Partnership on Health and Mobility in the Mining Sector project (2013-16) in South Africa, Lesotho, Swaziland and Mozambique

END OF PROJECT EVALUATION REPORT

FINAL REPORT PART I

Prepared by Sarraounia Public Health Trust

23 JUNE 2017

International Organization for Migration (IOM)
The UN Migration Agency

Kingdom of the Netherlands

Sarraounia

Acknowledgements

The Sarraounia Public Health Trust wishes to thank Project Managers at IOM and VSO for their assistance in the completion of this evaluation. Thanks in particular goes to David Makapela, Wambui Gititu and Menasie Ayalew.

Researchers on this team were:

Nancy Coulson

Dr. Cheryl Goldstone

Dr. Jaqualine Mangoma

Nirvana Pillay

Ziyanda Majombozi

Agostinho Simbine

Godfrey Dlulane

Fieldworkers Ayango Research

Project Management:

Francesca Bazzini

Abbreviations

AB	Advisory Board
AU	African Union
AfrEA	African Evaluation Association
AIDS	Acquired Immune Deficiency Syndrome
AMIMO	Association of Mozambican Mine Workers
AMODEFA	Mozambican Association for the Development of the Family
ANC	African National Congress
AU	African Union
CA	Change Agent
CANGO	Coordinating Assembly of Non-Governmental Organisations
CARE	Community AIDS Response
CCE	Community Capacity Enhancement
COIDA	Compensation for Occupational Injuries and Disability Act
COM	Chamber of Mines
COMESA	Common Market for Eastern and Southern Africa
CPC	Centre for Positive Care
DAC	Development Assistance Committee
DBE	Department of Basic Education
DFID	Department for International Development
DHIS	District Health Information System
DHMT	District Health Management Team
DM	Deputy Minister
DMHF	District Migrant Health Forum
DMR	Department of Mineral Resources
DOH	Department of Health
DOL	Department of Labour
DSD	Department of Social Development
EFF	Economic Freedom Fighter
EMAWA	Ex-Miners and Allied Workers Association of Lesotho
eNSF	Extended National Multi-Sectoral HIV and AIDS Framework
FGD	Focus Group Discussion
GDP	Gross Domestic Product
GF	Global Fund
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HR	Human Resources
IBBS	Integrated (HIV) Bio-Behavioural Surveillance
IEC	Information Education and Communication
IGA	Income Generating Activity
ILO	International Labour Organisation
IOM	International Organisation for Migration
IP	Implementing Partner
IRD	International Relief and Development
IRI	Impact Research International
KII	Key Informant Interview
LP	Limpopo Province
M&E	Monitoring and Evaluation
MBOD	Medical Bureau of Occupational Disease
MHSA	Mine Health and Safety Act
MOA	Ministry of Agriculture
MOH	Ministry of Health
MOL	Ministry of Labour
MOU	Memorandum of Understanding
MSF	Medecins Sans Frontieres
MTR	Mid-Term Review
MWA	Mine Worker Association
NAC	National AIDS Council
NATICC	Nhlango AIDS Training Information and Counselling Centre
NDOH	National Department of Health
NGO	Non-governmental Organisation
NSI	National Statistical Institute

NSP	National Strategic Plan
NUM	National Union of Mineworkers
OECD	Organisation for Economic Co-operation and Development
OTP	Office of the Premier
OVC	Orphaned and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PHAMESA	Partnership on Health and Mobility in East and Southern Africa
PM	Project Manager
POPA	Phoning Out Poverty and AIDS
RAISA	Regional AIDS Initiative of Southern Africa
RHM	Rural Health Motivator
SA	South Africa
SACU	Southern African Customs Union
SADC	Southern African Development Community
SAMA	Southern Africa Mineworkers Association
SAT	Southern African AIDS Training
SAT	Southern Africa Trust (SAT).
SB	Smashers Block
SC	Steering Committee
SD	Swaziland
SDCBF	Service Delivery and Capacity Building Framework
SDCBM	Service Delivery and Capacity Building Model
SGBV	Sexual and Gender Based Violence
SIDA	Swedish International Development Cooperation Agency
SLP	Social and Labour Plan
SNAP	Swaziland National AIDS Programme
SNEMA	Swaziland National Ex-Mine Workers' Association
SRHR	Sexual and Reproductive Health Rights
SWAMMIWA	Swaziland Migrant Mineworkers Association
SWANNEPHA	Swaziland Network of People Living with HIV/AIDS
TA	Technical Assistance
TB	Tuberculosis
TIMS	TB in Mining Sector
TOC	Theory of Change
TOR	Terms of Reference
TWG	Technical Working Group
UN	United Nations
URC	University Research Company
VHW	Village Health Workers
VSO	Voluntary Service Overseas
WB	World Bank
WDM	Waterberg District Municipality
WHA	World Health Assembly
WHO	World Health Organisation

Table of Contents

1. Introduction

The three-year Partnership on Health and Mobility in the Mining Sector Project (2013-2016) – hereafter referred to as the Mining Sector Project - was funded by the Dutch Ministry of Foreign Affairs in Southern Africa and was implemented in four countries Mozambique, Swaziland, Lesotho and South Africa. Collectively these are the four countries significantly affected by HIV and tuberculosis (TB), and that have communities, which have a deep, and long standing relationship with mining in South Africa. The International Organisation for Migration (IOM) and Voluntary Services Overseas (VSO) were the executing agencies for the Mining Sector Project which undertook to improve the health of current and ex-migrant mineworkers, their families and communities through strengthening research and evidence, influencing policy and by supporting migrant sensitive health service delivery and improved livelihood opportunity in 16 priority mining affected communities in the four countries. It was designed as a regional, national and local level intervention.

In December 2016 IOM commissioned the Sarraounia Public Health Trust to conduct an end-line evaluation of the Mining Sector Project. This report sets out the process for conducting the evaluation, summarises the key findings and provides recommendations based on these.

1.1 Background and Context

Southern Africa has been profoundly shaped by the legacy of more than a century of mining practice in South Africa. The ramifications of racist, exploitative and labour intensive mining practices under both colonialism and apartheid have resonance today. Geographical areas of Lesotho, Mozambique, Swaziland and South Africa are described as *'labour sending areas'* and have historically provided labour for South Africa's gold mines. These countries continue to provide labour for South African mines, although the number of workers who migrate to South Africa has decreased dramatically in the last decade. Despite this decline, the 'oscillating migrancy' of mineworkers remains and therefore, South African mining regions are *'destinations'* for migrant mine workers and border towns are *'transit areas.'* The Mining Sector Project aimed to improve the health of migrant current and ex-mineworkers, their families and communities in selected labour sending, transit and destination communities in South Africa, Lesotho, Mozambique and Swaziland.

Mining areas have HIV and TB rates that are higher than communities that are not impacted by mining in any way.[1] Mining affected communities whether labour sending, transit or destination are characterised by poor health status and related poverty, both of which are exacerbated by a relationship to mining. Living and working conditions place miners at risk of contracting HIV and TB. Gold mining also places mine workers at risk of developing silicosis over time. Migration, whether it be across countries, or in country, may interfere with the continuum of care and interrupt the course of treatment placing miners, as well as, their families and communities at risk of acquiring infection.

[1] PHRU 2017 TB, HIV and Silicosis in Miners Epidemiological Data on Tuberculosis, Multi-Drug Resistant TB, Silicosis and HIV among Miners and Ex-Miners in Southern Africa

Table 1: Summary of TB, HIV and Silicosis in Miners and their Communities in Lesotho, Mozambique, South Africa and Swaziland

	Characteristic	Lesotho	Mozambique	South Africa	Swaziland
Country statistics	Population size	2 100 000	27 978 000	54 956 900	1 300 000
	Incidence of TB per 100 000	852 (612 – 1 130)	551 (435-680)	834 (737 – 936)	733 (533 – 963)
	Proportion of estimated drug resistant TB (%)	3.2%	3.5%	2.1%	7.7%
	HIV prevalence in those aged 15-49 years	23%	11.6%	19.2%	28.8%
	% of TB patients who are HIV infected	72%	52%	61%	79%
Mining industry statistics	Most mined commodities	Diamonds, Sandstone, Aggregate	Bauxite, Gold, Graphite	Gold, Coal, Iron, Platinum, Diamonds	Coal, Asbestos, Diamonds
	Mining district or regions	Butha Buthe, Berea, Maseru, Mokhotlong	Mandla Kozo, Manjacze, Chibuto, Xai Xai, Cidade de Matolo, Maputo	North West, Gauteng, Free State, Mpumalanga and Limpopo Provinces	Hhohho, Shiselweni, Limbombo
	Size of mining population (formal mining sector)	15 911	174 906	493 921	2 520
	% of country GDP from mining	7.9%	3.5%	4.9% - 8.3%	2%
	Prevalence of TB in miners or mining area (per 100 000)	7 200	Unkown	3 000	5 194
	HIV prevalence in miners or mining area (%)	20%-40%	26%-42%	12% - 47%	20%
	Silicosis prevalence (%)	25%-26%	Unknown	22% - 32%	Unkown

Source: PHRU 2017 TB, HIV and Silicosis in Miners Epidemiological Data on Tuberculosis, Multi-Drug Resistant TB, Silicosis and HIV among Miners and Ex-Miners in Southern Africa

1.2 Project description

The Mining Sector Project was implemented in alignment with the Partnership on Health and Mobility in East and Southern Africa (PHAMESA). It responded to the World Health Assembly (WHA) Resolution no 61.17 on the *'Right to Health for Migrants'* whose four pillars include monitoring migrant health, policy-legal framework, migrant sensitive health systems and partnerships, networks and multi country frameworks. The three-year Mining Sector Project (2013-2015) (note some activities extended into 2016/2017) was funded by the Dutch Ministry of Foreign Affairs in Southern Africa and was implemented in four countries Mozambique, Swaziland, Lesotho and South Africa by the International Organisation for Migration (IOM) and Voluntary Service Overseas (VSO).

1.21 Rationale for the project

The project was designed to respond to the following five key issues/problems, which are summarised below and described at length in the project proposal:

1. HIV prevalence is higher and vulnerability to HIV and TB infection is more acute among mineworkers, their families and the surrounding communities. Communities in Lesotho, Mozambique, South Africa and Swaziland are particularly affected and this informed the selection of the project implementation sites.
2. 'Oscillating migration' in the mining sector – where migrants move between urban and rural areas and across borders – exacerbates this vulnerability as TB and/or HIV acquired in mines may fuel transmission in mine sending communities and contribute to challenges in treatment continuity and follow up.
3. Families left behind are profoundly vulnerable in terms of health and livelihoods due to poverty, lack of opportunities to generate income and food insecurity.
4. The spaces of vulnerability associated with the mining sector are conducive to both men and women engaging in multiple concurrent sexual partnerships, a major driver of the HIV epidemic in southern Africa

5. Awareness and capacity for addressing health and mobility in the mining sector in Southern Africa are limited among stakeholders in governments, private sector and mineworker worker associations (MWAs).

1.22 Project objective

The overall objective of the Mining Sector Project was to contribute to improved health outcomes of 20 000 migrant mine workers, their families and mining affected communities in Southern Africa with particular focus on mine worker sending, transit and destination communities of Mozambique, South Africa, Lesotho and Swaziland.

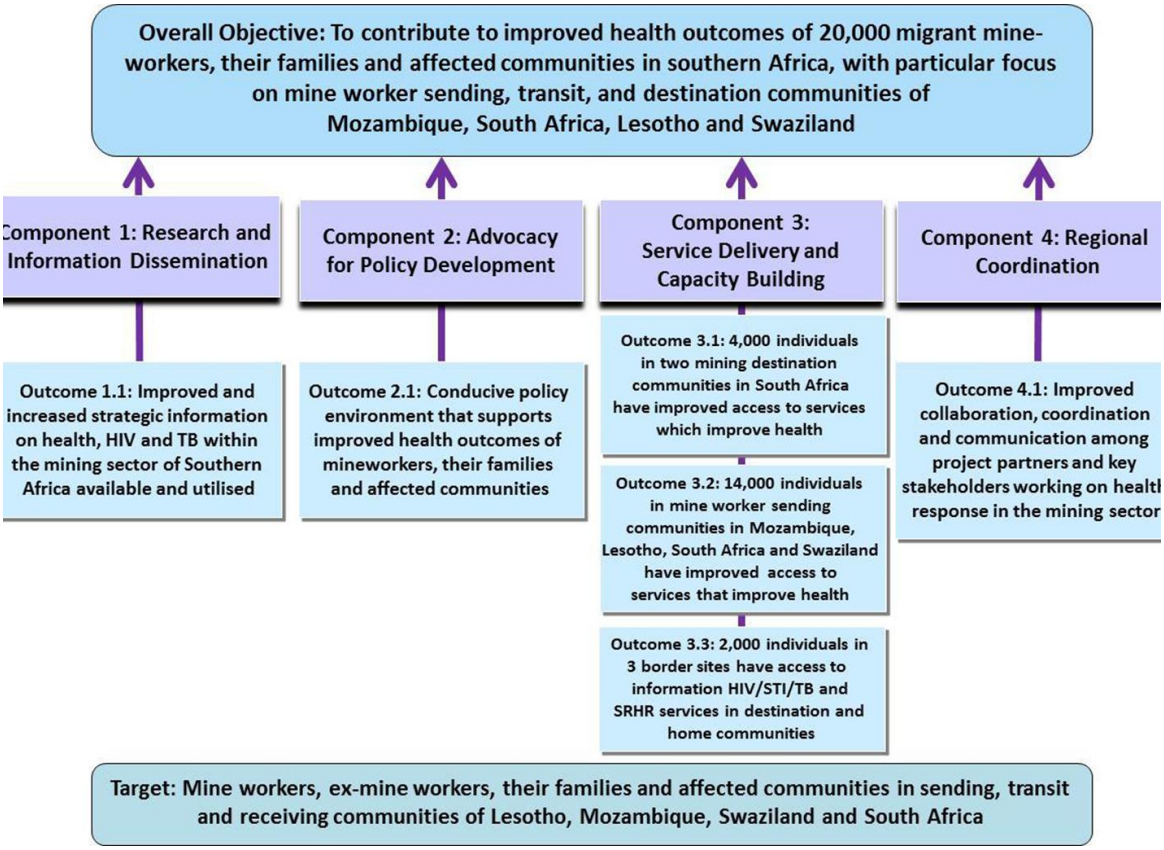
1.23 Project components and activities

The overall project was divided into four components –

1) Research and Information Dissemination with a focus on producing and distributing strategic information on HIV and TB in the mining sector of Southern Africa;
2) Advocacy and Policy Development to raise awareness of and build capacity for implementation of relevant policies, as well as strengthen the capacity of mineworker and ex-mineworker associations;
3) Service Delivery and Capacity Building interventions to directly improve access to services for 20 000 individuals in mineworker destination, sending and transit communities; and
4) Regional Coordination that aimed to facilitate coordination and partnerships internally among project partners/beneficiaries and with external stakeholders.

Project activities and outcomes were clustered under and reported against one of these components, which collectively were expected to positively influence the health of migrant mineworkers, their families and communities. The diagram below summarises the anticipated project outcomes according to the four project components.

Figure 1: Summary of overall objective, outcomes and components of the Mining Sector Project



The following key activites were carried out under each component of the programme and the routine monitoring and evaluation (M&E) system has linked measurement indicators and targets to these activities:

Research and information dissemination – key activities under this component included conducting four baseline assessments in target communities, a research piece on integrated HIV bio-behavioural surveillance (IBBS) as well as hosting activities such as workshops to disseminate the research findings.

Advocacy for Policy Development – IOM activities under this component focused on facilitating consultations and campaigns at country, biltateral, multicountry and regional levels to deepen understanding and promote coordination, as well as, provision of technical assistance (TA) for operationalisation of WHA Resolution 61.17 on Health of Migrants (2008) and the South African Development Community (SADC) Declaration and Code of Conduct on TB in the Mining Sector (2012). In turn, VSO focused on building capacity of the Southern Africa Mineworkers Association (SAMA) and its affiliates in Lesotho, Mozambique and Swaziland to effectively advocate for and implement initiatives that respond to the needs and rights of their members as regards HIV, TB and sustainable livelihoods. In line with VSO's ethos of volunteerism the primary strategy to accomplish this was the 6-8 month placement (and sometimes longer) of international volunteers within these organisations to build their institutional capacity.

Service Delivery and Capacity Building - This component aimed to reach 20 000 individuals in mineworker communities. IOM supported local partners to develop and implement a package of health education, promotion, prevention and care activities tailored to the local situation, utilising IOM's established Service Delivery and Capacity Building Framework (SDCBF). This involved the use of change agents (CAs) who conducted a range of peer education activities. VSO activities aimed to strengthen the organisational capacity of mineworker associations and increase family income among households of widows and orphans in migrant mineworker sending communities through involving approximately 1 100 women in phone businesses – the Phoning Out Poverty and AIDS (POPA) project.

Regional Coordination – Under this component the project was to establish regional and national project steering committees to facilitate internal (project) coordination and a regional M&E framework and communication strategy to facilitate project governance and control. To facilitate external coordination IOM would establish a Regional Partners Forum by working in consultation with SADC and other regional partners to facilitate bilateral and multilateral cooperation.

The results matrix developed at the start of the Mining Sector Project was revised during Project implementation. The results matrix aligned with the activities, as described above, was revised at the end of 2012 and finalised in early January 2013 and is dated 23rd January 2013.[2] In the following year, to ensure the Mining Sector Project kept aligned with PHAMESA II, the results matrix for the Mining Sector Project was again revised in 2014 (refer to results PHAMESA II Final Result Matrix PHAMESA II 31 May (2015)[3]) This amendment affected reporting against Outcome 3. Mainly because PHAMESA II had refocused on sexual and reproductive health rights (SRHR). This final revision meant that the outcome and output indicators for Outcome 3 changed. These revised indicators are the ones reported against in the country reports found in Part II of this evaluation report and on Table 7 of this report.

[2] 2013-01-23 IOM VSO Proposal and Results Matrix FINAL Revised

[3] 2015 31 May PHAMESA II Final Result Matrix

1.24 Project implementation sites

The project was implemented in 16 districts/regions in 4 countries – Lesotho, Mozambique, South Africa and Swaziland. The table below lists the implementation sites by country and classifies the mining community as a labour sending, transit or destination community.

Country	Number of implementation districts	Names of implementation districts/regions	Mining community type	Executing agency
Lesotho	5	Botha Buthe	Labour sending	VSO
		Leribe	Labour sending	IOM and VSO
		Mafeteng	Labour sending	IOM and VSO
		Maseru	Labour sending	IOM and VSO
		Thaba Seka	Labour sending	IOM and VSO
Mozambique	7	Gaza	Labour sending	IOM
		Inhambane	Labour sending	IOM
		Mabucuane	Labour sending	VSO
		Manhica	Labour sending	VSO
		Maputo City	Sending/transit	IOM and VSO
		Matola	Labour sending	VSO
		Maxaquene	Labour sending	VSO
South Africa	1	Waterberg	Labour destination	IOM
Swaziland	3	Lubombo	Labour sending	IOM and VSO
		Manzini	Labour sending	IOM and VSO
		Shiselweni	Labour sending	IOM and VSO
TOTAL	**16**			

1.25 Project partners

The complexity of the Mining Sector Project in terms of the multiple levels of intervention (regional, country, community) and the web of interactions that were necessary to realise this ambitious project required cooperation from a range of role-players and stakeholders. A number of project partners contributed to the project serving in various roles at the different levels of the project. IOM and VSO, RAISA (Regional AIDS Initiative of Southern Africa) were the executing agencies. IOM co-ordinated the project working out of the IOM South Africa, Country Office in Pretoria while VSO was tasked to address the livelihood component and strengthening of mineworker/ex-mineworker associations (MWAs).

Regional and national level partners included the World Bank. Southern Africa Development Community (SADC), National AIDS Councils (NACs), relevant government ministries including Health, Minerals and Energy and Labour, unions and MWAs, TEBA Development, private sector companies e.g. Mcel, Coca-Cola, United Nations (UN) agencies (UNAIDS, WHO, ILO), as well as international and local nongovernmental organisations (NGOs).

At the local level IOM and VSO supported in-country partner organisations and implementing partners (IPs) to implement activities. VSO managed POPA using in-country partner organisations that represented the interests of ex- and current migrant mineworkers (referred to here as mineworker/ex-mineworker associations or MWAs). IOM used IPs already engaged with local level health promotion activities. Table 2 below summarises the key project partners in each country over the lifecycle of the project.

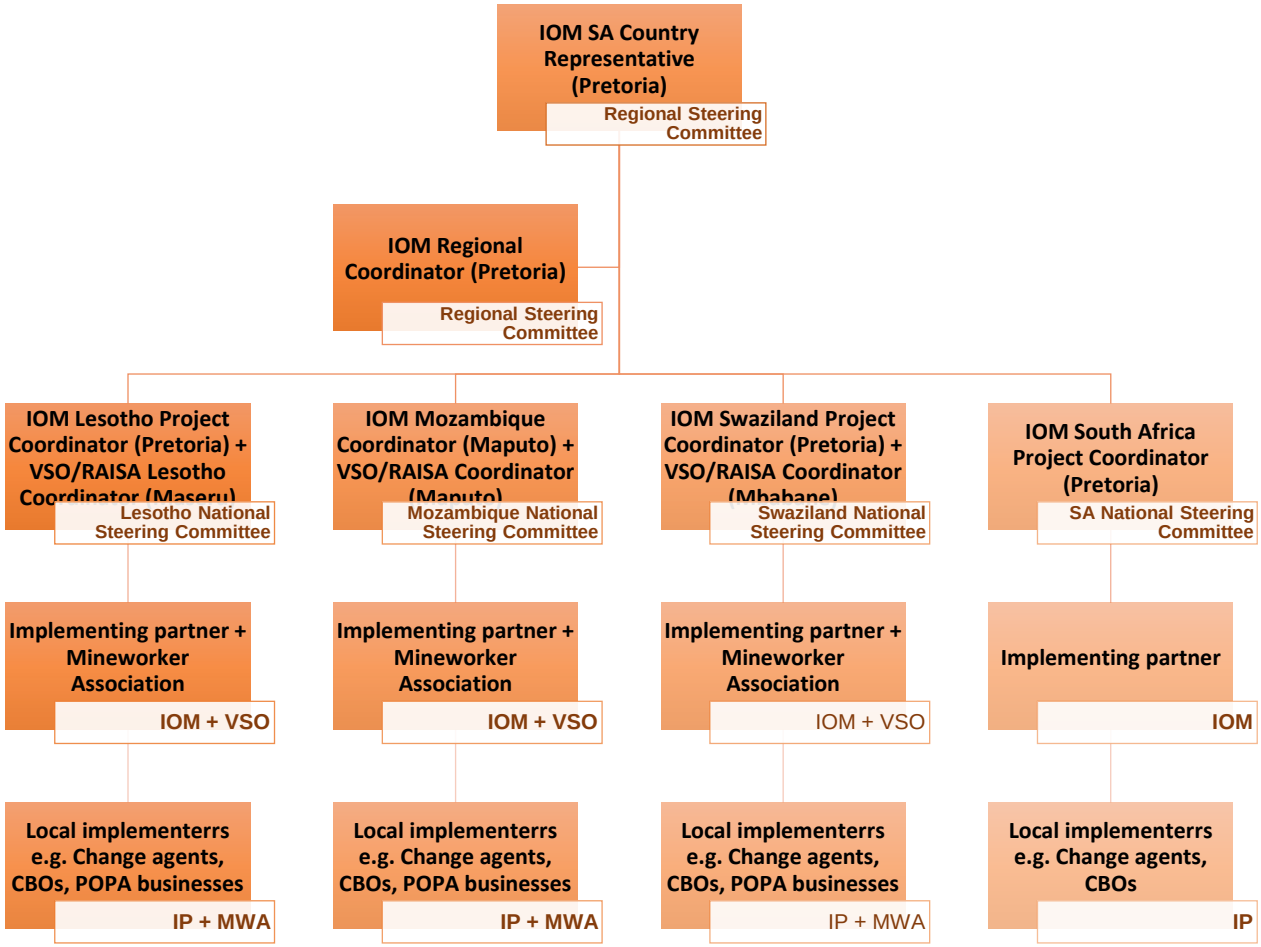
Table 2: Key implementation level partners by country

	Lesotho	Mozambique	South Africa	Swaziland
VSO-Mineworker association collaborations	– Lesotho Ex-mineworkers Association	– AMIMO – Kindlimuka in Moamba	N/A	– Swaziland Migrant Mine Workers Association (SWAMMIWA)
IOM appointed implementing partners	– CARE till Q4 2015 – Phelisanang Bophelong from 2016	– Associação Coalizãao da Juventude Moçambicana till October 2015 – Associação Pfuka Lixile from 2016	– CARE (2014-2015) – Centre for Positive Care (CPC) from 2016	– CARE till Q4 2014 – Swaziland National Network of People Living with HIV/AIDS (SWANNEPHA) from 2015

1.26 Project management and governance structure

The project management and governance structure for the Mining Sector Project as envisaged in the project proposal is illustrated in the figure below. The shaded blocks represent the project management reporting lines while the adjacent clear blocks represent the body responsible for playing the role/s of oversight, advisory, governance and/or coordination of the project.

Figure 2: Mining sector project management and governance structure



Project management and M&E oversight was provided to Lesotho, South Africa and Swaziland directly out of the IOM office in Pretoria, South Africa because there is not yet an IOM country office in Lesotho or Swaziland. The IOM office in Mozambique provided project oversight in that country.

1.27 Project implementation period

The Mining Sector Project was planned for three years (2013-15), but in practice was implemented over 4 to 5-years, between 2012-16. Activities undertaken by VSO were initiated in 2012 and completed in December 2015. The bulk of IOM activities were launched in 2014. IPs appointed by IOM continued implementing activities on the ground in all four countries until December 2016, and until April 2017 in Lesotho and South Africa only. These activities conducted beyond December 2015 were carried out on the basis of a no cost extension.

1.28 Project budget

The total project spend was €4, 971 143 of which € 2,965 633 was spent at a Regional level primarily covering staff and office costs, research, policy and advocacy work. €2,015 511 was spent mostly at the country level and covered the implementation costs of POPA and IOM's outreach peer education work. In relation to IOMs work at a country level Swaziland had the smallest spend per country. Mozambique, South Africa and Lesotho had double the spend of Swaziland. No country figures were made available for VSO POPA spend.

Table **3: Project spend as May 2017 (unaudited figures) in Euro**

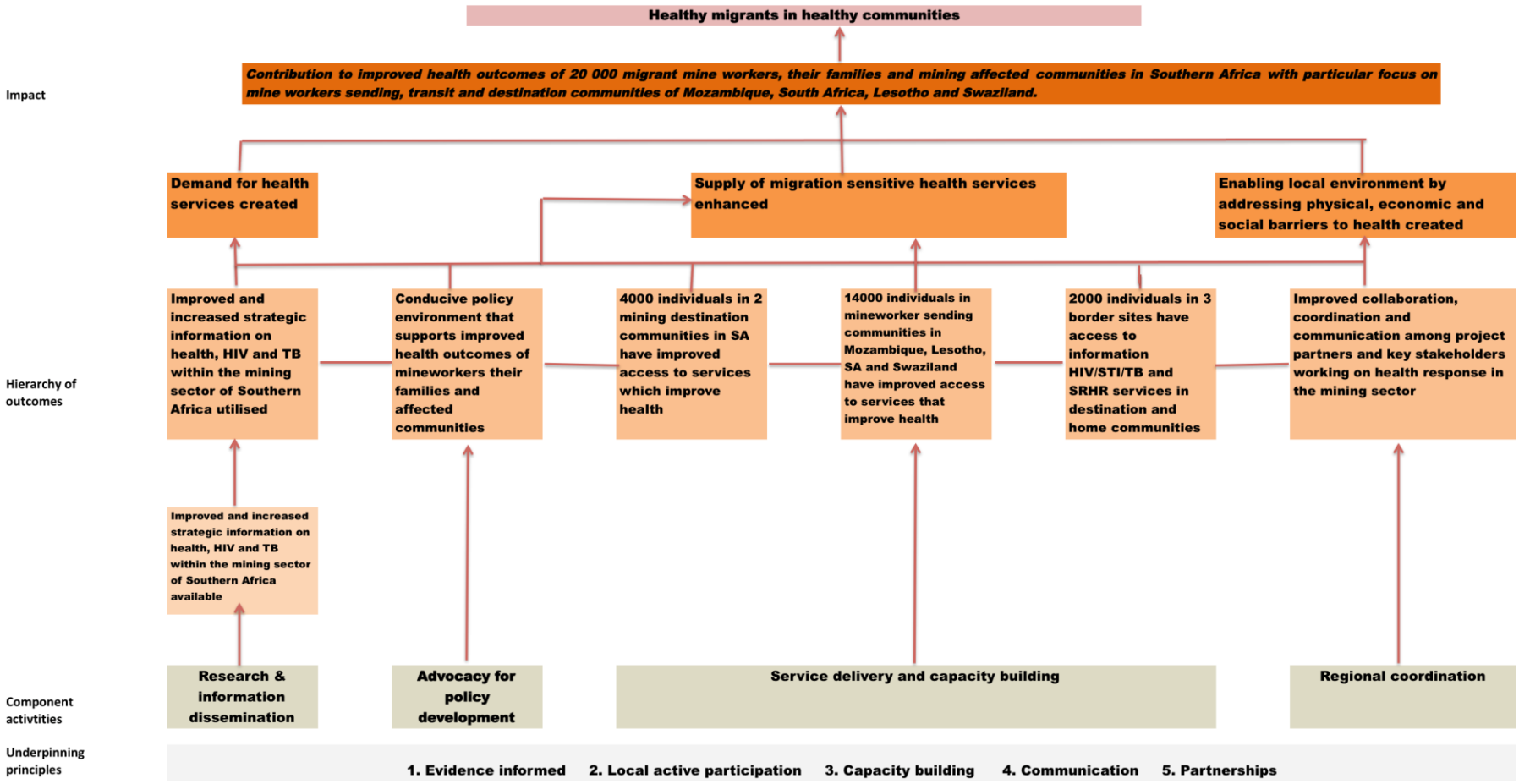
Project Component	Totals in Euros (VSO &IOM)	Region (IOM)	South Africa (IOM)	Swaziland (IOM)	Lesotho (IOM)	Mozambique (IOM)	POPA (VSO)
Research	396 062	396 062					
Advocacy & Policy	749 935	469 348					280 587
Capacity building & service delivery	1,377 187		248 892	92 800	195 839	196 973	642 683
Regional coordination	188 089	188 089					99 902
Monitoring & evaluation	123 995	123 995					
Staff & office costs combined	1,898 738	1,551,001					357 737
Overheads	237 138	237 138					
Grand Total	4, 971 143	2,965 633	248 892	92 800	195 839	196 973	1,281 007

1.29 Theory of change

The Project has not developed an explicit theory of change (TOC). The best approximation for a theory of change is the IOM Service Delivery and Capacity Building Model (SDCBM). Put simply, this framework hypothesizes that once a demand for health services is created, and the supply of migration sensitive services is enhanced within a socially and economically enabling environment, then the sum of the parts results in the best possible opportunity for positive health outcomes for migrant populations. SDCBM is a particularly valuable framework to understand the intervention on the ground in mining affected communities (refer to Outcome 3 in Figure 1).

The evaluation team used this SDCBM as a basis for constructing a theory of change (retrospectively) and to frame the write up of the evaluation findings. This facilitated the triangulation of data across countries to see if the high level hypothesis for change occurred in some instances and if any activities appeared to have acted as leverage points for this across all sites. The simplified, retrospectively constructed TOC is illustrated in Figure 3 below.

Figure 3: Project theory of change - retrospectively constructed and simplified



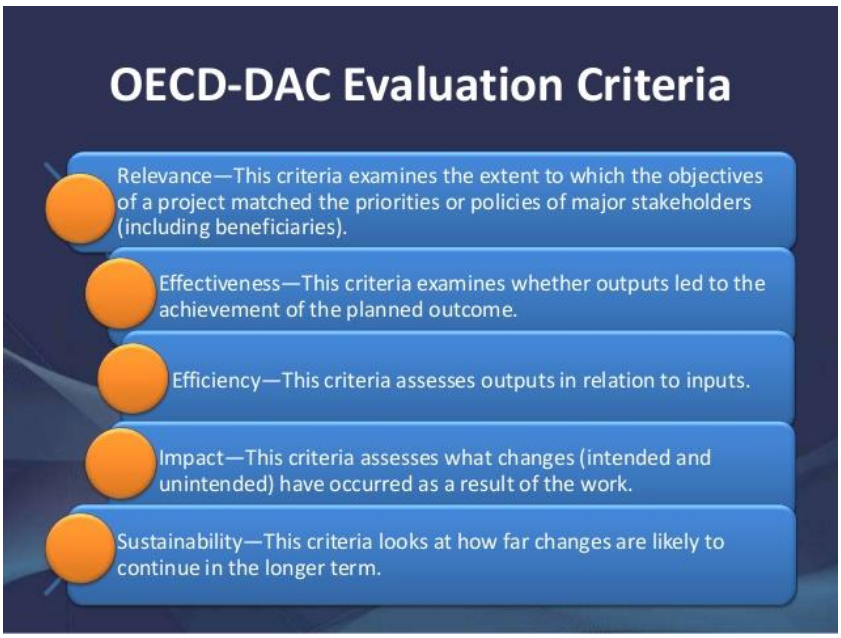
2. Approach and Methodology for the Endline Evaluation

2.1 Purpose of the evaluation

The purpose of the Endline Evaluation was to assess whether the project had achieved its targets and goals as outlined in the key outcomes. **The overall objective** of the evaluation as stated in the terms of reference (TORs) was to collect evidence to determine the overall project contribution in improving the lives of the target beneficiaries and in capacity building of stakeholders to address HIV and AIDS and other health challenges in the mining sector.

The evaluation set out to assess performance according to the OECD/DAC evaluation criteria[4] focused on relevance, efficiency, effectiveness, impact and sustainability (refer to Figure 4). To achieve this it was important that the OECD-DAC evaluation criteria was central in the formulation of evaluation methodology, research tools, data collection and analysis and that cross-cutting issues, such as poverty and gender are taken into consideration at all stages.

Figure 4: OECD-DAC evaluation criteria



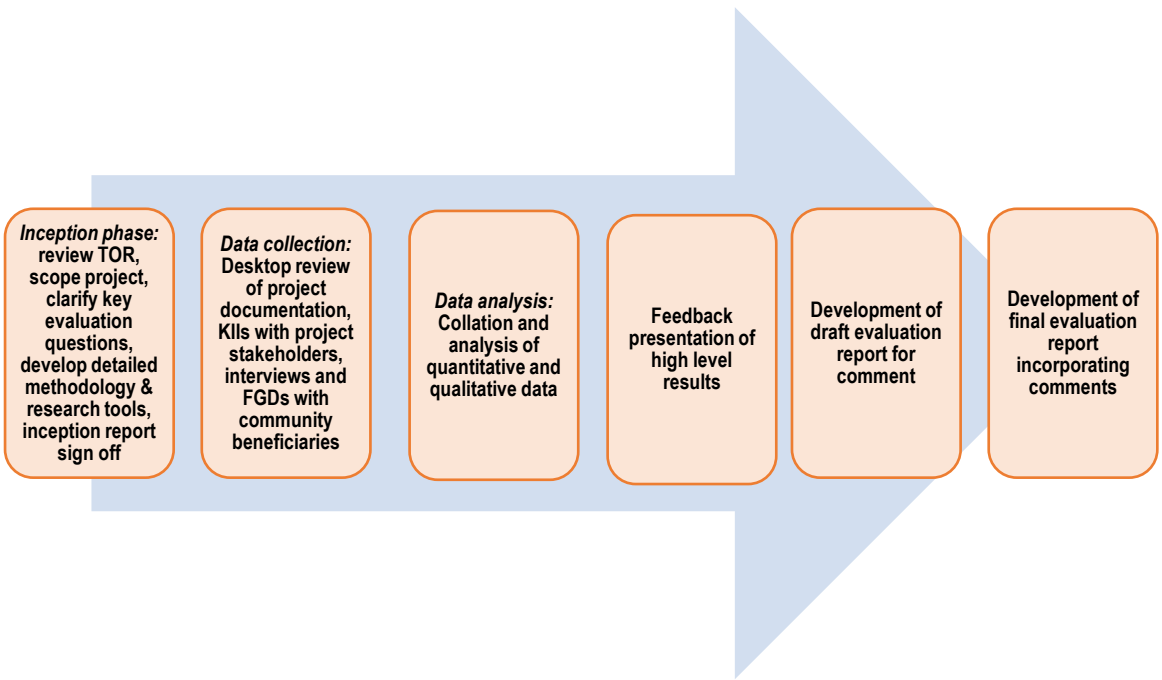
2.2 Process of the evaluation

The evaluation followed a 6-step process beginning with an inception phase to review the TOR, scope the project and clarify the key questions to guide the evaluation of this complex project. A number of consultative meetings were held with the project coordinators from IOM and VSO and the evaluation team to develop a clear, joint understanding of the research activities it was feasible to conduct as part of the Endline Evaluation; to identify and select the sites for the field study; and to generate a list of possible key informants. At the end of this very iterative process, the evaluation team developed the project inception report detailing the methodology, research tools and data analysis plan (First inception report dated 20 December 2016 and revised report 20 February 2017). The process of data collection started immediately after sign off of the inception report. Once the data had been analysed the evaluation team gave a presentation of the high level results and incorporated the feedback from the IOM/VSO project team to develop a draft evaluation report

[4] https://www.oecd.org/development/evaluation/dcdndep/47069197.pdf

for comment. These comments were used to refine the draft and develop the final endline evaluation report. This systematic process is represented in Figure 5 below.

Figure 5: Process followed for the Mining Sector Project Endline Evaluation



2.3 Key evaluation questions

The evaluation questions are aligned with the project components as well as the OECD-DAC evaluation criteria and both were used to frame the evaluation and to inform the methodology and tool development for both secondary data collation and primary data collection. The key evaluation questions as agreed between the evaluators and the IOM/VSO teams and listed in the inception report are:

1. **How did the external context impact on the project?**
    a. The response of stakeholders and beneficiaries
    b. Policy and political challenges
2. **How did the internal context impact on the project?**
    a. Including outputs in relation to inputs (focus on human resources and capacity development in relation to roll out at the regional, national and local levels.
    b. The management and partnership structures
    c. Budget and resources
3. **What difference has the project made to access to health promotion and clinical services for beneficiaries?**
    a. Combined evidence over 4 countries between 2012-16 (quantitative and qualitative monitoring data) VSO and IOM
    b. How effective has this project been?
    c. How did the four outcomes work together to produce this change?
4. **What are the prospects for sustained change?**
    a. Intended and unintended changes

2.4 Methodology

The evaluation used a mixed methods approach to data collection. This included a desktop review of project documentation, monitoring data, previous research and evaluations, as well as, primary qualitative data collection in the form of key informant interviews (KIIs), focus group discussions (FGDs) and observation site visits. The team conducted research activities at all three levels of project implementation - regional level, national level and a sample of the local sites (5 sites out 16) in the four countries. The research team consisted of a lead researcher assisted by two senior researchers who conducted the national level interviews and managed and directed the country research teams. An experienced researcher and fieldworker visited each local site to conduct the FDGs and local level KIIs. Besides providing strategic guidance and oversight for the project and holding overall accountability for the integrity of the evaluation, the lead researcher also conducted one country visit. A project manager provided administrative and logistical support and managed the project-related finances.

Data gathering for the Endline Evaluation commenced with an in-depth review of the Mining Sector Project documentation both from IOM and from VSO. This review included a compilation of both quantitative and qualitative data found in quarterly monitoring reports and site visit reports. This exercise helped to shape the primary data collection tools in terms of areas to probe and gaps to be filled during the fieldwork and site visits. Data collection tools were designed for each level of the evaluation and are found in Part II of the evaluation report. The process of document review took place between February-March 2017 when the evaluation team received the last tranche of project documents; data verification continued throughout the course of the evaluation. The verification of the monitoring data with IOM Project staff continued throughout the finalisation of the Endline Evaluation Report. Primary data collection in the form of individual KIIs, FGDs and site visits was conducted in the period February to April 2017.

2.41 Sample selection

Site selection

At the Inception Workshop held on 2nd December 2016 IOM and VSO Mining Sector Project staff identified five sites for local level Endline Evaluation research activities based on two criteria – sites where there is an overlap in IOM and VSO POPA activities under the Mining Sector Project, and sites that represent labour sending, transit and destination communities. The sites visited for the evaluation to verify findings and observations arising from the collation of existing secondary data, and to collect additional data in relation to OECD-DAC criteria, were Leribe and Mafeteng (considered one site) in Lesotho; Shiselweni in Swaziland; Maputo, Moamba (considered one site) and Ressano Garcia in Mozambique; and Thabazimbi in South Africa. Three of the sites – Leribe, Mafeteng, Shiselweni, Moamba and Maputo - are labour sending areas, one (Ressano Garcia) is a transit community and one (Thabazimbi) is a mining destination community.

Key informants

Primary data collection using individual key informant interviews was conducted at regional, national and site levels. IOM and VSO project co-ordinators based in Pretoria guided the evaluation team in the process of purposive sampling of individuals who held important roles within the Mining Sector Project and/or were key partners at each project level. A snowballing technique was used and in-country researchers interviewed other key individuals identified by country counterparts as necessary and important. At the site level the implementing partners were important respondents; they were also invited to direct researchers to other important potential interviewees.

Focus group participants

Implementing partners assisted in the purposive selection of focus group participants who had direct experience of project services (either IOM and/or VSO livelihood activities). Given the resources and time constraints for fieldwork it was not possible to randomly select focus group participants from a list of project

beneficiaries or change agents at a site level and therefore bias in the site based project selecting FGD respondents cannot be ruled out.

Data collection and quality control

Secondary data collection – IOM and VSO submitted a slew of electronic programme documents to the evaluation team. These were categorised by country and document type e.g. quarterly M&E reports, annual reports, baseline reports, previous evaluations etc. and saved in Dropbox. The researchers and senior researchers on the evaluation team had access to the Dropbox.

Qualitative - Primary data collection consisted of key informant interviews (KIIs) and focus group discussions (FGDs). KIIs were conducted at the regional, national and local level with members of the regional IOM and VSO implementation/technical advice team and with other regional representatives of key stakeholders in the mining, labour and health sectors. KIIs at the regional and national level were conducted face-to-face or over Skype. Interviews were conducted using a semi-structured interview technique with the assistance of an interview guide. Researchers experienced in conducting qualitative research and programme evaluations interviewed the respondents in Portuguese (Mozambique) and English (Regional, Lesotho, South Africa, and Swaziland).

At the local level KIIs with the local implementing partner and other stakeholders were complemented with three FGDs with beneficiaries and with Change Agents (one FDG with ex-mine workers and current mineworkers; one FGD with POPA beneficiaries; one FDG with local Change Agents).

Researchers able to work in local languages conducted all KIIs and FGDs at the local level. Researchers were oriented to the tools at a workshop prior to the initiation of any fieldwork. Notes were prepared about each KII and the FGDs were transcribed in English.

Table 3 provides a summary of the primary data collection. It shows the number of data collection sites per implementation sites per country, the number of KIIs and FGDs in each country (and number of participants in FGDs) who were reached with respect to this evaluation. Note with respect to the KIIs the bracketed figures on Table 3 indicate the number of interviews conducted. The non-bracketed figure is the number of requested interviews. Interviews did not take place for a range of reasons such as respondents being unable to commit to time and/or place for the interview, requiring written permission to participate, or respondents being on leave.

The team conducted a total of 58 KIIs of which 8 were at a regional level, 45 at country level and site level. Five KIIs were conducted with POPA beneficiaries (note these interviews were in addition to beneficiaries reached through the FGDs). In total 13 FGDs were facilitated reaching 89 beneficiaries and 42 change agents.

Table 4: Summary of primary data collection

Methods	Region	South Africa	Swaziland	Lesotho	Mozambique	POPA (3 countries)	Totals
Local data collection site		1 out of 1 implementing district	1 out of 3 implementing regions	2 out of 5 implementing districts	2 out of 7 implementing districts	5 out of 13 implementing districts	
KII national & local level	10(8)	14 (9)	7 (8)	5 (5)	21(17)	6(6)	53
KII POPA beneficiary		N/A	1	2	2		5
TOTAL KII	8	9	9	7	19	6	58
FGD conducted		2	2	2	4	3	13
FGD # Beneficiaries		19	7	10	24	29	89
FGD # Change Agents		13	10	10	9		42

2.42 Data management and analysis

Secondary quantitative data from programme documentation was collated on a data collection matrix (Excel spreadsheet) against Project output indicators. The majority of this data concerned the implementation of activities under Outcome 3. The evaluation team found numerous inconsistencies and insufficiencies in the quantitative data. This resulted in the decision to present only non-disaggregated project totals per year, per country, against output indicators (refer to the country reports in Part II and Table 7 in this report). Inconsistencies in the monitoring data concerned data gaps, inaccurate disaggregation and discrepancies between reports. The insufficiencies reflected the inadequate design and disaggregation of data that meant the evaluation team could not trace trends or even identify sites where implementation seems to have been particularly successful or not. The major observations made by the evaluation team about the quantitative monitoring data were as follows:

- Missing data for some quarters in years 2014, 2015 and 2016. This was compounded by missing disaggregated data by age and sex as per the indicator description which meant the evaluation team was unable to conduct any kind of trend analysis.
- Disaggregated figures for age and sex often did not tally with the totals, and some figures were hugely inaccurate.
- Data reported on for Change Agent activities in Mozambique included activities funded by SIDA under PHAMESA II. Thus figures for the Mining Sector Project activities in Mozambique are inflated.
- Monitoring data was reported on inconsistently between project documentation with different figures appearing in different documents.
- Examples were found in Project documentation that seemed to suggest that in some cases the data verification process was incomplete.
- Data was not disaggregated by implementation site so the evaluation team could not identify where activities implemented by IPs in country had been particularly successful or not.

Secondary qualitative data was found in the narrative and site visit reports submitted for review to the evaluation team. This was collated in a data matrix (excel spread sheet) for each country against key themes/focus issues and/or data source such as mid-term review or quarterly reports.

Primary qualitative data collected in the field was analysed using deductive themes aligned with the DAC/OECD criteria described above. These themes were used to construct the regional, country and POPA report (refer to Part II of the evaluation report). These reports were supported by the secondary quantitative and qualitative data where necessary and are described as integrated reports.

The findings of the regional, country and POPA integrated reports were used to construct the findings to the major evaluation questions and to make concluding recommendations.

2.43 Ethics

The African Evaluation Association (AfrEA) and South African National Evaluation Framework of 2011 were both consulted with respect to ethical considerations for the Endline Evaluation. AfrEA, of which Mozambique, South Africa and Swaziland are member countries, has published African Evaluation Guidelines setting out norms and standards for evaluations based on ethical principles and quality criteria.[5] In keeping with these every effort was made to ensure that the research process was socially sensitive and respected the rights of all participants, especially potentially vulnerable individuals, including, the beneficiaries and community members. Children under 16 did not participate in the FGDs. Participation was on the basis of informed consent and anonymity.

The South African National Evaluation Framework of 2011 distinguishes between evaluation and research and defines evaluation as data collection and analysis activities directed at learning, accountability, improving

[5] African Evaluation Association. African Evaluation Guidelines – Norms and Standards. 2006/07 Version. Available at: http://www.ader-evaluare.ro/docs/African%20Evaluation%20Association.pdf. Accessed on 2 May 2017

services and informing policy, planning and budgeting.[6] A review such as this, is therefore, not expected to be presented to an ethics committee, unless there is an intention to publish the results of the evaluation in a public forum.

2.44 Limitations to the study

The Endline Evaluation had some constraints, which were clearly articulated in the Inception Report dated 20th February 2017. The constraints focused on two major limitations:

1. **The absence of a theory of change** – the evaluation team has reconstructed a TOC against which to test the Endline Evaluation.
2. **The absence of quantitative baseline data for the overall Mining Sector Project against which to record change over time especially for Outcome 3 –** the outcome indicators found in the PHAMESA II Final Results Matrix (dated 31 May 2015) require baseline and endline surveys to establish change. This is because the indicators require a measure of the % change in the target population. Although detailed 'baseline' studies were conducted during 2014/15 in all four countries, these baseline studies were isolated to specific communities only and did not constitute a baseline for the Mining Sector Project as a whole.

Given limitation (2) the evaluation team with the IOM and VSO Project staff took the decision that additional qualitative information would be collected at a site level to strengthen the available output monitoring data. And that this would provide insight about the change brought about by activities funded through the Mining Sector Project in communities. As mentioned in the section on methodology, these sites were purposively sampled and bias in their selection, and with respondents interviewed on site cannot be eliminated.

[6] National Evaluation Framework.2011 Available at: http://www.thepresidency.gov.za/MediaLib/Downloads/Home/Ministries/National_Evaluation_Policy_Framework.pdf. Accessed on 13 November 2013.

3. Endline Evaluation Findings

The findings of this evaluation take data from the following sources:

- A desktop review of project documentation both quantitative and qualitative
- The collation of primary data collected in the field and analysed against OECD-DAC criteria

These sources have been written up into integrated reports that are found in Part II of this evaluation report. These reports include:

- An integrated report of regional findings
- An integrated report of national and local findings (South Africa, Lesotho, Swaziland and Mozambique country reports)
- An integrated report of POPA – including success stories.

A summary of the conclusions of the regional, country and POPA integrated reports with respect to OECD-DAC criteria is found in Table 6 at the end of this report. A summary of the overall output data for the IOM project is found in Table 7 at the end of this report. A summary of the overall output data for POPA is found in Table 8 at the end of this report. These combined sources provide the evidence for the findings presented here.

The overall findings are structured to answer the overarching evaluation objective and four questions set out on page 15 of this report. The text starts by addressing the four sub questions drawing evidence from the above sources including the referenced tables, before reflecting on the overarching evaluation objective in the conclusion. Examples are used from the integrated reports to illustrate the points made were necessary.

3.1 Evaluation question 1: How did the external context impact on the project?

The response of the key constituencies (government health and labour Ministries, MWAs and related stakeholders and in-country partner organisations) to the Mining Sector Project and the overall policy and political environment were used to frame the impact of the external context on the project**.**

In summary, the evaluation found that the Mining Sector Project was very relevant and was significantly supported by the external context at all three levels of the Project functioning. The summary of the findings with respect to OECD-DAC criteria (refer to Table 6) showed that the Mining Sector Project remained relevant because it addressed HIV and TB in mining districts where prevalence is higher than in the general population, and because poverty with few livelihood opportunities continue to face beneficiaries in these communities. At the local level the Mining Sector Project interventions were at times over overwhelmed by poverty; and that for the target beneficiaries, pension and compensation payments due to ex-mineworkers are unresolved for many contributing to local poverty.

3.1.1 At the region

At the Regional level there is an overwhelming response from key informants that the project was timeous and that the SADC TB in Mining Declaration 2012 propelled this work centre stage. The Mining Sector Project was described as, *"riding the crest of a wave."* (KII stakeholder region) Respondents spoke to the political opportunity at the time as Southern African countries grappled with the escalating TB epidemic associated with South African mining, *"You are spreading TB in our countries"* (KII stakeholder region). This politically favourable climate had a ripple effect for all levels of the Mining Sector Project. The mandate of IOM to work with migrant populations was deeply appreciated by other stakeholders at a regional level and both IOM and VSO were felt to have played an important role in supporting developments related to TB and HIV in mining affected populations, although in general the World Bank/Dfid and the Medical Bureau for Occupational Disease (MBOD) in South Africa) were considered as the lead policy and programme agencies.

At times it was difficult for the evaluation to clearly distinguish between what was regional and what was a national initiative, especially with respect to South Africa. This is not surprising given the profound impact South African mining has had both historically and today on neighbouring countries. An example of how the Mining Sector Project successfully rode the "*crest of a wave"* was described in South Africa where key informants reported that the Mining Sector Project played a significant role in facilitating a year long process of intense dialogues centred around reforming the compensation system in South Africa, and extending

services to the neighbouring countries of Botswana, Lesotho, Mozambique and Swaziland. Leveraging off the financial support and technical expertise provided by development partners, the process brought together key role-players responsible for compensation of ex-miners, ex-mineworker associations, labour unions, various government departments[7], and mining houses. The SA Deputy Minister of Mineral Resources chaired the Steering Committee, which provided oversight to the work of six technical working groups (TWGs)[8]. Papers presented by the TWGs were deliberated during a Summit on integration of compensation systems in Southern Africa, convened in May 2016. More than 200 delegates representing key stakeholder groups (governments and ex-mineworker associations) from across the region attended the summit, which was held in Johannesburg. Further work after the Summit resulted in a report that was delivered to the Southern Africa Ministers of Health and Labour in October 2016 and forms the basis of ongoing effort in this area.

"The success of this initiative was facilitated by multilateral agencies – it would have been difficult for MBOD to go forward with neighbouring country governments and associations without the involvement of IOM. Multilateral agencies are able to facilitate intergovernmental talks much easier than having bilateral engagements…" (KII stakeholder South Africa)

"If we didn't have that (financial support) *we would not have had funds to bring neighbouring countries to technical workshops. We would have invited them but they tell you they can't come because there is no money…".* (KII stakeholder South Africa)

3.1.2 At the national level

At the national level the Mining Sector Project achieved high-level government engagement both with politicians and with senior management and technical specialists in the Ministries of Health (MoH) and Labour (MoL) especially. Regional political commitments certainly aided this. The MoH and MoL were compelled by these developments to work together. In Lesotho and Swaziland the establishment of the Partnership Forums on Migration and Health are examples of this (refer to Box 1). However not all Ministries felt that the Mining Sector Project had achieved enough by just bringing all the role-players together. A minority of stakeholders felt that *"just talking"* wasn't enough and that the Mining Sector Project should have had more concrete deliverables at the national level. For example this could have included specific policy guidance and/or support with the training of health professionals able to deliver occupational health services.

Box 1: Swaziland National Policy and Co-operation Achievements

With support from the Mining Sector Project a HIV and TB technical working group (TWG), called the Partnership Forum on Migration and Health, was formed. The group held quarterly meetings since the inception of the Project and hosted a Summit in May 2015 involving government and civil society stakeholders relevant to the mining sector. Each stakeholder presented their contribution resulting in a 'harmonised' work plan where each stakeholder is aware of the strengths, resources and activities of the others fostering closer collaborations and working relationships. As a result of the work of the TWG towards the joint TB/HIV concept note for the Global Fund (GF) grant for the first time, miners and ex-miners, are included as a key target group in the national strategic plans (NSPs) of both Swaziland National AIDS Programme (SNAP) and the National TB Control Programme. There is also a closer working relationship between the two (HIV and TB) departments.

The establishment of partnership forums propelled MWAs into important consultative forums at the national level. VSO capacity building that initially focused on the regional Southern Africa Mineworkers Association (SAMA) but, that quickly saw the need to build capacity with MWAs at the national level, has ensured that mineworker voices are heard, both at the national and regional levels. Current and ex-mineworkers have been given a voice and a face for senior government officials and for local politicians. In Mozambique, for example the inclusion of the mineworker association, AMIMO into a process with the National HIV/AIDS Combat Council resulted in an important policy development that saw migrant mineworkers moved from vulnerable to priority groups according to PEN IV (National HIV and AIDS Strategic Plan)

[7] Such as ministries of health, labour, social development and mineral resources in SA and neighbouring countries

[8] Work streams included Policy and legislation, Organisation and management, Service delivery, Financing and Communication.

3.1.3 At the local level

At the local level across four countries ±270 000 individuals (end of 2016) were reached with health education and 205 widows were running businesses under the umbrella of POPA at the end of 2015. These significant achievements were positively impacted on by developments at the regional and national level, but in many instances, at the local level were overwhelmed by the extent of poverty in mining affected communities.

Developments at the regional and national levels had a knock on effect for the constituents of mineworker associations. For example, VSO activities in Swaziland to build the capacity of the mineworker association SWAMMIWA for advocacy and as network organization, also helped to strengthen their constituency on the ground.

"Beneficiaries had positive response because the project came at a time when miners were in a process of discussing with government regarding their compensation so it was timely." (National KII Swaziland)

But, as the Mining Sector Project implemented activities on the ground, the overwhelming poverty found in mining affected communities engulfed the well intentioned initiatives. Migrant mineworkers and ex-mineworkers live in situations of extreme poverty and food security and getting basic needs met were described in some cases as the more immediate imperative than health education provided by Change Agents. Change Agents found community members who were unable to take TB/ARV medication because of hunger and/or being unable to pay transport to get to the clinic. In South Africa migrant communities were afraid of not having documentation and xenophobia.

"But the most challenging thing is that people around this area starving, thus you will find others defaulting or not taking their medication the way they are supposed to." (FGD Change Agents Swaziland)

"Yes people are hardly interested in things that will not benefit their stomachs." (FGD ex-mineworkers and mineworkers Lesotho)

"A migrant has bigger fears e.g. being deported than wearing a condom and projects need to recognise this and work from where they are. However, the program reports on condom numbers distributed – biomedical interventions are easier to count" (KII stakeholder South Africa).

"… They stay in informal settlement, in shacks, face challenges of not having transfer letters from their countries health wise, as such they can't access health services, they live in fear because of xenophobia and are afraid to associate with local people, some are employed whilst the others are not." (FGD Change Agents South Africa)

In FGDs with ex-mineworkers the poverty associated with the failure of mining companies and/or governments to resolve the compensation and pension pay outs due to workers remains a priority.

"I came back with hearing problems after working many years at the mines, I was told I am going to be paid when I got home but that never happened. I then followed up and was told apparently my application was mistakenly not sent through but even today I have not received a cent from the mine." (FGD ex-mineworkers and mineworkers)

Despite the significant role played by IOM, through the Mining Sector Project at a Regional level, to address this, beneficiaries and key informants at a country and local level pointed to the failure of the Mining Sector Project to do more to address this protracted struggle. In one case it was proposed that there should have been training of doctors at the district level to support screening for occupational disease and the establishment of a database for compensation claims.

All respondents agreed that mineworkers and ex-mineworkers continue to face difficulties living in resource-constrained communities. Baseline assessments of target communities were delivered late and therefore the Mining Sector Project lacked timeous and reliable information to examine the context for proposed interventions. There were difficulties experienced on the ground that were due to an inadequate assessment of how to reach beneficiaries and with what services within the context of very resource constrained communities. For example, there were problems with the appointment of IPs (in Lesotho and Swaziland) because they were not actually resident in mining affected communities, and therefore hampered in their ability to quickly reach, and or establish the trust of beneficiaries. Or the IP, moved away from the target community (South Africa). In both cases, beneficiaries were short changed by this. Respondents in all countries felt POPA was spread too thinly across too many districts.

Summary findings:

At the **regional and national level** the Mining Sector Project was relevant, timeous and the SADC TB in Mining Declaration and Code of Conduct 2012 propelled this work centre stage. IOM made a major contribution to the 2016 Summit on the Integration of Compensation Systems and to the establishment of national Partnership Forums on Migration and Health. VSO has successfully supported through capacity development mineworker and ex-mineworker associations in Southern Africa to meaningful participate in these developments.

At the **local level** VSO capacity building strengthened the constituencies of mineworker and ex-mineworker associations. However the desperate poverty of mining affected communities overwhelmed some activities undertaken under the Mining Sector Project. Compensation and pension payouts remain unresolved for many beneficiaries and contribute to the experience of poverty.

3.2 Evaluation question 2: How did the internal context impact on the project?

The internal context for the Mining Sector Project was shaped by the extent to which the human resources, management and partnership structures and budget could meet the targets set for the project. This largely concerns the effectiveness and efficiency of the Project, as well as, issues related to cost and cost efficiency.

The summary of the findings with respect to the OECD-DAC criteria showed that Change Agents had been an effective means to reach large numbers of individuals with health education. However there was anecdotal evidence only of the quality of these interactions, M&E data was inconsistently collected and validated, their work was affected by the absence of a stipend (Swaziland, Lesotho and Mozambique), and/or there was high turn-over of Change Agents, stigma and discrimination impacted on their work and the IP was poorly selected in some instances. POPA was found to be spread too thinly across three countries and 13 districts with respect to the amount of resources. POPA also faced numerous implementation challenges on the ground (refer to section 3.3.3). At the regional level there was inadequate line management capacity for M&E and research and all the research outputs were delayed. Collaboration with local partners and the national Partnership Forum for Migration and Health were considered effective.

The mid-term reviews (MTRs) for PHAMESA II (dated 2016) and the Netherlands HIV/AIDS/SRHR Programme in Southern Africa 2012-2015 (dated 2014)) both reported that the Mining Sector Project faced challenges with respect to effectiveness and efficiency. The findings of this evaluation are that this did not change by the close of the project.

3.2.1 Effectiveness

3.2.1.1 Governance and management

There is limited evidence in Project documentation that measures were taken to respond to the specific challenges associated with effectiveness, and that these continued to hamper project implementation. This is despite Project documentation often providing useful recommendations. One possible underlying cause for this is that the governance and/or management within the Mining Sector Project was insufficient for the regional/four country project. The structure shown in Figure 2 in practice seems not to have adequately taken shape. Specifically a multi-sectoral and/or representative structure for the overall initiative at a regional level (regional steering committee) and country levels (national steering committee) were missing. There are several reasons for this.

The Regional Project Steering Committee (RPSC) was set up at the start (2013) but later integrated with the regional Programme Implementation Committee (PIC) for TB in the mining sector convened by the World Bank. This was a pragmatic step because both initiatives were reaching the same individuals. The PIC in practice was a large gathering of role-players (up to 80 people) across the region to share information and co-ordinate activities related to TB in migrant mineworkers and ex-mineworkers. It met five times during the lifetime of the Mining Sector Project. However the structure of the PIC was such that it could not function as a forum that could respond to the day-to-day difficulties experienced with the implementation of the Mining Sector Project, although it did ensure the Mining Sector Project was well networked with key role-players. Effectively this meant that the Mining Sector Project lacked formal multi-stakeholder governance.

One consequence of this is that Project managers working in the region and at a country level may not have felt that they had the authority and/or combined experience to manage difficulties on the ground. Probably the biggest challenges that faced the project were interventions on the ground being spread too thinly across districts, especially POPA. For example, the transport budget was inadequate in Swaziland to provide effective mentoring to POPA recipients. The pre-determination of districts led to the formation of a break-away MWA in Lesotho because ex-mineworkers in the Berea District felt they were being deliberately marginalized. Working with membership structures such as the MWAs is complex work, and although there is evidence in this evaluation that associations have grown because of the institutional development facilitated through VSO, the extent of the capacity gaps, and the expectations of these associations with respect to the Mining Sector Project made this challenging work for international volunteers. A multi-stakeholder governance structure/s at the regional and national levels could have responded timeously to some of these difficulties by reframing the scope of activities, reallocating the budget in conversation with the donor and providing support to project staff working on the frontline of change.

The management of the research component of this project also proved difficult. This may have arisen because of an internal reorganization in IOM that led to the technical expertise necessary to implement the

research component of the Mining Sector Project moving into the IOM Regional Office and away from a direct line function responsibility for the Mining Sector Project, which remained in the South African Office. Possibly as a consequence of this the baseline (which serves as a series of detailed situation analyses, rather than a baseline), in particular, was poorly executed for this Project as whole and the Integrated Biological Behavioural Surveillance (IBBS) study is still incomplete.

At a country level formal advisory, and or steering committee structures as mentioned above were also absent. Rather consultation and/or sign off were sought through Partnership Forums at the national or district level (as in South Africa). In Swaziland, the relevant government departments, led by the Ministry of Labour and the Ministry of Health, provided input and endorsed the project before any activities were implemented. These consultative structures were identified as having been effective. However the absence of a formal advisory or steering committee structure in South Africa for the Mining Sector Project contributed to 'communication breakdowns' between project managers based in Pretoria and local partners, that necessitated 'firefighting visits' and 'crisis management' especially when the IP changed. It also meant that there was suboptimal use of monitoring data for timely intervention and/or to adapt and redirect activities where necessary. A point that is revisited in the next section.

3.2.1.2 Monitoring and evaluation

Data generated through the process of M&E should be central to the decision-making associated with a project of this size given the number and complexity of role players. Instead the evaluation team observed that there were many difficulties with the M&E of the Mining Sector Project, some of which go back to the early design of the results matrix and then the subsequent redesign of the matrix one year into implementation, to bring it into alignment with PHAMESA II. Coupled with inadequate technical support at the centre of the Mining Sector Project, because of institutional change, this meant that these difficulties were not managed in the Project, and as a consequence the quantitative data in particular, used to provide evidence for Project activities, is incomplete.

M&E reports have only ever been shared with the donor, and no respondent for this evaluation who has been associated with this Project, at either the regional or country level, could state any figures or findings associated with the Mining Sector Project. The absence of a multi-stakeholder governance structure at the region and/or country level perpetuated this poor practice. Respondents in this evaluation commented that they had been part of other such studies but, have never been given a report.

3.2.2 .Efficiency

Evaluators were asked to consider both the efficiency and cost efficiency of the Mining Sector Project. Specifically this concerns the numbers of beneficiaries reached and project spend. Given that only high level spend figures are available and that the quantitative monitoring data is weak, evaluators can make preliminary observations only about this. The reach of activities on the ground is considered in the next section 3.3. This section will focus on findings pertaining to the Mining Sector Project spend.

3.2.2.1 Project spend

The total project spend was €4, 971 143 of which € 2,965 633 was spent at a Regional level primarily covering staff and office costs, research, policy and advocacy work. €2,015 511 was spent mostly at the country level and covered the implementation costs of POPA and IOM's outreach peer education work. In relation to IOMs work at a country level Swaziland had the smallest spend per country. Mozambique, South Africa and Lesotho had double the spend of Swaziland. No country figures were made available for VSO POPA spend. With respect to M&E, €123 995 was spent on M&E. This is 2% of the budget. Given the problems listed in the preceding section this figure suggests that too little was invested in M&E and that a regional, multi-country project like the Mining Sector Project either needs to be less ambitious with respect to expectations for monitoring data and/or ensure that it is sufficiently resourced.

The delays in appointing project management during the start-up phase of the Mining Sector Project also meant that the MTR Netherlands HIV/AIDS/SRHR Programme in Southern Africa reported low budget burn rate in the first two years. An extension of project activities into 2016/17 has meant that the projects funds have now been spent.

Country stakeholders did not contribute financially (in cash) to the project but provided in-kind contributions by providing meeting venues and in the form of time dedicated to project meetings, and/or by facilitating access to other relevant partners and structures or through mobilizing community support.

Organized a zozo/shelter for change agents to operate and hold their meetings in, since they do door to door and have no place to work in or meet with IOM representative when they come, also for them to hold FGDs in it, I asked the mine to donate it since I donated the land... (KII stakeholder South Africa)

POPA report that a total R450 000 was raised by MWAs as a result of capacity building. (refer to Table 8)

The success of the Mining Sector Project hinged on the co-operation of Change Agents to meet the targets set for Outcome 3 Capacity building and service delivery. Respondents on the ground reported that they needed both more time and more money to meet delivery expectations. These comments were directed to both the Change Agents managed through IPs, and VSO POPA activities despite Change Agents more than exceeding the reach targets set for this project (see section 3.3). Respondents at the site level cited the following issues as having a negative impact on operational efficiency of Change Agents: Lack of an office space from which Change Agents can conduct their administrative tasks, working as volunteers, lack of transport, and the late payment of reimbursables such as those incurred for transport. Change Agents were not remunerated for their outreach work with the exception of South Africa, where government pays a stipend to outreach workers. At best Change Agents received clothing for identification, caps, bags and start-up training. In Swaziland, Change Agents when asked, presented the following suggestion for improving the project *"…request money for transport and to buy soap or powder soap to wash our clothes."* (FGD Change Agents Swaziland). In Lesotho the late disbursement of funds to IPs resulted in teams on the ground experiencing personal hardship such as the non-payment of travel reimbursements and/or salaries to the co-ordinators of Change Agents.

Respondents described the income generating activities associated with POPA as *"expensive".* One stakeholder went as far as to say *"three times"* the amount of resources were needed. POPA not only met the start-up costs of beneficiaries, but also met the basic operational costs for the mineworkers associations. A couple of key informants commented that international volunteers were expensive. Troubled relationships between VSO and the MWAs did not help stakeholders in some instances believe there was strong financial accountability. The weak capacity of these associations was also felt to hinder efficiency.

Most income generating activities were initiated using seed funding of about R15 000. Beneficiaries reported using this money on a range of activities from fixing a house, building a shop and/or buying stock. However some beneficiaries struggled and reported that "*The money was too little to get going"* (FGD POPA beneficiary). *Even where income generating activities were succeeding beneficiaries described "limping along" or falling down*. *"I just fell (went bankrupt) because I had no one to help me." (FGD* POPA beneficiary)

Key informants felt POPA was overly ambitious and unable to support beneficiaries across all three countries and thirteen districts. *"I think the project could have been more successful if they had not been so ambitious to run all those districts, even though there are some beneficiaries there."* (KII stakeholder). Another key informant stated that more funds should have been invested in both training and human resources – especially the appointment of a co-ordinator in the districts where POPA was implemented.

Summary findings

Effectiveness could have been strengthened in the Mining Sector Project. Dedicated multi-stakeholder governance structures for the Project at the Regional and national level would have strengthened the responsiveness of the Project to challenges on the ground especially. The Project was also let down by its M&E which was possibly under-resourced.

Efficiency/cost efficiency was hampered by a delay in the appointment of project management, delays in the disbursement of funds and inadequate budget at the local level to support the scope of activities on the ground. Change agents were not remunerated for their work in three countries. The resources for POPA were considered to be inadequate for three countries and thirteen districts.

3.3 Evaluation question 3: What difference has the project made to access to health promotion and clinical services for beneficiaries?

The Mining Sector Project has improved access to health promotion and clinical services for beneficiaries at the regional, national and local levels. Table 5 lists the best available evidence of this against Project outcomes. Change agents were an effective means to reach ±10x the number of target beneficiaries. Policy developments at the regional and national levels are significant and will ensure that well in excess of 20 000 migrant mineworkers, their families and affected communities benefit for the future. POPA report assisting 205 widows with establishing businesses which could generate profit to support meet basic needs such as securing food and transport to the clinic.

Table 5 Mining Sector Project Outcomes and evidence of change

Overall objective	Best evidence	Comment
To contribute to improved health outcomes of 20 000 migrant mineworkers, their families & affected communities in Southern Africa, with a particular focus on mine worker sending, transit and destination communities of Mozambique, South Africa, Lesotho and Swaziland	Change Agents reached a large number of individuals ±270 000 with health education and made referrals to local health services	Mozambique totals ±100 000 include reporting for activities funding by SIDA under PHAMESA II. The ±270 000 is thus an inflated figure
Outcomes		
Component 1: Research & information dissemination		
Outcome 1.1 Improved & increased strategic information on health, HIV & TB within the mining sector of Southern Africa available and utilised	5 baseline studies complete IBBSS to be released 2017	All research studies for the Mining Sector Project were delayed
Component 2: Advocacy for policy development		
Outcome 2.1 Conducive policy environment that supports improved health outcomes of mineworkers, their families and affected communities	May 2016 Compensation Summit, MBOD reports twice the amount of money paid in compensation to ex-mineworkers in 2016/17 in comparison with the year before PEN IV Mozambique migrant mineworkers priority group for HIV New TB services introduced One stop shops in Swaziland & Lesotho	
Component 3: Service delivery & capacity building		
Outcome 3.1 4000 individuals in 2 mining destination communities in South Africa have improved access to services which improve health	±50 000 individuals reached with health education and/or health service referrals	One site only
Outcome 3.2 14 000 individuals in mine worker sending communities in Mozambique, Lesotho, South Africa and Swaziland have improved access to services that improve health	±113 000 individuals reached with health education and/or health service referrals in Lesotho and Swaziland alone	Mozambique data not disaggregated by site or from other SIDA funded PHAMESA II activities
Outcome 3.3 2 000 individuals in 3 border sites have access to information on HIV/STI/TB & SRHR services in destination & home communities	No figures available from Ressano Garcia, but Endline Evaluation site visit confirmed Change Agent activities	Mozambique data not disaggregated by site or from other SIDA funded PHAMESA II activities
Outcome 3.4 1100 widows supported through POPA	657 individuals trained (of whom 511 were widows) 205 widows running business at the end 2015	

	Beneficiaries reported using profits to meet basic needs such as food & access to clinics	
Component 4 : Regional Coordination		
Outcome 4.1 Improved collaboration, coordination and communication among project partners and key stakeholders working on health response in the mining sector	Regional PIC National Partnership Fora for Migration and Health (Swaziland, Lesotho)	

3.3.1 Health system strengthening

The Mining Sector Project primarily sought to improve access to health promotion and clinical services for 20 000 migrant mineworkers, ex-mineworkers, their families and communities. Although the Mining Sector Project has focused on reporting against Outcome 3 as evidence of this, it is the regional and national policy and system improvements such as compensation payouts, the delivery of new health services to support migrant mineworkers, the alignment of treatment regimens that will ensure access to health promotion and clinical services for beneficiaries improves for the long term. IOM and VSOs contribution to the policy environment cannot be easily quantified but ultimately this is the most likely long term impact of the Mining Sector Project. For example, MBOD reported that they had doubled payments to beneficiaries in 2016/17 but that this could not have happened without IOM.

"… Paid out R207million in 2016/17 2000 beneficiaries compared to R92 million in previous financial year; that means we doubled payments with new system and tracked payments to neighbouring countries. R76 mill (of the R207million) was paid to neighbouring countries" (KII stakeholder South Africa)

In Mozambique, a group of 467 registered beneficiaries was listed by Ministry of Work, Employment and Social Safety (MWESS) as the first group of ex-mineworkers to benefit from the new system of payments to neighbouring countries.

TB services specifically for ex-miners have been improved in Swaziland and Lesotho. *"After that we established clinics specifically for miners where they have an express queue – one in the TB centre (Manzini) and another in Shiselweni (Esithobelweni) where there is a doctor periodically that sees to their silicosis. These were established clinics but established a TB desk because of the project" (KII stakeholder Swaziland)* During the Easter and Christmas holiday seasons in all three labour sending countries the Mining Sector Project participated in campaigns at the border gates aimed at informing miners of the health facilities available and encouraging them to seek services. The project used national and local radio stations to raise awareness and create a demand for services. In Swaziland respondents reported 'linkages' and 'improved services' for miners and their communities as evidence of the success of the Project. The implementing partner (IP) in Swaziland has also started to report at Tinkundla level.[9] Besides building strong government-project relations this process enhances local level accountability and transparency

> *"Amongst others we have MSF who are providing us with leaflets we are distributing to during our campaigns, the Ministry of Health who are helping us with training, which is the TB department, Population Service International who are providing us with condoms, World Vision International provides us with home base care kits for bed ridden patients, ADRA who comes in when there is drought in the land. SWAMMIWA mobilizes ex-miner workers and hands out food parcels that comes from the Ministry of Labour."* (KII Stakeholder Swaziland)

Health workers have been sensitized to the rights of migrants and health (the Mining Sector Project reports 1104 in total refer to Table 7) and is an important contribution to mainstreaming migration.

3.3.2 Improved health seeking behaviour

At the local level Project stakeholders across countries report an increased knowledge and awareness of HIV and TB- related issues amongst ex-mineworkers, their families and community members, as well as, an improved demand for services. Monitoring data for the Mining Sector Project reports ±270 000 beneficiaries reached by Change Agents (no final figure submitted for the number of Change Agents trained refer to Table 7). In South Africa, beneficiaries were reached through Change Agents sourced through local structures and carers employed by local CBOs who were already conducting home based care (HBC) activities. The carers are

[9] High-level government structure that works at community level where the members of parliament come from

linked to the local clinics and receive a stipend from the DOH. This arrangement facilitates referrals from community to facility levels.

> *"They* (migrants) *now go freely to the clinics without fear, attend antenatal classes, no more giving birth at home, that shows our involvement is welcomed since they were afraid to do so." (FGD, Change Agents South Africa)*

In South Africa respondents working in local health facilities report that patients referred by Change Agents have high levels of knowledge regarding HIV and TB.

> *"They have reduced our work load. The patients are already knowledgeable when they come to the facility. So we do not have to spend too much time on education because change agents have already done that work." (KII Stakeholder South Africa)*

Phelisanang Bophelang (IP in Lesotho currently undertaking community work for the Mining Sector Project under an extension to April 2017) has approximately 155 Change Agents working in three different Community Councils in the District of Leribe. The work of the Change Agents is faced with several challenges. The first is the significant cultural/gender barriers to behaviour change. In Lesotho men are reluctant to use health services and reported condom use is low. Generally men do not report a supportive role for themselves in relation to their partners and attendance at antenatal care is low and many women do not access PMTCT services. At community dialogues Phelisanang Bophelong estimate 80% of those in attendance will be women. Stigma and discrimination related to HIV and TB was also keenly felt in Ressano Garcia in Mozambique and was the reason why sometimes people move from there to get treatment in Maputo or Matola in order to not be seen there in Ressano. Stigma was also a significant challenge for ex-mineworkers in Lesotho too. *"They (ex-mineworkers) have been taught on how to live without the fears of others judging them."* (FGD Change Agents Lesotho) Phelisanang Bophelang state that they put the emphasis on quality rather than quantity of household visits. Because of their interventions Phelisanang Bophelang report that they have seen a decrease in their referral figures because people are going anyway to the clinic without being seen first by a Change Agent.

The ex-mineworkers supported by the Change Agents were able to identify a significant change in their health seeking behaviour that not only meant they would now visit health services, but also felt bonded together as a group and able to offer assistance to each other.

> *"We were taught on how to take care of ourselves as men health wise, most of the miners or ex-miners are even afraid to go to the clinic when they are sick because they are afraid of what other community members are going to say about them. So we were taught how to not mind such things and to place our health first, now we are able to go get help from the clinics freely….and also as a community we have gotten close and we are able to assist one another."* (FGD ex-mineworkers and mineworkers Lesotho)

In Lesotho, Change Agents report that the burden of ill health of ex-mineworkers has been lessened on families.

> *"They (ex-mineworkers) are no longer affecting their family negatively hence they used to get very sick and the family would suffer, also some are on medication and their family members make sure that they take their medication as prescribed."* (FGD Change Agents Lesotho)

Although the above paints a positive picture not all respondents felt this way. In Mozambique the evaluation team reported that the majority of the mineworkers and ex-mineworkers were not reached by the Project and that evaluators noted a certain discontentment amongst FGD respondents. The majority of whom did not know about the existence of the Project and had never heard about it. In Lesotho, Change Agents also described being seen as *"fly by nights"* (ie. they will come and go) and being chased away especially by current mineworkers.

3.3.3 Income generating activities to support health outcomes

Between 2013-15 POPA trained 657 beneficiaries (511 of whom were widows) (Refer to Table 8). Presently (2017) there is no measure of how many of the start-up POPA businesses continue to function. POPA activities largely did not align with those of the Change Agents and operated independently in other communities. Therefore POPA also provided education to ±6000 individuals (refer to Table y) on priority health issues especially HIV.

Many respondents for this evaluation appreciated the design of the Mining Sector Project because of its commitment to income generation. This was because beneficiaries in the Mining Sector Project faced obstacles to their health such as not having enough food, no transport money to go to the clinic for screening and to collect medication, alongside inadequate information about HIV, TB, SRHR and gender based violence targeted for improvement by this Project. However it was a complex task establishing local businesses and POPA faced many challenges on the ground many of which are summarized in Box 2.

Generally POPA success stories focused on individual men and women who have been able to use their small profits to secure some basic needs such as transport to the clinic to collect ARVs and to buy more food for the household (Refer to POPA success stories Part II Endline Evaluation). Alternatively the success stories describe groups of beneficiaries (mainly women) who are working together successfully as a collective and have been able to initiate other business. Beneficiaries described psychosocial benefits that in some cases result because of being in a POPA group with others, *"Levels of stress also go down because you have people you speak with, which is the ones you share the container with."* (FGD POPA beneficiaries). Although POPA had a health component, it was the economic component that dominated. Where health training did happen it had the potential to make a significant impact.

"Yah it's true, something has changed because for example when we had training I really was at zero then it automatically improved the situation." (FGD ex-mineworker)

In Mozambique orphans became a target beneficiary for POPA because of both economic and social needs and the IOM intervention in Ressano Garcia followed suit and provided school material to some OVC in the short term.

However on the economic side, for every story of success there is story of failure too. Given the searing poverty and the challenges listed in Box 2 this should not come as a surprise. One key informant stated, "*These are very poor communities you can't have a blue print for a development initiative."* (KII stakeholder Lesotho)

Summary of Findings

The Mining Sector Project reached well in excess of 20 000 beneficiaries through support to health systems strengthening and service development at the regional and national levels and through outreach work in communities.

There are qualitative reports of improvements in health seeking behaviour amongst beneficiaries.

Stakeholders appreciated the design of POPA because beneficiaries are poor and poverty is a barrier to health. Where POPA business flourished it made a difference to the health and social development outcomes.

Box 2: Challenges arising in the implementation of POPA in three countries

Selection of beneficiaries

- Splintering of mineworker associations because of choice of districts for implementation (Lesotho Migrants Association established because Berea District not included by VSO – *"… was accused of leaving them out." (KII stakeholder))*
- AMIMO felt to be weak by some beneficiaries and in Moamba District, Kindlimuka was formed representing a group of 50 mineworkers and ex-mineworkers
- The number of beneficiaries was too small and not enough people benefited – expectations were raised in the target communities for more support
- There was insufficient engagement with the families of the beneficiaries. Some families felt they were "ok" and not really vulnerable. Their participation in POPA did not then work out as expected.
- In Swaziland POPA selected women with a track record of trying business ventures. These individuals found to be likely to be more successful.

Difficulties with the private sector mobile phone contractor

- In Mozambique beneficiaries reported being confused by the decision of One Cell to remove public cell phones, *"They taught people how to use these machines in order to generate rent, but suddenly they came without knowing why to collect the machines. They did not give us back again, so far we do not know why they acted in this way."*
- Contractual arrangements between VSO and the mobile cell phone provider meant that public phones were compulsory. This decision was not understood or supported by other stakeholders. *"We suspected VSO officials had another partnership with ….. (mobile phone provider)We felt exploited by them and VSO."* (KII stakeholder)
- Local stakeholders felt that mobile phone contractor was guilty of sabotaging POPA business by awarding additional business opportunities to others in the same community
- In some cases beneficiaries were unable to read print materials provided by service provider to assist with the establishment of a phone business. It became easier to involve the older children of ex-mineworkers in some instances.
- Security for the containers was not factored in.
- In Swaziland MTN did not provide mobile kiosks as originally planned
- Traditional leaders allocated land for containers but some were unethical

Sustaining local business

- The siting of containers caused some business to fail. "*In Nazareth, we introduced an additional phone shop alongside a successful business and that was a mistake. Both shops struggled after that."* (KII stakeholder)
- Mineworkers associations demanding rent/credit from beneficiaries and or conflict arising because of accusations with respect to the delivery of stock
- such as transport of stock and for security and providing credit to customers that is not returned
- Consortiums of POPA beneficiaries quarrelling that would leave business closed for several months
- Beneficiaries lost interest *"We had so much income at the start but then people lost the interest and I don't know why. I don't just work with VSO but also with other people who did not quit like these ones did."* KII stakeholders
- Beneficiaries not understanding the importance of keeping money to reinvest in the business and/or incurring costs

Project management

- Mineworkers associations both a beneficiary and having oversight of implementation, may have contributed to a conflict of interests.
- Mineworkers associations disadvantaged in this arrangement and unable to hold the donor to account *"We lacked skills to communicate the ways of working with donors."* (KII stakeholder)
- VSO felt the mining associations kept them inadequately informed about what was happening on the ground. Even suggesting that they *"lacked commitment because they wanted to be seen as donors and not as those who help the community change their lifestyle."* (KII stakeholder)

- In adequate capacity on the ground to respond to the difficulties that arose between the consortiums of POPA beneficiaries
- None of the mineworker associations had their own office and therefore basic costs such as rent had to be factored in. Also staff often worked as volunteers so did move on to other jobs.

Health outreach work

- POPA beneficiaries reported being trained on health issues. However they also reported they were unknown to the local clinic and this made them ineffective
- In Swaziland Rural Health Motivators were given kits as well as training
- In general the health component of the work was dominated by economic component. But *"30-40% of our work was about stigma"* (KII stakeholder)
- Transport to clinics for SRH services can be expensive for local people. One example of screening for cervical cancer quoted R200 for transport to and from the clinic just for the test.

M&E

- The service provider could monitor the sales on the public phones and voucher/recharges for cell phones but this did not provide adequate data for VSO who in one instance had to collect data from 300 beneficiaries in Mozambique.
- Problems were not picked up quickly enough to sustain businesses for longer. *"Monitoring is very important because people know exactly what is happening. Any human being faces difficulties and that's the part we have to focus on."* (KII stakeholder)
- The mining associations did not have cars to use to visit the districts. Budget was used to hire cars but this could only be done 1 car at a time which did not help with the necessity to visit several different districts at one time.
- Monitoring tools could have assisted to profile the POPA beneficiaries better.

3.4 Evaluation Question 4: What are the prospects for sustained change?

Although there were some comments from stakeholders to suggest that neither IOM nor VSO had adequately prepared local communities for the end of the Mining Sector Project there are elements of both IOM and VSO work that will be sustained.

The summary OECD-DAC criteria for sustainability found that sustainability in different contexts would either be through policy change, through partnership forums established at the national level, through changes to health services, the continuation of change agents and the on-going work of mineworker associations into the future.

3.4.1 Health services

Given the health systems strengthening discussed in the previous section the prospects for sustained change in the health service are good. The working partnerships fostered through the project have provided the platform for ongoing work through a regional grant through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Resources already mobilized through the GFATM with the support of the World Bank will underpin health systems strengthening in Southern Africa with respect to the TB response. Countries, like Swaziland are already gearing up to take over the financial and operational responsibility for running the mobile health services acquired through resources provided by the Global Fund. Swaziland has already acquired two one-stop shops as part of the regional Global Fund initiative to support the harmonisation of compensation systems for migrant mineworkers and ex-mineworkers.

Health service provision to migrants will continue through the public health facilities and health workers in some areas have been trained and the foundation has been laid for mainstreaming migrant health services. However to do this effectively will take years of dedicated work as governments in Southern Africa respond to the increasing migrancy of the population. For example, in South Africa it is not possible to measure the trends in uptake of health services on the part of migrants because nationality is not part of the information that is captured on the district health information system (DHIS). However respondents in this evaluation consider the policy shift that has happened during the lifetime of the Mining Sector Project to embrace migrant mineworkers and ex-mineworkers as significant and for the long term,

"In past would not find TB in the mines in any of the strategic plans. Now they (TB in the mines and migration) *are an integral part of the activities in the strategic plan that we will measure ourselves against…have shifted from ad hoc to structured activities within the plan and we will have to mobilise resources…"* (KII stakeholder Swaziland)

3.4.2 Change Agents

Change Agents have delivered a lot for the Mining Sector Project with very little personal financial gain. Respondents were unclear about what will happen to them now that funding for the Mining Sector Project has formally ended. One key informant said the Change Agents continue because *"they are those kind of people who tend to continue." (*KII stakeholder Lesotho). However without additional funding there will be no oversight or accountability for their activities, so there will inevitably be changes. Change Agents will be looking for jobs but, local stakeholders saw prospects for them too.

"I liked the structure of the Change Agents. These are very vocal people and can be used in other projects too." (KII stakeholder Lesotho)

Phelisanang Bophelong in Lesotho embarked on a programme of income generating activities to provide some local level funding to sustain the activities of the Change Agents. Organising the majority of the existing Change Agents (up to 100) into 1 of 5 income generating projects, it will remain to be seen if these can survive into the next 12 months. (Note each income generating project has up to 20 participant Change Agents). All projects are of an agricultural nature and are supported by Extension Officers from the Ministry of Agriculture (MOA). PHAMESA II continues to fund in 2017 Change Agents in Mozambique and South Africa.

3.4.3 Mineworker associations

The capacity building of MWAs that took place under the Mining Sector Project is likely to underpin their involvement in on going regional consultation at least in the short term (Box 3 gives a short description of this for Swaziland). The regional exchange programme between mineworkers associations was also felt to have had a lot of benefits because mineworker associations had, had the opportunity to learn from one another. The regional work had also introduced all associations to a broader range of development partners such as the World Bank and the Southern African Trust (SAT) and IOM/VSO provide some informal support to the

preparation of new funding proposals for mineworker associations. The Lesotho Ex-mineworkers Association (EMAWA) report that the mining company Harmony Gold is likely to make funding available to them. They report that they have been empowered to implement their own income generating activities (an orchard and vegetable projects) specifically with the purpose of creating income to sustain the organization. An approach they acknowledged came directly from their exposure to the POPA Project.

3.4.4 Income generating activities

Key informants proposed that there is a role for further funding for income generating activities. At least another 3 years. In Lesotho it was stated that almost 2/3rds of the containers used for phone business under POPA were no longer functional. POPA projects were considered by some to be too small to generate sufficient profits in the long term. Certainly the present inflationary climate is pushing profits downwards for beneficiaries. Beneficiaries spoke about making as little as R50 a week profit.

"There are some with chicken projects by those are now struggling owing to the inflation of the country as the prices tend to rise, so now it is difficult for them to afford." (KII stakeholder Mozambique)

"The design was good, my pain is that it is short lived." (KII stakeholder Lesotho)

In communities, saving schemes make a difference because women who are part of these arrangements are able to support each other when times are good and when times are more difficult. All respondents both at the local and national levels spoke about the importance of securing pension and compensation payments for ex-mineworkers as a fundamental contribution to poverty alleviation in traditional labour sending communities alongside providing income generating opportunities.

Box 3: VSO Capacity Building for Sustainability

"Some here they spent much of their time in the mines so they know nothing. They did not learn to do anything for survival. And when the work ended in South Africa they came back here to stay." (KII stakeholder POPA)

International Volunteer from Netherlands was placed in Swaziland by VSO for a period of 6 months. Her role was 'being an agent of change' for the Swaziland Migrant Mine Workers Association (SWAMMIWA). Her role was to add value and promote sustainability. As part of her work she was able to offer the partner organization, SWAMMIWA, team building workshops and personal profiles which enables the team to work better together and encourage the organization to grow.

Summary of Findings

Sustainability is underpinned by the health systems strengthening work of the Project and the capacity building of staff working in the public health sector and with the membership of mineworker and ex-mineworker associations.

The future of Change Agents and POPA beneficiaries is uncertain. Securing the pension and compensation payments due to ex-mineworkers remains a priority to alleviate poverty in mining affected communities alongside providing opportunities for income generation.

4. Conclusion

The overall objective of the evaluation as stated in the terms of reference (TORs) was to collect evidence to determine the overall project contribution in improving the lives of the target beneficiaries and in capacity building of stakeholders to address HIV and AIDS and other health challenges in the mining sector.

This evaluation found that the Mining Sector Project was very relevant and was significantly supported by the external context at all three levels of the Project functioning. The Mining Sector Project remained relevant because it addressed HIV and TB in mining districts where prevalence is higher than in the general population, and because poverty and few livelihood opportunities continue to face beneficiaries in these communities. At the local level the interventions were at times over overwhelmed by poverty; and that for the target beneficiaries, pension and compensation payments due to ex-mineworkers are unresolved for many, contributing to local poverty.

Change Agents were an effective means to reach large numbers of individuals with health education. However there was anecdotal evidence only of the quality of these interactions, M&E data was inconsistent, their work was affected by the absence of a stipend (Swaziland, Lesotho and Mozambique), and/or there was high turn-over of Change Agents, stigma and discrimination impacted on their work and the IP was poorly selected in some instances. POPA was found to be spread too thinly across three countries and 13 districts with respect to the amount of resources. POPA also faced numerous implementation challenges on the ground. At the regional level there was inadequate line management capacity for M&E and research and all the research outputs were delayed. Collaboration with local partners and the national Partnership Fora for Migration and Health were considered effective and this is making an impact on national policy.

The Mining Sector Project succeeded through the utilization of Change Agents to reach a large number of individuals ±270 000 (±10x the 20 000 target) and to make some positive impact on health seeking behaviour including referrals to local health services. It was also reported that in Lesotho and Swaziland, new TB services had been introduced and that the basis for the development of further migrant sensitive services has been laid. The Medical Bureau for Occupational Disease (MBOD) report that compensation payments to ex-mineworkers doubled in the last year because of regional collaboration. IOM is considered by MBOD to have been pivotal to this development.

An important commitment in the Mining Sector Project was to build income-generating activities for 1100 widows to support the families of ex-mineworkers to provide an enabling environment for health. Some POPA beneficiaries (of 657 people trained) have benefited economically and socially from POPA. 205 widows were running businesses under the umbrella of POPA at the end of 2015.

Sustainability in the different country contexts will take a different form either through national HIV/TB policy change, through partnership forums established at the national level, through changes to public health services, the continuation of change agents and the on-going work of mineworker associations to address membership needs.

The Mining Sector Project was constructed around four pillars. These pillars are 1) research and information dissemination, 2) advocacy and policy development, 3) service delivery and capacity building and 4) regional coordination. One of the questions put to the evaluation team is whether there is evidence for a theory of change and to what extent did the four pillars or outcome areas come together to produce change.

The Mining Sector Project national and regional partnership fora such as the Forums for Migration and Health (national level), the PIC and Compensation Summit (regional level) have supported change by ensuring partners no longer work in silos, that legacy issues for ex-mineworkers are addressed, that policy change in favour of migrant mineworkers and ex-mineworkers in relation to TB and HIV is supported and that health systems continue to be strengthened in this regard. There were powerful synergies between components two and four. However neither of these developments were especially supported by research commissioned through the Mining Sector Project and the IBBS study remains outstanding. Thus component one operated more independently.

Pillar three, service delivery and capacity building, by working with Change Agents successfully reached large numbers of individuals with health education and referrals to health services. Thus a demand for health services was increased. However at times qualitative evidence is that there are still considerable barriers to access that are associated with poverty, such as affording transport to health services, and having enough food to sustain adherence to treatment programmes. The response to HIV and TB are compromised by these.

Whilst POPA in some instances did provide a means to address some basic needs for recipients of support, poverty alleviation remains a priority in mining affected communities. Creating the enabling environment for migrant mineworkers, their families and communities to best manage their health remains a challenge.

4.1 Regional & country level conclusions

1. The Mining Sector Project successfully met the overall objective "*to improved health outcomes of 20 000 migrant mine workers, their families and mining affected communities in Southern Africa with particular focus on mine workers sending, transit and destination communities of Mozambique, South Africa, Lesotho and Swaziland."* This is because significant health system strengthening activities were undertaken in partnership with other major stakeholders to improve the prospects for migrant mineworker and ex-mineworker health in Southern Africa for the long term, especially with respect to TB. Monitoring data about the reach of activities on the ground suggest that ±270 000 beneficiaries (10x 20 000) were educated by Change Agents associated with the Mining Sector Project.

2. Policy and advocacy gains have been made. The regional and national level policy and partnership interventions supported by IOM through funding under the Mining Sector Project were significant in all countries. The health needs of migrant mineworkers and ex-mineworkers with respect to HIV, TB and the resolution of compensation payments for occupational injury and disease are policy priorities for the Ministries of Health and Labour in Swaziland, Lesotho and Mozambique. In South Africa it is a priority for the Department of Health and MBOD.

3. Capacity was built at all levels of intervention. Capacity was built through training provided by IOM on health and migration issues, and by VSO volunteers working with MWAs. Capacity building was complemented by national and regional fora that gave key stakeholders a platform to raise their issues. Mineworkers and ex-mineworkers have been given both visibility and a voice through the Mining Sector Project.

4. The Mining Sector Project was timeous and supported by the external/political context to realise the 2012 SADC Declaration and Code of Conduct on TB in Mining.

5. The effectiveness and efficiency of the Mining Sector Project remained a challenge during implementation. In particular the following areas were of concern,

    – Governance and management could have been strengthened at the regional and national level by ensuring the establishment of multi-stakeholder steering committees.

    – M&E was poorly resourced for a regional four country project. The quantitative data is inconsistent, insufficiently verified and therefore not a wholly reliable measure of its success.

    – Research studies were delivered late. There was insufficient line function technical expertise to manage this effectively.

4.2 Local level conclusions

1. Change Agents were effective to reach the target beneficiaries.

2. There is qualitative evidence of the positive impact of change agents especially with respect to health seeking behaviour including challenging HIV and TB related stigma, gender norms, xenophobia and referrals to clinics.

3. Implementation on the ground would have been assisted by all Change Agents receiving a stipend.

4.3 POPA conclusions

1. The Mining Sector Project gave VSO significant regional & country visibility.

2. The IOM-VSO partnership was successful – both parties learnt from each other.

3. Capacity building in MWAs was central to the overall success of the Mining Sector Project. The participation of MWAs ensured that regional and national policy developments were aligned with the needs of migrant mineworkers.

4. MWAs were able to oversee the implementation of POPA in partnership with VSO.

5. Many stakeholders involved with the Mining Sector Project quote POPA as evidence of success. There is qualitative evidence that some POPA businesses continue to function although there is no accurate data of what percentage have succeeded. At the end of 2015 205 widows were involved in running a business.

6. With respect to the resourcing POPA was spread too thinly across 3 countries and 13 districts. There were many challenges with the implementation and sustainability of POPA.

4.4 Recommendations

For the future the following recommendations are made:

1. VSO and IOM consider approaching South African mining companies who have employees in any of the labour sending areas where POPA and the work of Change Agents is implemented. The social and labour plan (SLP) is a mandatory requirement of all mining license holders within South Africa. The SLP requires companies to invest in income generating activities and social development activities in traditional labour sending areas, as well as, invest in skills training for mine workers facing retrenchment.

2. IOM continue to strengthen the national Partnership Fora for Migration and Health.

3. IOM continue to actively engage with MBOD, the World Bank and GFATM to,

    a. strengthen the health system with respect to TB, and

    b. to secure further compensation and pension payouts for ex-mineworkers as a fundamental contribution to poverty alleviation in mining affected communities.

Table 6 The OECD-DAC criteria summary of main findings from integrated reports (four countries, POPA and the Region)

OECD-DAC criteria	Key findings Swaziland	Key findings Lesotho
Relevance	• Project perceived as relevant because of high rates of HIV and TB • Timely – regional activities to harmonise systems to address TB in the mining sector • Delayed compensation for occupational diseases (and resultant poverty) are a priority for ex-miners and their families.	• HIV and TB are higher in mining affected districts than in other districts • The legacy of non-payment for occupational disease for ex-mineworkers contributes to painful levels of poverty.
Effectiveness	• Project reached ±46 000 individuals through community education; the quality of these contacts could not be assessed • ±5 000 persons referred for health and other services • 15% of referrals received services; distances/high transport costs are an obstacle	• The Migration and Health Partnership Forum has been successful at breaking down silos. • ±67 000 individuals had been reached through community education and that ±11 000 individuals had been referred to health services. • The appointment of the first IP based outside of Lesotho was a mistake and hampered set up and reach • More time for implementation would have improved performance.
Efficiency	• Efficiency gains (cost savings) – use of volunteers as CAs • Collaboration with other NGOs providing complementary services • Inefficiencies as a result of high turnover of CAs and need to retrain	• CAs reached communities but the absence of a stipend for their work contributed to difficulties on the ground.
Impact	• Potential for mainstreaming of migrant health services • Contributed to development of dedicated TB services for miners at 2 facilities and benefits from GF grant	• CAs report that the burden of ill health of ex-mineworkers has been lessened on families and that they have witnessed success with respect to challenging stigma. • The Migration and Health Partnership Forum secured trust between different stakeholders that has helped ensure policy will be migrant sensitive.
Sustainability	• Public health facilities will continue to provide services to migrants • Miners incorporated as key populations in national HIV & TB policies	• The present IP implemented a programme of IGAs to provide some funding to sustain the activities of the CAs. • The Partnership Forum for Migration and Health continues to meet quarterly under the stewardship of the MOH.

OECD-DAC criteria	Key findings Mozambique	Key findings South Africa
Relevance	• Location at borders and dynamic corridors where there are high levels of migrants and miners was important • High levels of HIV and TB-higher than general prevalence rates • Miners issues as related to compensation and occupational health a priority but little evidence of this changing on the ground	• Project perceived as relevant because of high rates of HIV and TB and no other providers of HIV and TB IEC in the community • Less relevant for miners who receive health benefits from mines; relevant for ex-miners and families of miners • IGAs to address the extreme poverty and interventions to address the social and structural determinants of health would have made project more relevant
Effectiveness	• Data suggests high levels of reach ±100 000 with health education, testing and referrals –however data shows inconsistencies • Working with local organisations and local systems (health and other community structures) • Working with CAs was supported • CAs hampered by high levels of stigma and discrimination	• Project reached ±50 000 individuals through community education; the quality of these contacts could not be assessed • 2 103 persons received health and other services as a result of referrals • Anecdotal evidence of improved antenatal clinic attendance, treatment adherence and retention in care (TB & HIV); DHIS does not make verification feasible
Efficiency	• Working with CAs assisted reach • Hampered by high levels of stigma and discrimination	• Efficiency gains (cost savings) - CAs received a stipend from government and in-country partners provided in-kind contributions • Inefficiencies as a result of high turnover of CAs and need to retrain
Impact	• Migrant and mining related concerns and health issues highlighted in local communities • Increased capacity of local community based organisations and CAs	• Potential for mainstreaming of migrant health services
Sustainability	• Existing community based organisations have greater awareness of migrancy and mining related issues • Work within existing health system	• Public health facilities will continue to provide services to migrants

OECD-DAC criteria	Key findings region	Key findings POPA
Relevance	• The regional component was timely and played a very constructive role in supporting the developments to respond to the SADC 2012 Declaration on TB in Mining, and in supporting the regional Compensation Summit held in Johannesburg in May 2016.	• Mineworker/ex-mineworker associations have been assisted to make the poverty and needs of mining affected communities better appreciated at national and regional levels. • IGAs are important in mining affected communities because of the deep levels of poverty.
Effectiveness	• Research and policy developments were insufficiently supported by effective communication/branding, M&E and research expertise. • Research outputs were all delayed.	• 205 widows running businesses at the end of 2015 • ± 6000 individuals reached with HIV and TB education • There were a range of factors on the ground that hampered the success of IGAs including working in too many districts, poor selection of IGA beneficiaries, internal conflict in consortiums of beneficiaries and problems with the private sector partner.
Efficiency	• There were many problems with the implementation of the M&E system, especially with the collection and collation of quantitative data. • Inadequate resources were available to support the implementation of M&E across four countries and sixteen districts. • Internal reorganization at IOM during the start-up contributed to there being insufficient research and M&E expertise with direct line function responsibility for implementation.	• Resources were considered to be too little for work in 13 districts across three countries.
Impact	• The impact of regional policy and advocacy work is significant and many more than 20 000 migrant mineworkers, ex-mineworkers, their families and communities will benefit because of this. • The Medical Bureau for Occupational Disease (MBOD) report that compensation payments to ex-mineworkers doubled in the last year because of regional collaboration. IOM is considered by MBOD to have been pivotal to this development.	• There has been extensive learning, VSO and mineworker and ex-mineworker associations made a meaningful contribution to regional and national processes. • Some POPA beneficiaries (of 657 people trained) have benefited economically and socially from POPA. • POPA businesses have collapsed in some instances. • There is evidence that the profits of IGAs have decreased in the present economic climate.
Sustainability	• Resources have been secured through the World Bank and Global Fund to continue health systems strengthening in relation to TB in two of the three labour sending countries (Lesotho and Mozambique). • PHAMESA II is to take over the funding of some of the Mining Sector Project CAs in South Africa and Mozambique from 2017. • Capacity building of mineworker associations and participation in regional fora has resulted in their leadership speaking on international platforms and contributing to consultation at the highest levels.	• Mineworker/ex-mineworker associations are networked with other funding partners for the future & in some instances have embarked on their own IGAs. • IGAs with a saving component built in to their operation are possibly more likely to succeed. • At the local level communities were possibly inadequately prepared for the end of the project.

Table 7: IOM monitoring data totals for all years 2015-2016/17 against output indicators

Outcome or Output	Indicator	Lesotho	Mozambique Note inflated figures includes PHAMESA II reporting	South Africa	Swaziland	Total	COMMENT
Monitoring migrants' health	Number of key national routine data collection instruments that incorporate questions on migration and health	-	-	-	-	-	
	Number of research studies conducted focused on migrants' health and migration-related health issues	1	2	0	0	3	
	One operational migration health knowledge sharing platform	-	-	-	-	0	
Policies and legal frameworks	Proportion of policy makers and stakholders with increased knowledge on migration health related issues and the importance of migration and health in health policies	1	1	0	2	4	
	Number of non-health sectors that have incorporated migration and health in their policies, legislations and strategies	0	1	0	0	1	
Increased knowledge	Number of individuals reached through community education	67841	106764	50507	46891	272003	
	Number of reproductive age individuals (15-49 years) reached with education on sexual and reproductive health	6569	42758	9407	1183	59557	Number does not add up to total. Difference is 360
	Number of community led initiatives to address the social determinants of health	33	59	6	10	108	
Strengthening service provision	Number of change agents trained to facilitate community dialogue	-	-	-	-	-	
	Number of change agents trained who demonstrate skills and capacity to facilitate community dialogues and education on the social determinants of health	383	297	240	349	1271	Number does not add up to total. Difference is 2.
	Number of individuals from key stakeholder organisations capacitated on migration and health	30	50	13	123	104	Number does not add up to total. Difference is 112.
	Number of health workforce members capacitated on migration and health	235	544	13	169	1104	Number does not add up to total. Difference is 143.

Improved service provision	Number of individuals referred for health and other services	11037	11004	2868	5011	29920
	Number of individuals referred for health and other services who received services at the referral destination	2003	10863	2103	755	15724
	Number of individuals referred for HIV testing	6488	3626	1490	2362	13966
	Number of individuals referred for HIV testing who received their HIV results at the referral destination	1331	4821	590	291	7033
	Number of individuals screened for TB	53167	10473	1769	15026	80435
	Number of individuals with TB symptoms referred for diagnosis and treatment in migration affected communities	68	250	202	380	900
	Number of referred individuals with TB symptoms who receive diagnosis and treatment at referral destination	997	250	103	364	1714
	Number of SGBV survivors identified and referred to service providers for support and protection	283	0	40	365	688
	Number of SGBV victims identified and referred to service providers for support and protection who received services at the referral destination	275	0	25	359	659
	Number of condoms and lubricants distributed	-	-	-	-	-
Multi-sectoral partnerships and networks	Number of initiatives that received technical support from IOM	0	5	0	0	5
	Number of multi-country and/or multi sectoral partnerships and networks established/strengthened for effective coordinated response to migration and health	0	3	0	0	3
	Number of partnerships with relevant stakeholder organizations formalized and/or strengthened	5	5	0	6	16
	Number of tools, guidelines and technical briefs on migration and health disseminated	0	2	0	0	2
	Number of relevant forums, dialogues, campaigns and conferences that include migration and health.	0	0	0	0	0

Table 8: POPA monitoring data for all years 2013-2015 against output indicators

INDICATORS		SWAZILAND	LESOTHO	MOZAMBIQUE	TOTAL	COMMENTS
Research and Information Dissemination	Number of research conducted	1	2	1	4	
	Number of baselines conducted	1	1	1	3	
	Number of other research conducted	0	1	0	1	
	Number of research report dissemination activities conducted	0	1	1	2	
Advocacy for policy development	Number of SAMA strategic planning meetings attended	2	3	2	7	
	Number of National consultations attended	3	3	3	9	
	Number of Regional consultations attended	5	3	3	11	
	Number of SAMA officials benefitted from capacity building activities nationally and regionally	3	5	5	13	
	Number of funding proposals developed and submitted by Sama	3	3	4	10	
	Amount of external funding mobilized by SAMA to leverage response to current and ex mine workers health needs	132 000	159 000	159000	450 000	No currency stated
	Number of SAMA and its affiliate representing health needs and rights of their members at relevant national and/regional for a	1	2	2	5	
Service delivery and Capacity Building	Number of local partnership established to address health challenges in mine worker sending communities	**6**	**5**	**5**	**16**	
	Number of partnerships with the private sector	2	2	2	6	
	Number of partnerships with local government	0	0	0	0	
	Number of partnership with local NGOs/CBOs	4	3	3	10	
	Number of individuals trained in HIV/TB prevention and care support (including HBC)	**56**	**81**	**339**	**476**	
	Female	45	70	288	403	
	Male	11	11	51	73	
Community Outreach (Health Education)	Number of Individuals Reached with Individual or Small Group HIV/TB Prevention Interventions	**30**	**1307**	**4650**	**5987**	
	Female	29	776	2790	3595	
	Male	1	531	1860	2392	
Small Enterprises (Livelihood and Food Security)	number of people trained in small business enterprise (livelihood and food security)	**118**	**162**	**377**	**657**	
	Female	84	106	330	520	

Male	34	56	47	137
Number of people trained in small business (livelihood and food security) who are widows	64	137	310	511
Female	64	137	310	511
Number of individual operating small businesses (livelihood and food security)	**102**	**88**	**131**	**321**
Female	59	68	92	219
Male	43	20	39	102
Number of people operating small businesses who are widows	60	52	92	204
Number of people deployed to provide support to SAMA officials	3	2	1	6