind of support or coordination would make it easier for government services to carry on parts of this work, if MSF were to leave?
16. Have there been moments where it was difficult to align the project with national or local systems, for example, because of staffing, planning, or other constraints?
17. Are there things that have made it harder for the Ministry to be more involved or to benefit more fully from the project?

Section 5: Influence and Learning

18. Has the project helped raise awareness or shift conversations around occupational health or mobile service delivery in any way?
19. Have there been any learnings or tools from the project that others in the health system have shown interest in?
20. Are there ways you think MSF could contribute more to informing national practice or policy?

Section 6: Final Reflections

21. If a similar project were to be designed in another district or context, what would you recommend keeping or changing?
22. Is there anything else you'd like to share about your experience with the Gwanda project?

Section 7: Knowledge Product

23. We'd like to make sure the evaluation findings are useful to you in practice. If we were to create a short knowledge product or summary from the evaluation, what format or content would actually be helpful for you or your team? What would you find most useful to see, share, or act on? Are there specific topics or findings you would want to see? Probe:
    a. "Would that be something visual like a one-pager, infographic, or presentation slide?"
    b. "Would you want findings broken down by theme, by group, or by what's working/not working?"
    c. "Who on your team would actually use this, and for what?"

INTERVIEW GUIDE - CBOS

Section 1: Role and Involvement

1. Can you tell us a bit about your organization and what kind of work you do in this community?
2. How have you been involved with the Gwanda project, whether formally or informally?
3. What kind of relationship or communication has there been between your organization and MSF?

Section 2: Community Needs and Project Relevance

4. What health issues do people in this community worry about the most?
5. Have you noticed whether the project is reaching the people who need the services the most?
6. From what you've seen or heard, do the services MSF provides match what people actually need?

Section 3: Accessibility and Community Experience

7. Are there groups or individuals who seem more comfortable using the services? Who might be left out?
8. What have you heard from community members about their experiences with the mobile clinics, health promotion, or outreach?
9. What helps people access these services? What makes it harder?

Section 4: Collaboration and Local Dynamics

10. Have there been opportunities for local organizations like yours to give input or help shape how the project is delivered?
11. What kinds of partnerships or coordination have been useful between MSF and other groups in the community?
12. Are there ways this collaboration could be improved?

Section 5: Changes and Results

13. Have you noticed any changes in the community since the project began around health, awareness, or behaviour?
14. Are there any stories or examples that stand out to you?
15. Are there things that still feel like they're missing?

Section 6: Looking Ahead

16. What do you think would help make this kind of project last, even if MSF steps back?
17. Are there people, groups, or systems that could continue some parts of this work in the future?
18. What support would be needed to make that happen?

Section 7: Final Thoughts

19. If this project were to be started again, here or in a different area, what would you suggest doing differently?
20. Which aspects of the model (e.g., mobile clinics, outreach strategies) do you regard as the most impactful?
21. Is there anything else you'd like to share about your experience or what you've observed?

Section 8: Knowledge Product

22. We'd like to make sure the evaluation findings are useful to you in practice. If we were to create a short knowledge product or summary from the evaluation, what format or content would actually be helpful for you or your team? What would you find most useful to see, share, or act on? Are there specific topics or findings you would want to see?

Probe:

a. "Would that be something visual like a one-pager, infographic, or presentation slide?"
b. "Would you want findings broken down by theme, by group, or by what's working/not working?"
c. "Who on your team would actually use this, and for what?"

INTERVIEW GUIDE - ASM/SEX WORKERS/HOST COMMUNITIES[14]

Section 1: General Context

1. What kind of health problems do people around here often complain about either at home, at work, or from the environment? [Probe: Is it the water? The dust? The work?; Who gets sick most, children, men, women?]
2. Do you think mining work affects people's health? In what ways? (wait for their answer, if silence give them examples like breathing problems, chest pain, or contact with chemicals or dust?)
3. Where do people usually go when they are sick or need health advice?
4. Do people in this area have access to clean water for drinking and washing? Probe if needed: Where do most people get their water from?
5. What happens with waste, like garbage or dirty water? Is it managed in a safe way?
6. Do you think working or living near mining sites affects the environment, like air, water, or soil? Probe if needed: Have you noticed anything changing, like bad smells, dirty rivers, or sickness caused by the work?

Section 2: Service Awareness

7. Have you heard of mobile clinics or outreach activities in this area? (Probe to confirm whether these are MSF or from other partners)

*Based on the answer to this question, follow **Path A** if the person has used MSF services, or **Path B** if they have not.*

Path A – For Participants Who Have Used MSF Services

8. Have you used any MSF services? If yes, what kind of services have you used?
9. What types of health services do you know are offered (wait for an answer, if silence give them the example of TB screening, family planning, HIV testing, or child immunizations)
10. Can you tell us about your experience? What went well and what could be better?

[14] To ensure accessibility, data collectors will provide real-time translation of the interview guide into Shona or Ndebele, based on participants' language preferences and comfort.

11. Have you noticed any changes in your health or well-being since using these services?
12. From what you have seen, are there people in your community who still struggle to access the health services offered by these clinics?

Path B – For Participants Who Have Not Used MSF Services

13. Have you ever thought about using the MSF services? If not, what has stopped you?
14. What would make you more likely to use these services in the future?

Section 3: Feedback and Preferences

15. Do you feel there is any specific service introduced by the project that filled a longstanding gap?
16. What other kinds of health services do you wish were offered here?
17. Do you feel the service locations and hours are convenient for you and others?
18. If someone moves to a new site or changes jobs, what will make it easier for them to keep getting health care?

Section 4: Community Perceptions and Influence

19. What do people in your community think about MSF and its services?
20. Do community leaders or others play a role in encouraging or discouraging people from using MSF services?

Section 5: Participatory Activities

Battery Activity[15]

Now that we've talked about your experiences, we'd like to ask a few quick questions using this battery drawing. A full battery means there's been a lot of change. An empty battery means nothing has changed. You can point to the picture to tell us how charged you feel the battery is for each area.

Battery Themes (choose 2–3 based on context):

- Getting health care when you need it

[15] The battery technique is a participatory visual tool that asks participants to show how "charged" (or depleted) they feel about specific aspects of change. Participants will be given drawings of batteries at different charge levels (0%, 25%, 50%, 75%, 100%) and will be asked to pick a drawing to answer each question.

    - Think about before the project and now, how easy is it to get help when you're sick or need a check-up?
- Feeling safe and respected when using services
    - When you go to the clinic or speak to health workers, do you feel treated with respect?
- Knowing more about health issues like HIV, TB, or silicosis
    - Has what you know about these issues changed? How full is your battery for new knowledge?
    - Do you feel you've learned more about your health and options compared to before?
- Confidence that these services will still be available in the future
    - If MSF were to stop working here, how likely is it that you'd still have access to good care?

Facilitator prompts for each theme:

- How full is your battery when it comes to [theme]?
    - E.g. How full is your battery when it comes to getting help for health problems caused by mining work, like lung issues or exposure to chemicals
- Why do you feel that way?
- Has this changed for you since the project started?

Most Significant Change

Now we'd like to ask you to think about one story. Since MSF started working here, what's the most important change you've seen, either in your own life or in your community?

- What happened?
- Who was involved?
- Why is this change important to you?

Follow-up prompts (if needed):

- Was this something you expected or unexpected?
- Has it affected the way you think about health or services?
- What made this change possible?

Section 6: Closing Reflections

21. Have you noticed any changes in your own health or in your community since MSF started working here?
22. If this project were to continue or expand, what would you like it to focus on?
23. Is there anything else you want to share, something we didn't ask but you think is important?

INTERVIEW GUIDE - MSF HEALTH WORKERS

Section 1: Your Role and Work Environment

1. Can you tell us a bit about your role in the project and the kinds of tasks you do day to day?
2. What does a typical clinic day or outreach visit look like for you and your team?
3. Are there particular parts of the work that tend to take more time or energy than others?

Section 2: Reaching the Community

4. From what you've observed, who seems to make the most use of the services? Are there groups you don't see as often?
5. What are some of the reasons people choose to come or not come to the clinic or outreach services? Why are some sites low engagement?
6. Have you had to adapt the way you do things to better fit the needs of certain groups?

Section 3: Working Conditions and Support

7. What kinds of tools, supplies, or training have been most helpful to you in doing your job?
8. Are there areas where you or your team feel like you could use more support?
9. Have there been moments where things felt especially hard to manage or deliver?

Section 4: Perceptions of Change and Results

10. Have you noticed any changes in the community or among service users since the project began?
11. Are there any moments or stories that made you feel the project is making a difference?
12. Have there been any unexpected results, things that surprised you?

Section 5: Observations About Health and the Environment

13. We're also interested in how people's health might be affected by their environment, especially in mining areas.
14. Have you noticed any health issues among patients that seem linked to the environment, like unclean water, poor sanitation, or chemical exposure from mining?
15. Do you talk with patients about how to protect themselves from these risks, like using clean water, staying safe near mining sites, or handling chemicals?

16. Are there any MSF services or education efforts related to environmental health that you're involved in? Probe: This might include clean water, hygiene, or safe waste practices.

Section 6: Collaboration and Communication

17. How do you usually communicate or coordinate with other health workers, community actors, or MSF teams?
18. What helps make that coordination go smoothly? What sometimes gets in the way?

Section 6: Looking Ahead

19. If MSF were to step back in the future, what parts of the project do you think could continue? What might be harder to keep going?
20. What would help make your work more sustainable in the long run, for you and for the people you serve?
21. Is there anything about the model (mobile clinics, outreach, health promotion) that you think others could learn from?

Section 7: Final Reflections

22. If you could change one thing to make the work easier or more effective, what would it be?
23. Is there anything else you think we should understand about your role, the project, or the community?
24. Are there any additional comments, recommendations, or reflections you'd like to share?

INTERVIEW GUIDE - TRADITIONAL LEADERS AND MINING ASSOCIATION REPRESENTATIVES

Section 1: Community Context and Health Needs

1. What kinds of health problems are most common among miners or people living in this area?
2. In the past, where would people usually go if they were sick or needed medical care?
3. Have you noticed any groups in the community who tend to face more difficulty getting health care?

Section 2: Experience with the Project

4. When the MSF team first arrived in this area, how did people respond to their presence and services?
5. How have people's views about the mobile clinics or health promotion work changed over time, if at all?
6. What do people come to you with, either concerns or compliments, about the project?

Section 3: Inclusion and Access

7. Are there any groups that tend to use the services more often? Are there others who stay away or hesitate?
8. From what you've seen, are services being offered in a way that makes it easy for most people to attend?
9. What do you think helps people feel comfortable using these services? What might be holding others back?

Section 4: Collaboration and Local Role

10. Has your role as a leader or representative involved working with MSF in any way, such as helping with outreach, problem-solving, or connecting them to others?
11. Have you seen any benefits (or challenges) to having MSF work alongside local actors or organizations?
12. Are there ways your leadership or association has been involved in helping the project run smoothly?

Section 5: Changes and Impact

13. Have you noticed any changes in the health or behaviour of community members since this project started? If so, can you give some examples?
14. Are there things that people now talk about more, for example, TB, HIV, mining-related illnesses, or mental health? If so, can you give some examples?
15. Can you think of any specific stories or examples that show how the project has affected individuals or the community?

Section 6: Future Outlook and Sustainability

16. If MSF were to leave one day, what do you think would happen to the services they're providing?
17. Are there parts of this project that you think local leaders, communities, or the government could take on?
18. What kind of support or preparation would help to make that possible?

Section 7: Reflections and Suggestions

19. If a similar project was going to start in another mining area, what would you suggest they do the same, or differently?
20. Is there anything else you'd like to share about your experience with this project, or what the community still needs?

For Mining Association

Section 8: Knowledge Product

21. We'd like to make sure the evaluation findings are useful to you in practice. If we were to create a short knowledge product or summary from the evaluation, what format or content would actually be helpful for you or your team? What would you find most useful to see, share, or act on? Are there specific topics or findings you would want to see?

Probe:

a. "Would that be something visual like a one-pager, infographic, or presentation slide?"

b. "Would you want findings broken down by theme, by group, or by what's working/not working?"

c. "Who on your team would actually use this, and for what?"

INTERVIEW GUIDE: MSF ADVOCACY, OPERATIONAL RESEARCH, AND REGIONAL FOCAL POINTS

Section 1: Your Role and Link to the Project

1. Can you tell us a bit about your role and how it connects to the Gwanda project, even indirectly?
2. What types of involvement, input, or updates have you had related to the project over time?

Section 2: Relevance and Strategic Fit

3. From your perspective, how does this project align with MSF's broader strategy, whether regionally or thematically?
4. Are there aspects of Gwanda that you think stand out as particularly relevant or timely, given MSF's work with mobile or hard-to-reach populations?
5. Have there been discussions about how insights from this project might apply to other contexts?

Section 3: Research and Learning

6. Have any findings, case studies, or learning moments from Gwanda been shared or used beyond the project team?
7. Are there elements of the project that you think offer lessons for how MSF approaches operational research or advocacy?
8. What makes it easier (or harder) for learning from a field project like this to be picked up by others in the movement?

Section 4: Advocacy and Policy Influence

9. Has the project contributed, directly or indirectly, to broader conversations on occupational health, mobile health, or community-based care?
10. Have there been opportunities to connect project-level insights to national, regional, or global policy spaces?
11. Are there ways MSF could more intentionally use its experience from this project to inform policy or public debate?

Section 5: Challenges and Opportunities

12. Are there any challenges you've noticed in how projects like Gwanda connect upward to advocacy or organizational learning spaces?

13. What would help bridge the gap between implementation and influence, whether through documentation, timing, or internal processes?
14. If MSF wanted to get more value out of projects like Gwanda at the strategic level, what might that look like?

Section 6: Final Reflections

15. What, if anything, has surprised you about this project?
16. Are there any final thoughts you'd like to share about how Gwanda connects to MSF's learning, policy, or regional efforts?

DEBRIEF GUIDE: HEALTH PROMOTION - SERVICE USERS

Section 1: Understanding and Clarity

1. What part of today's session stood out to you the most?
2. Was there anything that felt confusing or hard to follow?

Section 2: Relevance of the Messages

3. Do you feel like the session talked about issues that matter to you or people around you?
4. Was anything shared today that felt especially useful or new?

Section 3: Communication Style

5. How did you feel about the way the information was shared, the tone, examples, or how the facilitator spoke?
6. Was it easy to ask questions or speak up if you wanted to?

Section 4: Accessibility and Inclusion

7. Did you feel the session spoke to people like you and your situation?
8. Is there anything that could be done to make these sessions more welcoming or comfortable for others?

Section 5: Suggestions

9. Is there something you wish had been included in the session that wasn't?
10. What would make sessions like this even better?

OBSERVATION GUIDE: CLINIC AND OUTREACH ACTIVITIES

ACCESSIBILITY AND ENTRY INTO SERVICES

No	Indicator	Yes	No	Comments
1	Are the clinic and outreach spaces easy to find and physically accessible?			
2	Are there signs or people helping to direct clients?			
3	Are there long wait times, and how are they managed?			
4	Do people from different groups (e.g. miners, women, youth, sex workers) appear to access services comfortably?			
5	Are clinic hours adapted to local needs (e.g. early morning, late afternoon)?			
6	Is the outreach site located within easy reach of the communities it's meant to serve?			

Notes to capture:

- Location setup, visible barriers, group dynamics, wait time estimates, flexibility of hours

PATIENT FLOW AND ORGANIZATION

No	Indicator	Yes	No	Comments
1	Is there a clear and smooth flow from arrival to departure?			
2	Are patients being registered, triaged, seen by staff, and referred in an organized way?			
3	Is there crowding or confusion at any points?			
4	Is there a queue or appointment system that people are following?			
5	Are staff helping manage the flow to avoid bottlenecks?			
6	Are outreach or health promotion sessions happening alongside clinical care?			
7	Is the wait time from arrival to service starting less than 30 minutes.			

Notes to capture:

- Steps in the service journey, informal support roles, bottlenecks, staff coordination

COMMUNICATION AND INTERACTION

No	Indicator	Yes	No	Comments
1	How do staff communicate with patients? Are they using clear, respectful language?			
2	Are staff listening to patients and answering their questions?			
3	Are procedures and treatments explained in a way that patients understand?			
4	Are interpreters or multilingual staff present when needed?			
5	Do staff seek consent before examinations or treatment?			
6	Are occupational risks discussed during outreach?			

Notes to capture:

- Verbal and non-verbal communication, tone, clarity, responsiveness, consent practices

PRIVACY AND CONFIDENTIALITY

No	Indicator	Yes	No	Comments
1	Are consultations taking place in a private space (tent, vehicle, or partitioned area)?			
2	Can patients speak freely without others overhearing them?			
3	Is there visual privacy for patients during procedures?			
4	How are patient records or sensitive information handled by staff?			

Notes to capture:

- Physical layout, visibility and audibility of patient conversations, staff discretion

REFERRAL PROCESSES AND CONTINUITY OF CARE

No	Indicator	Yes	No	Comments
1	Are staff explaining referral options to patients clearly?			
2	Do patients receive follow-up instructions or contact information?			
3	Is there any visible evidence that referrals are being tracked or followed up?			
4	Are referral tools or forms available on-site?			

Notes to capture:

- Referral conversations, documentation, whether patients understand where to go next

INCLUSIVITY AND RESPONSIVENESS TO MARGINALIZED GROUPS

No	Indicator	Yes	No	Comments
1	Are women, youth, treated differently, positively or negatively?			
2	Are staff interacting respectfully with people from diverse groups (e.g., LGBTQ+, ethnic minorities)?			
3	Are patients accompanied or supported by others (e.g., peer workers)?			
4	Do services appear to be adapted for mobile populations (e.g., flexible ID requirements, portable records)?			
5	Are staff making an effort to reach out to people who might otherwise be excluded?			
6	Are health materials or messages shared in local languages?			
7	Did staff or health promoters talk about mining-related health risks (e.g. dust, chemicals, lung problems) during outreach or group sessions?			

Notes to capture:

- Examples of inclusion or exclusion, staff behaviour toward different groups, outreach strategies, language use

ENVIRONMENTAL CONSIDERATIONS

No	Indicator	Yes	No	Comments
1	Is clean water available at or near the site (e.g. for drinking, handwashing)?			
2	Are hygiene or sanitation facilities present, clean, and accessible?			
3	Are there any visible environmental risks nearby (e.g. mine tailings, stagnant water, open defecation areas)?			
4	Was environmental health mentioned during any outreach, education, or consultation activities?			

Notes to capture:

- Availability and cleanliness of water and sanitation facilities, any visible environmental hazards, and whether environmental health messages were shared during outreach or consultations.

General Comments or Observations:

VERBAL CONSENT: GROUP DISCUSSIONS

Project Title:

Formative Evaluation of the Basic Healthcare Project for Artisanal and Small-Scale Gold Miners

Purpose of the Discussion: This discussion is part of an independent evaluation of the GWANDA project, which provides health services to miners, sex workers, and host communities. We want to understand your experiences and what could be improved.

What You Will Be Asked to Do: You will be asked to share your views and experiences related to the project during a group discussion. The discussion may last up to 90 minutes. You can choose not to answer any question and can leave at any time.

Confidentiality: We will not record your name. What you say will be grouped with others' responses, and no one will be identified individually. We ask all participants to respect each other's privacy and not share what is said outside the group.

Voluntary Participation: Your participation is voluntary. You are free to stop participating at any time.

Do you agree to take part in this conversation?

(If yes):

Thank you. Let's begin.

(If no):

That's completely fine. Thank you for your time.

For interviewer documentation only (not read aloud):

- Participant gave verbal consent to participate:

  ☐ Yes
  ☐ No

- Interviewer name: _____
- Date: _____

If you have any questions or concerns, please contact the evaluation team leader: Leva Rouhani: lrouhani@hwefa.com

VERBAL CONSENT: LOW LITERACY PARTICIPANTS

For use in individual or group conversations

Hello, my name is [NAME]. I work with a team that is doing an independent evaluation of the MSF health project here in Gwanda. This includes mobile clinics, health talks, and outreach activities. We're not part of MSF, but we want to understand how the project is working for people like you.

I'd like to ask you a few questions about your experience. You do not have to answer anything you don't want to. You can stop the conversation at any time. There is no payment, but your answers will help us understand what is working well and what could be better.

We will not record your name or anything that can identify you. What you tell us will be kept private. The information will be grouped with other people's answers and shared in a report with MSF and others working on health services.

Do you have any questions?

Pause to answer questions.

Can you please tell me:

Do you agree to take part in this conversation?

(If yes):
Thank you. Let's begin.

(If no):
That's completely fine. Thank you for your time.

For interviewer documentation only (not read aloud):

- Participant gave verbal consent to participate:
  ☐ Yes
  ☐ No
- Interviewer name: _____
- Date: _____

If you have any questions or concerns, please contact the evaluation team leader: Leva Rouhani: lrouhani@hwefa.com