Terms of Reference

Doctors Without Borders/Médecins Sans Frontières (MSF) is an international medical humanitarian organization determined to bring quality medical care to people in crises around the world, when and where they need regardless of religion, ethnical background, or political view. Our fundamental principles are neutrality, impartiality, independence, medical ethics, bearing witness and accountability.

The Stockholm Evaluation Unit (SEU), based in Sweden, is one of three MSF units tasked to manage and guide evaluations of MSF's operational projects, and works primarily with Operational Centre Brussels. For more information see our website evaluation.msf.org.

Promoting a culture of evaluation is a strategic priority to be accountable, seek for continuous improvements and achieve organizational learning. MSF does not evaluate only because of external requirements, for example donors related ones. These Terms of Reference should be seen as a starting point for the evaluation process. The evaluator(s) are welcome to challenge them and suggest for example different or additional perspectives, as they see fit during the inception phase. The evaluation process should rely on solid methodology to achieve credible results and should also ensure to put values and use in the forefront. The evaluation must involve and include different actors and counterparts in an adequate manner during the whole process.

Evaluation of the Basic Healthcare project for Artisanal and Small-Scale Gold Miners, Gwanda, Zimbabwe	
Starting date:	April 2025
Duration:	Final report to be submitted by latest October 2025
Requirements:	Interested applicants should submit: 1) A technical proposal 2) A financial proposal 3) CV 4) A previous (relevant) work sample
Deadline to apply:	Tuesday, April 15th [23:59 CET]
Send application to:	evaluations@stockholm.msf.org
Other:	We value quality over quantity. Providing only the requested and necessary documentation should prove your interest, capacity and competency in the best possible manner.

The SEU engages a Consultation Group (CG) in this evaluation process with the goal of increasing understanding, buy-in, learning during the process, and the quality of the results. The CG is headed by an Evaluation Commissioner (EC). They contributed to the finalization of this ToR.

BACKGROUND

Zimbabwe is struggling with provision of basic health care services since the year 2000. With the collapse of its economy at that time, investments in health decreased and lack of basic health supplies and infrastructure as well as health professionals leaving the country were the consequences[1]. Zimbabwean population, whose majority is living in rural areas, is confronted with challenges as consultation payments, shortages of drugs and medical supplies, and health care staff[2]. Main health needs of the country are reflected in high HIV prevalence (12.9%)[3], heavy burden of TB/HIV and Multidrug Resistant (MR)/Rifampicin Resistant (RR) TB, with a TB incidence of 211/100 000[4].

About eight million artisanal and small-scale miners (ASM) operate in Africa with 54 million people dependent on the sector for their livelihoods[5,6]. Close to 90% of Zimbabweans are not formally employed and two million[7]are engaged in ASM where they produce 77% of the country's gold to contribute towards 8% of GDP[8,9]. Zimbabwean ASM come from socially differentiated groups with a wide range of education and economic backgrounds[10,11]. Poverty, lack of employment prospects and hopes of significant financial reward are drivers for a situation characterized by protracted socio-political and economic crisis.

Most mining activities occur along the Great Dyke which is approximately 550 km long and divides the country from north to south. It contains significant reserves of gold, chrome, nickel, and platinum. Near the southern end is Gwanda, the capital of the province of Matabeleland. Gwanda was founded in 1900 as a settlement of gold miners and prospectors and has grown into a business hub surrounded by some of the largest gold producers (Blanket, Freda, Horn, Jersey, and Vubachikwe Mines), as well as Pretoria Portland Cement (PPC). According to the Central Statistics Office[12], the district population per 2022 was 124,458 with 26,773 households. An estimated 10-20,000 individuals are involved in ASM activities, but it is difficult to confirm this figure to date as this population is mobile and difficult to count.
Gwanda town has one Provincial Hospital with emergency-, paediatrics-, maternity-, orthopaedic-, eye- surgery-, x-ray-, lab-, and general services. There are two mission hospitals, 6 MoHCC clinics, 1 urban council clinic, 13 rural district council clinics, and 6 private consulting doctors in urban Gwanda.

[1] Khameer K. The future of health in Zimbabwe. Global Health Action 2018
[2] MSF Medical Strategy Gwanda project 2023.
3 MoHCC, ICAP. Zimbabwe Population-based HIV Impact Assessment 2020.
4 WHO Data. Tuberculosis incidence dashboard 2023.
[5] Intergovernmental Forum. Global Trends in Artisanal and Small Scale Mining: A review of Key numbers and Issues [Internet]. Available from: https://www.iisd.org/system/files/publications/igf-asm-global-trends.pdf
[6] Ledwaba P, Nhlengetwa K. When policy is not enough: prospects and challenges of artisanal and small-scale mining in South Africa. J Sustain Dev Law Policy. 2016 Jul 26;7(1):25.
[7] Chipangura, N., "We are one big happy family: the social organisation of artisanal and small-scale gold mining in Eastern Zimbabwe, The Extractive Industries and Society, Vol. 6, Issue 4, 2019
[8] Ledwaba P, Nhlengetwa K. When policy is not enough: prospects and challenges of artisanal and small-scale mining in South Africa. J Sustain Dev Law Policy. 2016 Jul 26;7(1):25.
[9] Mining Zimbabwe. Mining Contributes Over 77% of Total Gold Deliveries to Fidelity in January [Internet]. [cited 2023 Feb 11]. Available from: https://miningzimbabwe.com/asm-contribute-over-77-of-total-gold-deliveries-to-fidelity-in-january/
[10] Mpofu, S. and Mpofu, T.P., Assessment of knowledge levels and attitudes of ASGM towards chemical contamination in the Mhondoro-Ngezi District, Zimbabwe, International Open and Distance learning Journal, 2017
[11] Mabhena C., Mining with a Vuvuzela: reconfiguring artisanal mining in Zimbabwe and its implications to rural livelihoods, Journal of Contemporary African Studies, 2012
12 Ministry of Finance and Economic Development Zimbabwe. Population Census Dashboard https://zimbabwe.opendataforafrica.org/

ASM are globally exposed to dangerous working conditions, violence and extortion[19]. Assessments in the context of Zimbabwe by MSF revealed social activities and behaviours including alcohol and substance use, engagement with sex work services while away from their communities and families, late seeking and use of health care, and incomplete treatments that risk drug resistance, especially with antibiotics. Many miners live and work in remote areas often in male groups, facing poor water and sanitation conditions and limited access to health care due to distance, cost and stigma. ASM are predominantly male, between 25 and 54 years old and completed secondary education level[13]. Despite the increase in ASM activities, very little information is available on the concurrent physical and mental health needs and the factors driving risk behaviors of ASM. There are additional environmental health risks from exposure to silica dust, mercury and cyanide contamination. Zimbabwe studies showed a 19% prevalence of silicosis among young ASM who have mined for less than 10 years. The same group revealed a prevalence of 6.8% for TB and 18% for HIV infection[14]. A recent systematic review revealed a 35% pooled increased risk of TB for silicosis patients and silica exposed individuals[15]. HIV was assessed repeatedly to be an additional risk factor for TB in silicosis patients[16],[17]. ASM are exposed to mercury during amalgam smelting and ingestion of contaminated food or water, with studies in the nearby areas of Kadoma and Shurugwi indicating that 52% of ASM had Human Blood Material (HBM) levels, exceeding the thresholds values of HBM I and II[18].

MSF activities

MSF has been working in Zimbabwe since 2000. Extensive HIV/AIDS/TB/Gender based Violence (GBV) interventions were carried out in Matabeleland province from 2000-2013 under MSF-OCBA (Spain). MSF-OCA (Netherlands) operated in the country until 2017. MSF-OCB (Belgium) is the only section remaining in the country since 2018. Until 2023 OCB supported health facilities in Matabeleland South province, in Plumtree and Beitbridge. Currently, OCB has a project in Mbare, a Suburb in the south of the capital Harare, where SRH service for adolescents are provided. OCB also continues in Matabeleland province, in Gwanda district, focusing on basic healthcare for the ASM population, associated sex workers, and host communities.

Gwanda was chosen as the area of intervention due to the growing number of ASM sites, poor health indicators and small number of local actors who intervene regularly in the area. A series of explorative assessments culminated in signing Memorandums of Understanding (MoU) on district and provincial level by July 2023 at which point the project became fully operational. The healthcare service provision designed, and in the process of being implemented, integrates occupational health (silicosis screening), environmental health (heavy metal contamination monitoring), infectious disease management (TB/HIV/Sexual Transmitted Infections (STI)), mental health, basic healthcare provision including on sexual and reproductive health (SRH) for this vulnerable and high-risk population. The project is planned for 3 to 5 years total, starting from its inception in December 2023, and its main objective is stated '*to contribute to the reduction of the morbidity and mortality for the most vulnerable population including artisanal small-scale minors, sex workers and surrounding communities in Gwanda district'*. It is currently designed along five pillars, while not all are yet implemented.

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[13] Moyo D. The Triple Burden of Tuberculosis, Human Immunodeficiency Virus and Silicosis among Artisanal and Small-Scale Miners in Zimbabwe. International Journal of Environmental Research and Public Health. 2022

14 Moyo D. The Triple Burden of Tuberculosis, Human Immunodeficiency Virus and Silicosis among Artisanal and Small-Scale Miners in Zimbabwe. Int. J. Environ. Res. Public Health 2022, 19, 13822.

15 Jamshidi P. Silicosis and tuberculosis: A systematic review and meta analysis. Pulmonology 2023

16 Shafiei M. Risk factors and control strategies for silicotuberculosis as an occupational disease. New Microbe and New Infections 2019

17 Corbett EL. HIV infection and silicosis: the impact of two potent risk factors on the incidence of mycobacterial disease in South African miners. AIDS 2000

[18] Mambrey V., et al. Artisanal and small-scale gold mining: A cross-sectional assessment of occupational mercury exposure and exposure risk factors in Kadoma and Shurugwi, Zimbabwe. 2020

(1) Basic health care (HIV, TB, Silicosis, SRH, Mental Health and STI's),
(2) Community outreach activities on mobilization and health promotion,
(3) Water and Sanitation activities targeting environmental health issues,
(4) Advocacy, health policy, research activities, and
(5) Emergency preparedness planning.

Aiming to align with the successfully proven concept of Differential Service Delivery (DSD)[19], MSF focuses on health care service approaches that drive better self-care, patient-centric approaches, enhanced local capacity, and that can be extended to other mining contexts in Zimbabwe, and Africa. In that sense health care service provision (model of care) is designed to deliver (1) mobile and decentralized to overcome barriers of access, (2) holistic and integrated, (3) collaborative with community-based organizations, MoH, and using locally developed success models, and (4) influenced by DSD to motivate self-care and peer-support and reduce facility dependence. Contacts are established with governmental, local, and international stakeholders, including Ministry of Health and Child Care (MOHCC), Zimbabwe Health International (ZHI), Centre for Sexual Health and HIV AIDS Research Zimbabwe (CeSHHAR) Key Populations Program, Zimbabwe Miners' Federation, Zimbabwe Mining Safety and Environmental Council, mining site committees, and traditional healers.

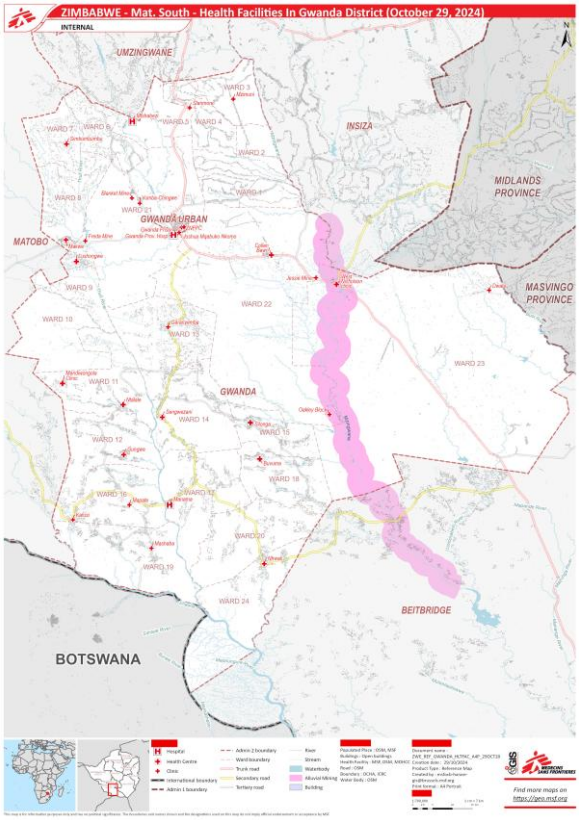
Mobile clinics are a key element of medical activities within the current project strategy. Two teams rotate through different sites around Gwanda. They are to be equipped with a portable X-ray diagnostic for TB and silicosis screening by the first half of 2025 and are planned in collaboration with community-based organizations (CBOs) within the ASM community. Each mobile clinic sees an average of 60 to 70 patients per day, in fluctuating numbers where new sites continue to be identified. In the months September to November 2024, a total of 2578 Outpatient Department (OPD) consultations were registered. The most frequent documented conditions were general aches and pain, followed by acute upper respiratory tract infections and HIV status. In the same period 2610 individuals were screened for TB (positivity rate 6%), 2094 for Silicosis (positivity rate 8%), 1195 received HIV testing and counselling, 164 were diagnosed with STI's, and 215 received Family planning consultations. Further, 174 Health Promotion sessions were conducted, with a total of over 5000 individuals participating[20].

MSF has some prior experience in mining sites and highly mobile populations and where risk behaviour influences poor health outcomes. Nevertheless, the Gwanda project represents a rather new area of work as MSF has not historically engaged with this sector on a scale. The project is aware that the current approach has limitations in its sustainability beyond MSF presence. To fully understand the success of the health care service provision (model of care) so far, and to identify opportunities to motivate sustainability pathways, the evaluation will encompass the full scope of the project and embedded processes, including medical, operational, communities and policy dimensions.

Based on this the Gwanda ASGM-BHC Project further intends to draw example learnings for intervention models for ASM and host communities that can be replicated and be used to advocate for strengthened self-care initiatives and changes in national protocols and policies towards a more

[19] "Differentiated service delivery, previously referred to as differentiated care, is a person-centred approach that simplifies and adapts HIV services across the cascade in ways that both serve the needs of people living with and vulnerable to HIV and optimize available resources in health systems." Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a public Health approach. WHO 2021
[20] MSF Monthly Medical Reports_Gwanda project October to November 2024.

comprehensive package of healthcare service delivery for people living marginalized and reduced access to health care.



PURPOSE AND INTENDED USE

PURPOSE of this formative evaluation is to reach insights into the appropriateness and effectiveness of each project's component so far and identify inefficiencies in its implementation. The evaluation should provide a detailed description of the project with a specific focus on the healthcare service delivery (model of care) as per now implemented, assess sustainability of the current project strategic design and suggest possible improvements.

INTENDED USE of this evaluation is to inform strategic orientation within the next planning phase of the project happening in July/August/September 2025, with a specific focus on real-time adaptations to the current healthcare service delivery (model of care). It will further guide sustainability and continuity planning of the project. The evaluation process and findings will potentially also serve as a learning opportunity for MSF OCB on health interventions targeting ASM populations.

EVALUATION CRITERIA AND QUESTIONS

1. How appropriate is the project to its context?
    a. How appropriate are the project activities to the humanitarian medical needs considering their socio-cultural, political, economic etc. realities of the target populations?
    b. How appropriate are the current operational research and advocacy efforts in achieving the projects objectives?
    c. What adaptations to the project and specifically to the current healthcare service activities (model of care) can improve the appropriateness of the project?

2. How effective is the project in reaching the set objectives?
    a. Are the activities with a specific focus on the health service delivery (model of care) effectively leading to the project's objectives so far?
    b. What improvement or opportunities exist for the project to influence policy changes in occupational health of the targeted population?

3. How efficient is the project in implementing health service delivery?
    a. What are potential inefficiencies in the delivery of healthcare services?
    b. What are the opportunities for improving efficiency specifically on the current healthcare service activities (model of care)?

4. How sustainable is the project and its activities?
    a. How far do the currently designed project activities focus on sustainability, and what are the challenges to do so?
    b. In what roles and how have the different stakeholders been involved so far and how do collaborations with different stakeholders look like?
    c. How can the project adapt its project design and activities to prospect a successful continuity of health service delivery after MSF closure?

These questions represent the current interest of the requesting parties of the evaluation. We encourage the evaluator(s) to consider adaptations in case different and/or additional interests from the stakeholders consulted are discovered in the inception phase. Any deviation from the ToR need to be transparently justified in the inception report.

EXPECTED DELIVERABLES

1. **Stakeholder analysis and engagement strategy**

   Analysis of primary and secondary stakeholders (MSF and external) relevant for the evaluation should be identified and a contextualized plan on their level of engagement throughout the evaluation process presented.

2. **Inception Report**

   As per SEU standards, after conducting an initial document review, assess data availability and conduct preliminary interviews. An initial group session to clarify the conceptualization of the project so far (Theory of Change/Logical Model) might be required. This will confirm the evaluation questions or justify diversion and propose a detailed evaluation proposal, including theoretical and methodological approaches.

3. **Real time learning**

   Systematic and continuous communication with key stakeholders should be maintained throughout the process to foster and document process learning. Regular feedback to and from the SEU, the Evaluation Commissioner and Consultation Group will be an essential part.

4. **Working and validation session**

   As part of the evaluation process at least three working sessions with the CG and the Commissioner are to be held to create space for live discussion on the evaluation's progress, validate preliminary findings and recommendations, and keep track on the contextualization of the evaluation.

5. **Draft and Final Evaluation Report**

   As per SEU standards. It will answer the evaluation questions and will include conclusions, lessons learned and recommendations as well as address and keep track on written and verbal feedback from evaluation stakeholders. An executive summary will be required, and to be delivered additionally as a separate document.

6. **Dissemination and Use**

   A webinar presentation to the MSF movement will be required. Other dissemination products targeting service users and other stakeholders will be explored during the evaluation process and confirmed at a later stage of the process.

TOOLS AND METHODOLOGY PROPOSED

In addition to the initial evaluation proposal submitted as a part of the application (see requirement chapter), a detailed evaluation protocol should be prepared by the evaluators during the inception phase. It will include a detailed explanation of proposed methods, and its justification based on validated theory/ies. It will be reviewed and validated as a part of the inception phase in coordination with the SEU. The approach should ensure triangulation of data sources, involving diverse perspectives (potentially including participatory approaches) from relevant stakeholders.

As the project expects the evaluation to feed into upcoming decision making soon, the Evaluator(s) are expected to identify (innovative) approaches to ensure real time learning continuously during the

evaluation process. For this purpose, a more intense involvement of the SEU Evaluation Manager/Officer during the process might be discussed.

RECOMMENDED DATA SOURCES

The Evaluation team might identify sources beyond the list below:

- Project documents (project proposals, logical frameworks, situational reports, annual reports, field visit reports)
- MSF guiding documents (OCB strategy, OCB medical reports, MSF medical guidelines and others)
- MSF medical data routinely collected by the project, anonymized raw data and/or aggregated data (GIS, DHIS2, Excel, ActivityInfo[21]) and potentially by Ministry of Health
- Documentation regarding the ongoing operational research initiatives in the project
- National and regional documentation (Memorandum of Understanding, technical strategies, guidelines, policies)
- Relevant external resources and documentation (literature, evaluations, external reports from other actors)

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	Flexible.
Timing of the evaluation	Start: April 2025 Data collection: July 2025 Finalized report: October 2025

PROFILE/REQUIREMENTS FOR EVALUATOR(S)

- **Requirements:**
  - Proven competencies and professionalism in humanitarian medical evaluation
  - Formal background/degrees in Public Health, Epidemiology, or any relevant fields
  - Experience and/or knowledge in community-based programming in at least two of the technical areas of the project (STI, TB, Silicosis, HIV, Mental Health, Environmental Health, SRH etc.)
  - Knowledge and/or experience in working with the target population (ASM), or similar vulnerable, marginalized groups
  - Fluency in English (spoken and written)
  - Strong facilitating, team leading and stakeholder engagement skills

- **Assets:**
  - Experience or knowledge/understanding of MSF's way to operate
  - Experience in advocacy or health policy programming

[21] https://www.activityinfo.org/

- Knowledge and proficiency of local language(s)
- Experience in systematic participatory approaches
- Professional experience in Zimbabwe or the South African region

APPLICATION PROCESS

The application should consist of:

- A technical proposal
- A budget proposal
- CV(s)
- A previous work sample

The proposal should include a reflection on how adherence to ethical standards for evaluations will be considered throughout the evaluation, as well as how values and perspectives of different stakeholders will be brought into the process. Due to the sensitivity of covered aspects and the vulnerability of the population, the evaluator(s) will need to demonstrate an understanding of the evaluand and its context and reflect this in the methodology as well as the team set-up.

Offers should include a separate quotation for the complete services, stated in **Euros (EUR).** The budget should present consultancy fee according to the number of expected working days over the entire period, both in totality and as a daily fee. Travel costs (such as flight tickets, local transportation or accommodation), if any, do not need to be included as the SEU will arrange and cover these. However**, MSF does not pay any per diem.** Consultants should therefore ensure that their fee estimates cover any other costs typically associated with per diem.

MSF is committed to apply responsible data protection principles across all its activities, including evaluations, through the respect of both Humanitarian principles and European GDPR. During the evaluation process, you will potentially access, collect, store, analyze and eventually dispose of MSF and its patients' sensitive and personal data and information (SPDI). Please take special note of the SEU's Ethical Guidelines in preparing your proposal considering what tools and solutions you will use, how you will work to mitigate any data incident, and how you will dispose of any data collected once the evaluation is completed.

Applications will be evaluated on the basis of whether the submitted proposal captures an understanding of the main deliverables as per this ToR, a methodology relevant to achieving the results foreseen, and the overall capacity of the evaluator(s) to carry out the work (based on the CV and the submitted work sample).

Interested teams or individuals should apply to **evaluations@stockholm.msf.org** referencing **GAMIN** no later than 15/04/2025**.** We would appreciate the necessary documents being submitted as separate attachments (proposal, budget, CV, work sample and such). Please include your contact details in your CV.

Please indicate in your email application on which platform you saw this vacancy.

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SELECTION PROCESS

Our selection process is designed to be comprehensive and fair, based on the specific requirements outlined in this ToR, alignment with MSF principles, evaluator competencies, quality of proposal, budget assessment, and interview with the short-listed candidates.