AN EVALUATION OF

Basic Healthcare Project for Artisanal and Small-Scale Gold Miners in Gwanda, Zimbabwe

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STOCKHOLM EVALUATION UNIT

BACKGROUND

The **Basic Healthcare Project for Artisanal and Small-Scale Gold Miners (ASM) in Gwanda, Zimbabwe**, 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.

This 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.

METHODOLOGY

- Mixed Methods Approach
- Participatory method
- Desk review
- Analysis of routinely collected medical data
- 221 Key Informants (interviews and focus groups)
- Clinic and Outreach Observations

RECOMMENDATIONS

1. **Formalize and resource the peer educator model** with clear roles, incentives, and supervision, and link them to local committees and leaders. Provide simple referral tools so peers can track and support relocating miners.
2. **Prioritize a knowledge and evidence handover** to MoHCC rather than transferring outreach activities. Share evidence on population needs, service-use patterns, and barriers to care; practical insights on community-oriented service delivery; and guidance on required system improvements.
3. **Expand partnerships** with traditional leaders, mining associations, and CBOs to diversify support and co-funding and maintain health promotion after MSF exits.
4. **Address lingering stigma** associated with mobile clinics from earlier NGO programs that hosted HIV clinics. Involve trusted voices to normalize care-seeking, and equip peer educators with anti-stigma messages.
5. **Consolidate and hand over advocacy and research outputs** before exit. Package operational research into briefs, toolkits, and case studies for use by civil society, mining unions, and health authorities.
6. **Pilot and optimize service delivery models.** Test mixed delivery models using peer educators and local structures; redirect freed MSF resources to extend clinic hours and increase visit frequency in high-density areas. Test efficiency measures and collect cost, workload, and continuity data to inform transition and build evidence for funders.

MAIN 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 reduce barriers of distance, cost and stigma, bringing essential care where static services are inaccessible. Health promotion is locally resonant 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 no patient tracking. Advocacy and operational research are promising but remain nascent, with limited evidence of policy influence so far.

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

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 will likely endure, while the full mobile clinic model is financially unsustainable without external funding. Integration with the MoHCC remains symbolic, constrained by resource shortages and limited capacity for uptake.