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

END OF PROJECT EVALUATION REPORT

Part II: Appendices

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APPENDIX 1
Swaziland (SD) Report

Country context

Swaziland (SD) is a landlocked country bordered by Mozambique to its northeast and by South Africa (SA) to its north, west and south. It is one of the smallest countries in Africa in geographic size and economy. The country is divided into four regions (districts)[1]. SD is classified as a lower-middle income country with a GDP per capita of $9,714. As a member of the Southern African Customs Union (SACU) and Common Market for Eastern and Southern Africa (COMESA), its main local trading partner is South Africa. Swaziland's currency, the lilangeni, is pegged to the South African rand. Swaziland's major overseas trading partners are the United States and the European Union. The majority of the country's employment is provided by its agricultural and manufacturing sectors. Due to high unemployment and a large rural population, SD has become a major source of labour for SA especially in the mining sector. SD is a member of the Southern African Development Community (SADC), the African Union (AU), the Commonwealth of Nations and the United Nations (UN).

The health sector

The Swazi population faces major health issues; HIV/AIDS and, to a lesser extent, tuberculosis (TB) are serious challenges. In 2013, Swaziland had an estimated life expectancy of 50 years. The population of Swaziland is fairly young with a median age of 20.5 years; people aged 14 years or younger constitute 37.4% of the country's total population. The present population growth rate is 1.195%.[2]

Health facilities are far for most of the populace with people having to travel at least 10 km to reach the nearest facility. Government facilities are often under-resourced and overwhelmed by large numbers leading to long patient waiting times. The slow service and expensive transport costs discourage patients from attending health facilities for regular checkups and TB treatment.[3]

Key NGOs working in the health (HIV/TB) sector include Medecins Sans Frontieres (MSF), University Research Co.,LLC (URC), and the Nhlango AIDS Training Information and Counselling Centre (NATICC) and those in food security or livelihoods include the Coordinating Assembly of Non-Governmental Organisations (CANGO), World Vision, as well as International Relief and Development (IRD). There are currently no NGOs dealing specifically with the health and social benefits of miners. The health programmes provided by NGOs are aimed at people in the general population affected and infected with HIV and AIDS and TB.

A baseline study conducted in 2014 in Lavumisa, Shiselweni District (n=942) found that approximately 90% of the respondents had been tested for HIV with 71% being tested every six months while only 32% of the respondents had previously been screened for TB. More than three quarters of respondents indicated they were aware of how TB is transmitted and around 73% of the respondents knew how TB can be prevented. About half the respondents indicated that patients with HIV and TB face discrimination.

[1] Hhohho, Lubombo, Manzini, and Shiselweni
[2] https://en.wikipedia.org/wiki/Swaziland
[3] Situation analysis report

Mining associations

Swaziland has two mining associations namely, Swaziland Migrant Miners Workers Association (SWAMMIWA) and Swaziland National Ex-Mine Workers' Association (SNEMA), which advocate for health compensation and access to social benefits of current and ex miners. The budget constraints of these two organisations were noted as a limiting factor in their activities to address the health challenges of miners and the threat of poverty for ex miners and their families.

Policies and Legal Framework

Swaziland ranks as one of countries with the highest prevalence of HIV/AIDS and TB in the SADC region. The state over the years has enacted legislation and formulated policies aimed at alleviating this problem. The most important of these are listed in Table 1. These national policies and legislation are not specific to the mining sector, miners and ex-miners. They have been adopted for individuals affected by HIV/AIDS and TB (though the miners and ex-miners are viewed as a key population) and the two pieces of occupational legislation focus on miners and ex-miners among other employees. The main limitation of the Workmen's Compensation and Occupational and Safety acts is that of jurisdiction. They apply to compensation, health and safety incurred within Swaziland only. Studies have demonstrated that occupational health issues especially TB finds its origin in South African mines to which only South African law applies in the absence of an appropriate Treaty.

Swaziland is a signatory to several international conventions as listed in the table below, but has not ratified International Conventions that have the ability to provide individual rights, if domesticated, to migrant mineworkers as well as other relevant employees.

Table 1: National legislation & policies and International conventions to which SD is a signatory

National Legislation and policies	International Conventions
• **The Extended National Multi-Sectoral HIV and AIDS Framework (eNSF) 2014-18, 2014.** • **Framework for HIV and AIDS 2009-2014.** • **National Tuberculosis Strategic Plan, 2006-2010.** • **The Workmen's Compensation Act, 1983.** • **Occupational and Safety Act, 2001.**	• International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families, 1990* • African Charter (15September1995). • International Covenant on Civil and Political Rights, 1966* • ILO Migration for Employment Convention (Revised), 1949 (No.97)* • ILO C143 Migrant Workers (Supplementary Provisions) Convention, 1975 (No.143)* • ILO C189-Domestic Workers Convention, 2011, (No.189)* • UN Declaration on the Human Rights of Individuals Who Are Not Nationals of the Country in Which They Live (1985)*

Conventions marked * have not been ratified

Regional Conventions and Policies

Swaziland is a signatory to the SADC Declaration and Code of Conduct on Tuberculosis in the Mining Sector in 2012. The SADC Declaration on TB is the main regional guiding policy for a coordinated response to the management of TB among miners and ex-miners within SADC. Swaziland and South Africa have a Bilateral Agreement on labour. This Agreement, however, focuses on the free movement of labour between the two countries. It is silent on the transfer of Social Benefits, Pensions and Health Compensation.

Project activities

The project activities are summarized below according to the four project components:

Research and information dissemination – A baseline survey, conducted in Lavumisa in Shiselweni District, was completed in the latter part of 2014. The results were utilized to inform programming. A second piece of research, an integrated biological and behavioural survey on HIV and TB will be completed in September 2017. The results will provide the technical background for government's national response to HIV and TB.

Advocacy and policy development – This component was closely linked to regional coordination. IOM provided technical assistance (TA) for two high level meetings led by the Ministry of Labour (MOL) with the participation of other key government ministries such as the Ministry of Health (MOH). MOL convened a summit involving 70 key government stakeholders that developed a resolution regarding mineworkers' compensation. This became the feeder document for the Joint Technical Cooperation Agreement (between South Africa and Swaziland) whose intention is to harmonise systems and policies for compensation and the occupational health and safety of mineworkers. The agreement is yet to be signed off.

Service delivery and capacity development – consisted of raising awareness on issues related to health (HIV and TB) and health services. This component was outsourced to a local country-implementing partner. The model used change agents (CAs) on the ground to provide peer education. CAs ranged from young adults living in the community to community leaders such as chiefs, traditional and church leaders. CAs work as volunteers and do not earn a salary, but are provided with the resources (health education and screening materials) to carry out their work. Potential patients identified during screening are referred to health services for definitive diagnosis and treatment. On the supply side, health workers (professionals working in the facilities and lay health workers in the facilities and community) were trained on heath and migration. There was a paper-based up and down referral system from community to health facility and back. This component of the project interfaced closely with the work VSO conducted to improve livelihoods.

Country coordination – IOM was instrumental in the formation of a technical working group (TWG) called the Partnership Forum on Health and Migration that focuses on HIV and TB. Meetings have been held quarterly since the inception of the project. The forum ensures that the (HIV and TB related) activities carried out by NGOs, development partners and civil society working in each region are conducted in a

coordinated fashion.

Project partners by component

Table 2: Key country partners by project component

PROJECT COMPONENT	KEY PARTNERS SWAZILAND (SD)
Research and information dissemination	
Advocacy and policy development	*Government*: Ministry of Health (MOH) especially National Tuberculosis (TB) Control Programme and Swaziland National AIDS Programme (SNAP), Ministry of Labour (MOL) *Ex-mineworker Associations:* Swaziland Migrant Mineworkers Association (SWAMMIWA)
Service delivery and capacity building	*Implementing partners:* Swaziland Network of People Living with HIV/AIDS (SWANNEPHA) *Government:* Regional Departments of Health, Agriculture, Local political office bearers *Civil society:* Informal collaboration with other development partners working in Shiselweni e.g. MSF, PSI, URC etc.
Regional coordination	Refer to regional report

Project management and governance

The Swaziland (SD) country project was managed 'remotely' from the IOM office in Pretoria as IOM does not have a country presence in Swaziland; offices are being set up and will be functional during 2017. In 2015 a consultant, who functioned as a member of staff, was appointed as a focal person for the project. She was housed within the National TB Programme. Oversight for monitoring and evaluation of project activities was provided from the IOM office in Pretoria.

The project does not have an official oversight or advisory body such as a Steering Committee (SC) or Advisory Board (AB). However, the relevant government departments e.g. Ministries of Labour and Health provided input and endorsed the project prior to implementation. Ethical clearance was obtained for the baseline survey with regular feedback on the results. The implementing partner (IP) has also started to report at Tinkundla level.[4] Besides building strong government-project relations this process enhances local level accountability and transparency.

SWANNEPHA took over the role of IP in 2015 when the contract with Community AIDS Response (CARE) came to an end. SWANNEPHA's strength is its extensive network of community-based organizations that extends to the most rural parts of the country. At the time of the evaluation 157 change agents (CAs) were active on the project. The SWANNEPHA regional coordinator oversees the activities of the

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

three facilitators who receive a stipend from the project to supervise the CAs' activities.

The community groups/cooperatives working on the income generating activities (IGAs) have established boards to oversee the finances and decisions around their particular projects. The IGAs are presented in more detail in the Phoning out Poverty and AIDS (POPA) report.

Project performance

Major Achievements

National level

In SD, the advocacy and policy development component achieved major gains. With support from the project a HIV and TB technical working group (TWG), called the Partnership Forum on Migration and Health, was formed. The group has 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, thus fostering closer collaborations and working relationships. As a result the TWG work towards the joint TB/HIV Global Fund (GF) grant concept note, for the first time, miners and ex-miners, are included as a key target group in the national strategic plans (NSPs) of both SNAP (Swaziland National AIDS Programme) and the National TB Control Programme. There is also a closer working relationship between the two (HIV and TB) departments.

IOM provided technical assistance (TA) towards harmonizing compensation systems, occupational health and safety policies as well as treatment regimens and guidelines. This fell under the interwoven project components of advocacy, policy development and regional coordination. As an output of these activities a joint technical cooperation agreement between SA and SD has been tabled, but had not yet been signed at the time of the evaluation.

Site Level

A total of 349 CAs trained over the life cycle of the project demonstrated the competence to provide HIV education and facilitate community dialogues. Of these 157 CAs were actively engaged in project activities at three sites - Somntongo, Matsanjeni and Dzombodze - in the Shiselweni region. Sites were selected to target areas with the highest concentration of families/households of ex-miners. VSO supported income-generating activities (IGAs) in Lebombo and Hhohho in addition to the three IOM sites.

The project works closely with the Ministry of Health (MOH) and other development partners at regional level. The creation of empowered communities was cited as a key achievement of the project. This led to community driven initiatives to harness the strengths of various partners and the creation of synergies to benefit communities. A

total of 10 community led initiatives were held to address the social determinants of health, more than trebling the overall target of 3 community events over the lifespan of the project.

"For example, they themselves (the community) *approached World Vision to provide extra items for the home based care kits and other initiatives to provide pit latrines, sewing projects…" (National KI, Project Partner).*

"…And we sometimes call our partners who will come and do some testing and MSF who will do the screen of TB, some will be checking STIs, family planning and those who will testing HIV…" (Focus Group, Change Agents)

Table 3 below presents, in tabular format, a summarized version of the routine project monitoring data that was collected and collated on the IOM project M&E system.

Table 3: Performance against targets and indicators

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
Monitoring migrants' health	Number of key national routine data collection instruments that incorporate questions on migration and health	-	-	-	-	-	0	
	Number of research studies conducted focused on migrants' health and migration-related health issues	-	-	-	-	-	0	
	One operational migration health knowledge sharing platform	-	-	-	-	1	0	
Policies and legal frameworks	Proportion of policy makers and stakeholders with increased knowledge on migration health related issues and the importance of migration and health in health policies	-	-	-	-	-	2	Capacity building of senior level stakeholders
	Number of non-health sectors that have incorporated migration and health in their policies, legislations and strategies	-	-	-	-	-	0	
Increased knowledge	Number of individuals reached through community education	18 000	32 061	9 000	12 195	27 000	45 999	Target exceeded
	Number of reproductive age individuals (15-49 years) reached with education on sexual and reproductive health	-	0	1 080	1 183	1 080	1 183	Target reached
	Number of community led initiatives to address the social determinants of health	-	10	3	5	3	10	Target exceeded. Figures for

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
								2014/15/16 don't tally
Strengthening service provision	Number of change agents trained to facilitate community dialogues	400	-	120	78	520	78	
	Number of change agents trained who demonstrate skills and capacity to facilitate community dialogues and education on the social determinants of health	300	209	80	10	380	349	Exceeds the # of CAs trained. Figures for 2014/15/16 don't tally
	Number of individuals from key stakeholder organisations capacitated on migration and health	!00%	0	100	123	100	123	Target exceeded
	Number of health workforce[5] members capacitated on migration and health	60%	126	15	43	??	169	
Improved service provision	Number of individuals referred for health and other services	8 000	4 408	1 200	603	9 200	5 011	Ambitious target partially achieved
	Number of individuals referred for health and other services who received services at the referral destination	-	267	360	488	360	755	15% of referrals received services
	Number of individuals referred for HIV testing	5 200	2 189	360	173	5 560	2 362	Ambitious target partially achieved

[5] Includes community health workers as well as health professionals

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
	Number of individuals referred for HIV testing who received their HIV results at the referral destination	1 200	159	216	132	1 416	291	Target set too high
	Number of individuals screened for TB	8 000	9 096	7 000	5 930	15 000	15 026	Target achieved
	Number of individuals with TB symptoms referred for diagnosis and treatment in migration affected communities	100%	2	7 000	164	-	380	Target set too high
	Number of referred individuals with TB symptoms who receive diagnosis and treatment at referral destination	60%	248	60%	116	-	364	96% of TB referrals received treatment
	Number of SGBV survivors identified and referred to service providers for support and protection	50	332	300	33	350	365	Target achieved
	Number of SGBV victims identified and referred to service providers for support and protection who received services at the referral destination	30%	29	-	27	-	359	98% of SGBV referrals received support
	Number of condoms and lubricants distributed	40000	-	50 000	114 548	90 000	114 548	Total target exceeded in 1 year
Multisectoral	Number of initiatives that received technical support from IOM	-	-	-	-	-	0	

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
partnerships and networks	Number of multi-country and/or multi sectoral partnerships and networks established/strengthened for effective coordinated response to migration and health		6	-	-	-	6	
	Number of partnerships with relevant stakeholder organizations formalized and/or strengthened	-	-	-	-	-	0	
	Number of tools, guidelines and technical briefs on migration and health disseminated	-	-	-	-	-	0	
	Number of relevant forums, dialogues, campaigns and conferences that include migration and health.						0	

Relevance

Respondents were unanimous in listing issues surrounding the compensation for occupational diseases as one of the leading 'issues' for ex-mineworkers and their families and households. The project was very timely in that the mineworker associations were 'beginning to become organized'. The activities to build the capacity of SWAMMIWA for advocacy and as a network organization ensured that the voice of ex-miners was represented at the policy table on a national and regional platform and 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 KI, MOH)*

> *"…Creating awareness and linkages so that associations have an entry point into government departments; motivated them* (ex-miners) *to participate in their association because they saw that people from other parts of the world came and know about them – gave them a voice; building the capacity of these organisations was one of the objectives…" (National KI, MOH)*

The government as well as community members recognize TB and HIV amongst miners as a big problem. However, the MOH programme is largely driven by donor agendas e.g. PEPFAR priority groups such as young women and girls. The project leveraged funding from other development organisations like the World Bank (WB) and Global Fund (GF) and miners are now specifically targeted as a priority group in the country programmes.

Poverty and unemployment are key underlying causes of the poor health experienced by ex-miners, their families and households; many cite challenges regarding access to compensation for mining-related illnesses as a key contributor. As a result, the income generating aspects of the project were most often top of mind amongst respondents interviewed for the evaluation.

> *"Main problem is that they don't get their benefits and that leads them into poverty so children drop out of school. There isn't anything else that they are doing even if they are not infected or do not have silicosis they are exposed to abject poverty." (National KI, MOL)*

> *"It is passing of our husband, and there is no where we can asked for assistance for whatever we need, and who helps us when our houses are falling. Who can we call upon and say, honey the house is falling? The children are hungry, there is no food in the house, and we need food!" (FGD, Beneficiaries)*

> *"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)*

> *"IGA was a way to enable community members to seek the service - when you have the knowledge you still need to have a source of income to be able to seek the service. Also when it comes to HIV & TB they need to feed well, so with the farm based IGAs even if they didn't make money they could have food." (National KI, Project Partner)*

Effectiveness

Change agents (peer educators) conduct community education activities using a variety of modalities. These included home visits, small group discussions and community dialogues, which sometimes involve community and traditional leaders. A total of approximately 46 000 individuals were reached through community education activities, exceeding the target of 27 000 persons to be reached by 170%. It should be noted that the monitoring data makes no comment on the quality of these person contacts. Persons with symptoms of HIV and TB are referred to health facilities for a definitive diagnosis. A total of 5 011 community members were referred for health and other services and 755 (15%) received services at the referral site. Of 2 362 persons referred for HIV testing only 291 (12%) received their results at the testing facility. A total of 15 026 persons were referred to health facilities after a positive TB symptom-screening test and 364 (2%) received diagnosis and treatment at the clinic or hospital. Newly diagnosed patients are put in contact with expert patients located at health facilities and in the community where they are linked to community support groups. SWANNEPHA conducted an exercise to map all organisations in SD working in the sector and the close working relationship with SWAMMIWA enabled effective targeting and access to households in communities with a high number of ex-miners.

The project challenges experienced by project stakeholders revolved mainly around resource constraints – relying on volunteers to provide services meant a high attrition rate amongst CAs who are constantly on the look out for paid employment; community members referred for treatment require finances to access health services which are located a long distance from hard-to-reach communities; social issues such as food insecurity decrease adherence to treatment. All these highlighted the need for and relevance of the IGAs. The project funding model (reimbursement for activities carried out by SWANNEPHA) and delayed payments also curtailed the roll out of project activities.

"…money for transport because although health services are free they sometimes have to travel long distances e.g. must travel to Manzini for CA Cx screening - transport costs from Nhlangano to Manzini is R100 one way so transport is expensive even though test is free and they must come back for results..." (National KI, Project Partner).

"And some you will find that there is no food in the house. The parcels we receive we are supposed to give those people who are sick. And sometimes is not that they are sick, it is because there is no food." (FGD, Change Agents)

"The other challenge is clothing and the money they don't have because they are unable to collect their medication or go for treatment if they sick. Even if they are referred there is no money to go to Esithobelweni….how do they continue taking their pills.." (FGD, Change Agents)

The project utilized technical experts from IOM, the MOH and consultants to provide training and information, education and communication (IEC) materials. Training was provided in a number of areas including HIV and TB, migration and health, and gender; the audiences varied from CAs, health workers and community leaders. During the Easter and Christmas holiday seasons the 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. The project uses national referral tools.

"SWANNEPHA has helped us, and given us hope to accept the disease and live with this condition, assisting and teaching our families not to stigmatize us and accept us. And not abandon us. So that we can live with them. So that is the challenge we're faced with as the people who were working in the mines." (FGD, Ex-miners)

The project capacitated 123 individuals from key stakeholder organisations on migration and health. Training was also conducted to capacitate health workers in the community and those working in facilities on migration and health. According to the routine monitoring data a total of 169 health workers were capacitated. The SWANNEPHA team conducts quarterly site monitoring visits. The last oversight visit from IOM was held in April 2016. The document review reveals 'data quality issues' and that the 'reported data is not verified'.

Respondents report 'linkages' and 'improved services' for miners and their communities as evidence of the success of the project. These are not sufficiently captured in the project monitoring data. The IOM focal person assisted with partner coordination.

"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." (KI, IP)

"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" (KI, MOH)

Efficiency

The MOH and development partners working in the region contributed to the project in kind (refer to linkages above). Some partners provide mobile testing and treatment services during campaign days.

None of the respondents interviewed for the evaluation were in a position to comment on the cost efficiency of the project. At an implementation level most the budget was *"used on reaching out to beneficiaries, training that involved beneficiaries and for general communication between staff members."*

The CAs presented the following suggestion for improving the project *"…request money for transport and to buy soap or powder soap to wash our clothes."*

Impact

All project stakeholders 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. Health workers have been sensitized to the rights of migrants and health; mainstreaming has not yet taken place. TB services specifically for ex-miners have been set up at two health facilities.

> *"Before miners were just sitting at home thinking they are forgotten even the country benefited from the revenue they brought in. So it* (the project) *uplifted their spirits; they no longer feel neglected and forgotten…" (National KI, MOH)*

> *"We are not considered, by the mine and our government. We use to contribute amount of money to the government. Even TEBA is not considering us, not even once has they called us and do something towards our efforts, nor give us money. They are not giving us anything…" (FGD, Ex-miners)*

> *"URC have taken up TB in the mines; supporting the ministry to deliver services in the Lebombo region; they are running the Sithobela clinic, providing the doctor TB Care II…." (National KI, MOH)*

Respondents report a 'bigger uptake' of services by ex-mineworkers. SD benefited from the deployment of a mobile service unit equipped with X-ray and laboratory facilities from SA, which provided screening for TB and silicosis to ex-miners in order to facilitate identification and processing of those eligible for compensation. SD has acquired a similar mobile unit for a national TB/silicosis prevalence survey; thereafter the unit will be used for outreach activities in hard to reach areas. The vehicle was acquired as part of the GF grant.

Sustainability

Health service provision to migrants will continue through the public health facilities. Health workers have been trained and the foundation has been laid for mainstreaming migrant health services.

> *"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…" (National KI, MOH)*

> *"Management of diseases like silicosis has improved; health care workers have been trained to manage them properly. IOM did this training maybe not directly, but paid consultant or URC would train based on what was found on the ground… brought partners together" (National KI, MOH)*

The country will take over the financial and operational responsibility for running the mobile health services at the end of the GF grant period. SD has acquired two one-stop shops as part of the regional GF initiative to harmonise compensation systems.

Conclusion

The Mining Sector Project is extremely timely in the context of unfolding southern African regional initiatives addressing TB in the mining sector; the country has gained resources for better service provision as a result. The focus on HIV and TB in migrant miner communities is very relevant in terms of the high prevalence of these infections in SD and especially in miners. However, for direct and indirect project beneficiaries issues of compensation are often foregrounded and their health issues were viewed as secondary to their extreme poverty and food insecurity. The project was successful in increasing demand for services in migrant communities and sensitising health workers on health and migration. The model of using volunteers, who themselves are poor, to implement the project led to a high turnover of CAs who were constantly on the look out for paid employment. The project was instrumental in prioritizing miners as a key population in national health policies; this bodes well in terms of the project gains being sustained.

Table 4: Summary of Swaziland findings against the OECD-DAC criteria

OECD-DAC criteria	Key findings Swaziland
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.
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
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
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
Sustainability	• Public health facilities will continue to provide services to migrants • Miners incorporated as key populations in national HIV & TB policies

APPENDIX 2
Lesotho Report

Country context

Lesotho, officially the Kingdom of Lesotho is an enclaved, landlocked country in southern Africa completely surrounded by South Africa. It is just over 30,000 km2 (11,583 sq mi) in size and has a population slightly over two million. Its capital and largest city is Maseru. About 40% of the population lives below the international poverty line of US $1.25 a day and it is considered a low income country. The population distribution of Lesotho is 25% urban and 75% rural. Lesotho has a century long history of supplying labour to the South African mining industry. Today the number of men migrating for mine work has reduced as the South African gold mining industry continues to decline. However, it is estimated that 50 000 Basotho men migrate to work in South African mines every year, with 60% of them being considered highly mobile, travelling between Lesotho and South Africa once or twice a month.6

The health sector

Lesotho is severely afflicted by HIV/AIDS and TB. Both present a major problem. TB incidence is 852/100 000 in 2015 and overall HIV prevalence is 23%.7 The highest prevalence of HIV and TB are in the districts from which most mineworkers and ex-mineworkers live, namely Maseru, Berea, Leribe and Mafeteng. All of which, with the exception of Berea, were included in the Mining Sector Project. In these sites HIV prevalence is above 25%. Lesotho operates a comprehensive primary health care service, but there are many constraints. Access for many rural people is made very much more difficult by a harsh mountainous terrain. There are also serious shortages of staff, equipment and drugs to support the running of the service. However despite this there have been gains for infant and under-5 mortality. The Ministry of Health (MOH) has a programme of outreach workers called village health workers (VHWs).

The Lesotho baseline study was conducted in Maputsoe, in Leribe District. The study found that 45% of respondents in the household survey (701 households) reported that one person in their household had fallen sick in the three months prior to the survey, and only 1% of respondents reported being covered by medical aid. Thus the vast majority of respondents were dependent on the public health services and 87% reported using these services. Respondents identified local NGOs/CBOs providing education and services related to HIV as Alafa, Kick for life, MA Nurse Ahae and New Start. Services related to TB support were less readily identified. Although issues related to TB were raised during focus group discussions with current and ex-mineworkers and their wives. There it was stated that mineworkers are at risk of both injury and TB. It was also noted that one of the major challenges faced by the TB patients in Maputsoe was the lack of food and that patients were too hungry to adhere to medication.8

[6] IOM 27 March 2015 Baseline Assessment of Health and Mobility in the Mining Sector of Southern Africa Lesotho Country Report

[7] 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

[8] IOM 27 March 2015 Baseline Assessment of Health and Mobility in the Mining Sector of Southern Africa Lesotho Country Report

Mining associations

Mining related organisations in Lesotho include TEBA Ltd, Southern Africa Mines Association (SAMA) and Ex-Miners and Allied Workers Association of Lesotho (EMAWA). TEBA Ltd is a South African company that historically recruited labour for South African mines, today it plays a more developmental role and assists miners and ex-miners in activities such as using the Ubank network to transfer money to their families and to access social benefits. SAMA is an umbrella NGO registered in Lesotho and comprises of national mineworker associations from Lesotho, Swaziland and Mozambique. In contrast to TEBA, EMAWA is a membership organisation of ex-mineworkers. EMAWA states that their role is three fold; (1) To facilitate livelihood programmes to retrenched mineworkers; (2) To assist in the completion of forms and processes required for the payment of benefits; (3) To assist ex-miners in the prevention and management of HIV/AIDS, TB and silicosis. One of the difficulties faced by all of these organisations is tracing ex-mineworkers in Lesotho. This is because there is no formal address system in Lesotho and mineworkers may come from remote areas that are hard to access.

Policies and Legal Framework

Despite Lesotho's labour sending history, national policies from the turn of the 21st Century have not made specific reference to the health needs of current and ex-mineworkers, including diseases acquired at mines. This is despite the impact of oscillating migrancy being well documented with respect to HIV especially. During the implementation of the Mining Sector Project the focus on the vulnerability of mineworkers, ex-mineworkers and their families and communities significantly improved (see following findings) within the Ministry of Health, but during the Mining Sector Project implementation the policy position was found as listed on Table 1.

Lesotho has not ratified most of the International Conventions that will provide beneficial rights to current and ex-miners and their families. Where Lesotho has ratified some of these International Conventions, domestication of these Conventions into Lesotho legislation is required for individuals to acquire rights enshrined in these Conventions.

Table 5: National policies and International conventions to which Lesotho is a signatory with relevance to migrant mineworkers

National Legislation and policies	International Conventions
• **Lesotho National Health Policy (Labour migration is not identified as a social determinant of health).** • **The Policy Framework on HIV/AIDS Prevention and Management (2000) (Migration identified as a risky factor for diseases).** • **National Tuberculosis Programme Policy (Mines not identified as a source or cause).** • **The National HIV Prevention Strategy for Multi-Sectoral Response to The HIV Epidemic in Lesotho (2012/13-2016/17 (Miners identified among the key populations).** • **The National Strategic Development Plan (2012/13-2016/17) (Miners not mentioned)**	• International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families, 1990 (24 September 2004) • African Charter (10 July1992). • International Covenant on Civil and Political Rights, 1966 (9 September 1992) • ILO Migration for Employment Convention (Revised), 1949 (No.97)* • ILO C143 Migrant Workers (Supplementary Provisions) Convention, 1975 (No.143)* • ILO C189-Domestic Workers Convention, 2011, (No.189)* • UN Declaration on the Human Rights of Individuals Who Are Not Nationals of the Country in Which They Live (1985)*

Conventions marked * have not been ratified

Regional Conventions and Policies

Lesotho is also a signatory to the SADC Declaration and Code of Conduct on Tuberculosis in the Mining Sector in 2012. The SADC Declaration on TB is the main regional guiding policy for a coordinated response to the management of TB among miners and ex-miners within SADC. South Africa and Lesotho have a Bilateral Agreement on the free movement labour. The Agreement is not properly supported by relevant legislation and policies in the two nations and there is lack of coordination between the two states. It is silent on the transfer of Social Benefits, Pensions and Health Compensation.

Project activities

The project activities are summarized below according to the four project components:

Research and information dissemination – A baseline survey conducted in Maputsoe, in Leribe District was completed in 2014 and reported on in early 2015(Impact Research International (IRI)). IOM was also able to include migration and health variables into the 2016 Lesotho census. A second piece of research, an integrated biological and behavioural survey on HIV and TB will be completed in September 2017. The results will provide the technical background for government's national response to HIV and TB.

Advocacy and policy development – In 2014, IOM supported the MOH launched a campaign for Basotho medical diaspora to make a contribution to the skills shortages in the Lesotho health service. This programme is envisaged to provide a roadmap for short and medium term return programme for medical professionals. KESI Business Solutions based in Maseru were contracted by IOM to develop the Lesotho Migration and Health Strategy. There have also been regular quarterly meetings of the multi-sectoral Partnership Forum on Health and Migration that focuses on HIV and TB.

Service delivery and capacity development – This component was outsourced to local a country-implementing partner. The model used change agents (CAs) on the ground to provide peer education. At a site level an implementing partner(IP) was appointed to role out health activities on the ground through the appointment of change agents. Presently Phelisanang Bophelong has approximately 150 Change Agents working in three community councils in the district of Leribe. Work in this area commenced in 2014, the three areas are Maputsoe Urban Council, electoral division 9 (48 000 population), Litjotjela Community Council, electoral division 9 (22 000 population) and Hleoheng Community Council electoral division 7 (28 000 population). At that time CARe had oversight of CA activities until the present IP was appointed in November 2015. Work with local health care providers to ensure they are more migrant sensitive commenced in 2014.

The CAs provide information about HIV, TB, SRHR and gender based violence. They ensure there is referral to local health services for HIV testing and TB screening. They also distribute condoms. Each CA is required to visit a minimum of 10 or a maximum of 50 households a month. The CAs also facilitate community dialogues or attend local meetings to discuss the social determinants of health. They also supported a cross-border screening campaign facilitated by the District Health Management Team (DHMT) between 20-25 December 2016 to identify individuals with HIV and TB as they entered back into the country. Although Dutch funding is now complete these CAs are presently working under an extension January-April 2017. CAs are provided with a cap, T-shirt, bottle, bag, IEC materials and condoms. They are retrospectively paid R350 per quarter to cover transport costs.

Country coordination – IOM was instrumental in the formation of the Partnership Forum on Health and Migration that focuses on HIV and TB. Meetings have been held quarterly since the inception of the project (2014). The forum ensures that the (HIV and TB related) activities carried out by NGOs, development partners and civil society working in each region are conducted in a coordinated fashion.

Project partners by component

Table 6: Key country partners by project component

PROJECT COMPONENT	KEY PARTNERS LESOTHO
Research and information dissemination	
Advocacy and policy development	*Development partners:* International Organisation for Migration (IOM), Voluntary Service Overseas (VSO), World Bank (WB) *Government*: Ministry of Health (MOH), Ministry of Labour (MOL) *Private sector:* TEBA *Organised Labour:* Ex-mineworkers Association, Mining Development Agency
Service delivery and capacity building	*Implementing partners:* Care AIDS Response 2013-15, Phelisanang Bophelong Nov 2015- Nov 2016 *Government:* Leribe District Health Management Team, 3x District Councils, District Administrator, Ministry of Agriculture extension officers *Civil society: AHF, PSI, CHAL* *Private sector:* Econet
Regional coordination	Refer to regional report

Project management and governance

Lesotho was a site for both IOM and VSO activities although only IOM related activities are discussed in this country report. IOM activities were focused at the national level and at the site level.

In 2014 a project steering committee was established and the Lesotho Migration and Health Partnership Forum was established with MOH and the Ministry of Labour (MOL) which met quarterly throughout the period of project implementation from 2014. This forum continued to meet on a quarterly basis at the time of the evaluation. It is the central body through which IOM facilitated its work in Lesotho. IOM acted as the secretariat for this Forum during the duration of the Mining Sector Project, and the Head of the TB and HIV Programme, MOH chaired. The Forum has approximately 25 regular members including government, development partners and civil society groups. The EMAWA is an important stakeholder in this sector and their role in relation to the Dutch Project is discussed more fully under the POPA report. The current IP Phelisanang Bophelong also attends the Forum.

All respondents for this evaluation reported no involvement in the governance or decision making related to the Mining Sector Project. Phelisanang Bophelong continue to report once a month to an IOM focal person based in Pretoria, and not to the IOM senior programmes assistant based in Maseru.

"We didn't contribute to project governance, they told us what they wanted to do. The donors came with preferred districts." (KII stakeholder)

Project performance

Major Achievements

National level

MOH report that the Forum has been valuable and has facilitated involvement their involvement in TIMS (TB in Mining Sector) Programme, the Southern Africa TB Health Systems Strengthening Programme (World Bank/Global Fund) and information sharing with civil society groups. the Forum has supported other developments such as a working partnership between IOM and the ILO to provide a more general labour and migration policy, encouraged TEBA to establish an induction programme for migrant mineworkers leaving Lesotho for South Africa

Site Level

In 2016/17 155 Change Agents (CAs) conduct activities at three sites - This worked despite an observation in the baseline that outreach workers who are not government sponsored village health workers (VHWs) may not be recognised.[9] CAs themselves 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.

At the local level Phelisanang Bophelong report that there is an increase in health service utilisation related to HIV, TB and family planning although this evaluation was not able to verify this observation or attribute it to the IOM CAs. However clearly in some cases CAs continue to make a contribution to health service delivery and in at least one case a CA has subsequently become a member of the clinic committee advising the clinic on the needs of the community.

Table 3 below presents, in tabular format, a summarized version of the routine project monitoring data that was collected and collated on the IOM project M&E system.

[9] IOM 27 March 2015 Baseline Assessment of Health and Mobility in the Mining Sector of Southern Africa Lesotho Country Report p72

Table 3: Performance against targets and indicators

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
Monitoring migrants' health	Number of key national routine data collection instruments that incorporate questions on migration and health	-	-	-	-	-	0	Not achieved
	Number of research studies conducted focused on migrants' health and migration-related health issues	-	1	-	-	-	1	
	One operational migration health knowledge sharing platform	-	-	-	-	-	0	Not achieved
Policies and legal frameworks	Proportion of policy makers and stakeholders with increased knowledge on migration health related issues and the importance of migration and health in health policies	-	1	-	-	-	1	
	Number of non-health sectors that have incorporated migration and health in their policies, legislations and strategies	-	-	-	-	-	0	Not achieved
Increased knowledge	Number of individuals reached through community education	18 000	46 954	20 000	20 887	38 000	67 841	Target exceeded
	Number of reproductive age individuals (15-49 years) reached with education on sexual and reproductive health	-	-	5 000	6569	5 000	6 569	Target exceeded
	Number of community led initiatives to address the social determinants of health	-	60	3	3	3	63	
	Number of change agents trained to facilitate community dialogue	400	-	150	155	550	155	

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
Strengthening service provision	Number of change agents trained who demonstrate skills and capacity to facilitate community dialogues and education on the social determinants of health	300	228	75	83	375	311	Total figure exceeds the number of CAs trained
	Number of individuals from key stakeholder organisations capacitated on migration and health	100%	-	30	30	-	30	
	Number of health workforce members capacitated on migration and health	60%	235	30	0	-	235	
Improved service provision	Number of individuals referred for health and other services	8 000	9 361	2 000	1676	10 000	11 037	
	Number of individuals referred for health and other services who received services at the referral destination		1711	1 000	292	1 000	2 003	
	Number of individuals referred for HIV testing	5 200	4997	1 000	1491	6 200	6488	Target exceeded.
	Number of individuals referred for HIV testing who received their HIV results at the referral destination	1 200	1168	500	163	1 700	1331	Target not achieved.
	Number of individuals screened for TB	8 000	45787	3 000	7380	11 000	53167	Target exceeded

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
	Number of individuals with TB symptoms referred for diagnosis and treatment in migration affected communities	100%	7	150	181	-	188	
	Number of referred individuals with TB symptoms who receive diagnosis and treatment at referral destination	60%	936	150	61	-	997	Number treated greater than number referred
	Number of SGBV survivors identified and referred to service providers for support and protection	50	263	50	20	100	283	Target exceeded
	Number of SGBV victims identified and referred to service providers for support and protection who received services at the referral destination	30%	263	-	12	-	275	
	Number of condoms and lubricants distributed	40 000	-	50 000	48 029	90 000	48 029	
Multi-sectoral partnerships and networks	Number of initiatives that received technical support from IOM	-	-	-	-	-	0	
	Number of multi-country and/or multi sectoral partnerships and networks established/strengthened for effective coordinated response to migration and health	-	-	-	-	-	0	
	Number of partnerships with relevant stakeholder organizations formalized and/or strengthened	-	5	-	-	-	5	

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
	Number of tools, guidelines and technical briefs on migration and health disseminated	-	-	-	-	-	0	
	Number of relevant forums, dialogues, campaigns and conferences that include migration and health.						0	

Relevance

At the national level the key stakeholders didn't share a uniform response to the Mining Sector Project. Whilst the Lesotho Migration and Health Partnership Forum was reported by some to be a valuable contribution to co-ordination between role-players, in one case it wasn't supported. IOM felt that as a result of the Forum issues related to migration and health and internal migration were much better understood. Concerns about TB have dominated the Forum and the MOH report that as a consequence mineworkers and ex-mineworkers are an important key population for them. Importantly the MOH report that the Forum has been valuable and has facilitated involvement their involvement in TIMS (TB in Mining Sector) Programme, the Southern Africa TB Health Systems Strengthening Programme (World Bank/Global Fund) and information sharing with civil society groups.

"IOM calling stakeholders together, that was really helpful." (KII stakeholder)

Respondents all agreed that mineworkers and ex-mineworkers continue to face difficulties. One of these is the challenge of securing compensation for occupational disease. The MOL were disappointed that the Mining Sector Project had been unable to more directly support this process in Lesotho, especially with regard to the training of doctors at the district level to support screening for occupational disease, and the establishment of a database for compensation claims.

The ensuing poverty associated with legacy of non-payment for occupational disease for mineworkers is painful and the FGD conducted at the site level with current and ex-mineworkers pointed to the searing poverty for many living in traditional labour sending areas.

"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)

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

In Leribe, on the walls of the Phelisanang Bophelong office a poster issued by the MOH reported that in 2015, 31% of women and 19% of men visiting health services in Leribe were HIV positive.

"Lesotho is number one in the world for TB. We as the [District Health Management Team] DHMT appreciated the support for World TB Day. The Change Agents also help track our TB defaulters. TB notification is going down. People don't want to be screened for TB. We need to provide incentives for people to screen" (KII Stakeholder)

Respondents reported that the work of the CAs is important. Phelisanang Bophelong reported that Community Councils like the model of CAs on the ground because they are local people. The Community Councils reflect the system of dual governance in Lesotho involving both

traditional leadership and elected councillors. In fact, 3 of the Phelisanang Bophelong CAs are elected councillors and 2 are women head chiefs.

The work of the CAs is faced with several challenges. The first is the significant cultural 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. Poverty is the other major obstacle. Income generation is the key priority for many Basotho. Respondents in FGDs spoke of the extreme poverty in Leribe that meant people went hungry and unable to take medication.

> *"People say we have nothing in our stomachs. We can't take medication on an empty stomach." (KII stakeholder).*

In other cases FGD respondents lacked transport money to attend health services.

Possibly because of the complexity of these obstacles, the response to the work of the CAs varied. The ex-mineworkers supported by the CAs 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 healthwise, 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)*

However, this was not always the case and CAs reported being seen as *"fly by nights"* and chased away especially by current mineworkers.

> *"…, some community members say we are home breakers because of our interventions in other people's homes and others see us as their counselors." (FGD Changes Agents)*

CAs also reported that some clinics responded negatively to them whilst others more easily embraced their services.

> *"They (clinics) say all these NGOs come and go so they make money out of people then drop them in the end. On the other hand other clinics do work hand in hand with us. For an example, they sign and they stamp the papers we give some of our patients." (FGD Change Agents)*

Both government and NGOs used outreach community workers in other programmes. The integration of CAs with the work of government sponsored VHWs and alignment with other

NGO groups doing similar outreach health work presented a problem for Phelisanang Bophelong at first.

Effectiveness

At a national level the Lesotho Migration and Health Partnership Forum has prevented stakeholders working in silos, including relevant government ministries, donor initiatives and civil society groups. The Forum alongside work addressing migration issues, now includes information sharing on a range of other important initiatives such as the TB prevalence study being conducted in 5 districts funded by the Clinton Foundation.

At the site level between 2014-2016 it is reported that ≥67 000 individuals had been reached through community education and that 11 000 individuals had been referred to health services. At the site level it was felt that the IPs have struggled to respond to the social determinants of health. Both the extreme poverty (no transport money to health services) and the cultural barriers interfered with the number of beneficiaries who could benefit from interventions. Phelisanang Bophelang reported that the District Health Management Team (DHMT) had a monthly project to take health services into hard to reach villages. A tent is used to offer health services for a day. Phelisanang Bophelang has also established "men as protectors" groups to promote a more positive role for men in relation to family health and wellbeing to address the cultural barriers to health seeking behaviours.

In Leribe, Phelisanang Bophelang realized that buy-in for the work of the CAs was lacking when they took over the project in November 2015. They spent a considerable amount of time establishing good relationships with the Community Councils and they report this has made a huge difference to the effectiveness on the ground. As a consequence in the last year they have successfully trained local stakeholders on migration and health working through the community councils.

Phelisanang Bophelang have a programme of regularly reporting including monthly site visits and a quarterly review of site data. The latest verified data Nov 2015-Dec 2016 reported 20 887 beneficiaries reached and 1 673 referrals of which the majority were for HIV testing, with 181 referrals for TB screening. 48 000 condoms were distributed. Phelisanang Bophelang put the emphasis on quality rather than quantity of household visits. They report that they have seen a decrease in our referral figures because people are going anyway to the clinic without being seen first by a CA.

Data collected for M&E was not presented at the Migration and Health Partnership Forum. Other evaluation studies have not been shared at this Forum or with the implementing partner.

Efficiency (including cost efficiency)

At the national level stakeholders reported contributing in kind to the Mining Sector Project, primarily through making staff time available to attend meetings, workshops and site visits. Most stakeholders felt the Mining Sector Project was cost efficient. Partly because there were limited resources and therefore wastage was minimal. One stakeholder felt the Project had failed so couldn't be considered cost efficient on account of its lack of clear deliverables. Other

stakeholders felt that the feeling of not having achieved is because of the overwhelming challenges. Time rather than money was felt to be solution to this.

The original decision in 2013 to appointment an IP who was not based in Lesotho was a mistake. This definitely hampered the set-up of local level activities and the final coverage of beneficiaries. Time was unanimously identified as the factor that would have contributed to improved reach. There was some frustration that Mining Sector Project resources were cut at the moment when the Project was more formally established.

> *"We needed more time to reach more beneficiaries. It took the first year to set up, the momentum is at the 4th year. We need to educate donors you cannot cut when you are at your peak." (KII stakeholder)*

The role of CAs is central to reaching beneficiaries. The Mining Sector Project had relied on CAs to work as volunteers. There have been no stipends paid and CAs said that the caps and T-shirts helped them look presentable so that people take them seriously. However, they also complained about the lack of incentives to take on the role which was thought to hamper recruitment of new Agents. Some of the CAs are village health workers (VHWs) who are paid R500 a month by the MOH. Other CAs rely on an additional travel allowance that they get when working for other donor funded projects. Despite this limited funding on the ground, payments from IOM still arrived late on two occasions causing the CAs and the Coordinator to go unpaid for a period. In Leribe, two facilitators were appointed to help co-ordinate activities in each of the three community councils. The facilitators reported that they would have been able to communicate more effectively if they had been provided with airtime. Local stakeholders also requested more IEC materials including CDs to assist with local education.

Impact

At the national level the Migration and Health Partnership Forum is still functioning despite the closure of Mining Sector Project funding. This is regarded as an important development because both the MOH and the MOL have brought people in to present at this Forum. One key informant commented on how the Forum had brought about trust that had helped ensure policy will be migrant sensitive.

> *"We gained trust through the forum. We were sent government HIV strategies to assist make 'migration friendly'" (KII stakeholder)*

Comments by key informants suggest that the Forum has supported other developments such as a working partnership between IOM and the ILO to provide a more general labour and migration policy, encouraged TEBA to establish an induction programme for migrant mineworkers leaving Lesotho for South Africa and facilitated Lesotho's involvement in both the TIMS Project and the World Bank/Global Fund Southern Africa TB Health Strengthening Programme.

At the local level Phelisanang Bophelong report that there is an increase in health service utilisation related to HIV, TB and family planning although this evaluation was not able to verify this observation or attribute it to the IOM CAs. However clearly in some cases CAs continue to

make a contribution to health service delivery and in at least one case a CA has subsequently become a member of the clinic committee advising the clinic on the needs of the community. CAs themselves 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.

"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)

"They (ex-mineworkers) have been taught on how to live without the fears of others judging them." (FGD Change Agents)

Sustainability

The Migration and Health Partnership Forum as has been stated above is now a project of the MOH. One stakeholder was deeply critical of the manner in which IOM closes projects stating *"IOM projects just end. They just keep quiet." (KII stakeholder).* This suggests that processes for sustainability and closure may have been scant for some stakeholders.

Phelisanang Bophelong embarked on a programme of income generating activities to provide some local level funding to sustain the activities of the CAs. Organising the majority of the existing CAs 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 CAs). These projects are all of an agricultural nature and are supported by Extension Officers from the Ministry of Agriculture (MOA). The purpose of these projects is to provide for some basic needs of the CAs, provide transport money for the work of CAs and to sustain the cohesion between groups of CAs. Each income generating project received about R20 000 seed money provided by the Mining Sector Project. Already Phelisanang Bophelong has seen difficulties arising in the dynamics between the members of these projects. The likelihood of all 5 projects becoming successful is probably quite low. An earlier partnership with the MOA would have maximized the opportunity for success. IOM reported that they experienced livelihood work as costly. Not all Community Councils opted for the development of income generating projects to sustain their CAs. One Council requested that the final disbursement of funds by the Mining Sector Project should be to assist with securing water, which was critical in a specific community.

One key informant noted that at the moment the CAs continue because *"they are those kind of people who tend to continue." (*KII stakeholder). However shortly (from May 2017) without additional funding there will be no oversight or accountability for their activities, so there will inevitably be changes. CAs will be looking for jobs too but local stakeholders saw prospects for them too.

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

Conclusion

Respondents perceived the Mining Sector Project as relevant because HIV and TB are serious health concerns in this mining affected community as in others. At a national level the Partnership Forum for Migration and Health has been successful at breaking down silos, although addressing the problems of all stakeholders will help cement co-operation between all partners for the future. The ensuing poverty associated with legacy of non-payment for occupational disease for mineworkers is painful and the FGD conducted at the site level with current and ex-mineworkers pointed to the searing poverty for many living in traditional labour sending areas.

At the site level between 2014-2016 it is reported that ≥67 000 individuals had been reached through community education and that 11 000 individuals had been referred to health services.

The decision in 2013 to appointment an IP who was not based in Lesotho was a mistake. This definitely hampered the set-up of local level activities and the final coverage of beneficiaries. CAs are an effective mechanism to reach communities about important health issues. However the absence of a stipend for CAs in the Mining Sector Project contributed to difficulties on the ground. Time was unanimously identified as the factor that would have contributed to improved reach.

CAs themselves 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 Partnership Forum for Migration and Health had secured trust between different stakeholders that has helped ensure policy will be migrant sensitive

The stewardship of the Migration and Health Partnership Forum has been taken over by the MOH. The present IP embarked on a programme of income generating activities to provide some local level funding to sustain the activities of the CAs.

The slow process to resolve the payment of compensation to mineworkers affected by silicosis and other occupational disease needs continued support. This will also help relieve the extreme poverty experienced by communities living in traditional labour sending areas. Although this is not the focus of this project it remains a priority for migrant mineworkers.

Table 3: Summary of Lesotho findings against the OECD-DAC project criteria

OECD-DAC criteria	Key findings Lesotho
Relevance	• 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	• 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	• Change Agents reached communities but the absence of a stipend for their work contributed to difficulties on the ground.
Impact	• Change Agents 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	• The present IP implemented a programme of IGAs to provide some funding to sustain the activities of the Change Agents. • The Partnership Forum for Migration and Health continues to meet quarterly under the stewardship of the MOH.

APPENDIX 3
Mozambique Report

Country context

Mozambique, officially the Republic of Mozambique, is one of the poorest and most underdeveloped countries in the world. Mozambique is endowed with rich and extensive natural resources. The country's population is around 27 million. Mozambique has been one of the major sources of mine labour to the South African mining sector dating way back into the early 1900's. The Association of Mozambican Mine Workers (AMIMO) reports that approximately 35 000 Mozambican mineworkers are still working on South African mines.[10] The baseline survey commissioned for the Mining Sector Project in a South Africa/Mozambique border area reported that 81% of 681 respondents stated that poverty was one of the major causes of ill health.

The health sector

According to the 2015 UNAIDS Report, Mozambique has 1,5 million people living with HIV, an adult (aged 15-49) prevalence rate of 10.5% and 1,4 million adults aged 15 and over living with HIV.[11] According to the National Statistical Institute data (NSI 2007), it is one of the most affected African[12] countries by the HIV pandemic affecting all levels of the population, particularly the young.

In the south of Mozambique, where the project was implemented, more specifically in Maputo and Gaza, the Gaza province has the highest prevalence rate of 21.1% in the country among the population of 15 to 49 years old (prevalence rates of 19.8% in Maputo), as referenced in the National Inquiry of Prevalence Displays, Behavioral risks and Information about HIV/AIDS in Mozambique (INSIDA), 2009. Gaza is thought to be the most affected province due to the number of oscillating migrant mineworkers who historically and today work on the gold and diamond mines from South Africa, where there is high HIV prevalence. It is thought that the multiplicity of mines and the range of highways and railways connecting Maputo, Gaza and South Africa, all contribute to the high prevalence levels.

Regarding tuberculosis, data provided by the Health Ministry in February 2017, indicate that Mozambique is one of the 22 countries with highest rates of people with TB.[13] The Health Ministry estimates that 64 000 people are infected with TB every year, 60% of which are relapses. An additional and worrying point is that from all the cases, about 51% are TB related to HIV/AIDS. TB is considered a national emergency and perhaps of even greater concern than HIV, malaria, cholera and other diseases. Miners and ex-miners and consequently their sexual partners and

[10] IOM 29 March 2015 Baseline Assessment on Health and Mobility in the Mining Sector of Southern Africa Mozambique Country Report completed by Impact Research International

[11] http://www.unaids.org/en/regionscountries/countries/mozambique

[12] ONUSIDA, 2009 and INSIDA, 2011.
National HIV Combat Council (NHCC), 2016, p. 12.

[13] Ministry of Health personal communication, Mozambique field team

their families living in high prevalence communities in the south of the country are some of the most vulnerable to HIV and TB infection.

The baseline survey in Mozambique was conducted in Ressano Garcia which is a transit community on the border between Mozambique and South Africa. In this survey 681 interviews were conducted in the area. Although the sample was nearly two thirds women respondents, only 29% reported knowing organisations that were educating people about HIV and AIDS. Very few people were aware of any organisation responding to the epidemic of TB. An earlier study by IOM found that although Mozambique mineworkers working in South Africa could access South Africa services, 50% of mineworkers reported that xenophobia made this difficult.[14]

Mining Associations

The major association representing mineworkers is Organizacao dos Mineiros Mocambicanos (AMIMO). The challenges that AMIMO face are complex. In the main, AMIMO is required to deal with the challenges experienced by mineworkers, ex mine workers and their families principally in the following areas:

- Pensions, including those of ex-miners
- Salary payments in Mozambique
- The health of mineworkers, ex-miners and their families (TB, HIV, and others).
- The socio-economic quality of life (employment, occupation, reintegration)
- The challenges of recognizing the political and historical contribution of mineworkers in the last two centuries and their contribution to the economy of Mozambique.

A smaller ex-mineworkers association, Kindlimuka operates in Moamba in Gaza Province. TEBA Ltd, a South African company, that has been historically involved the recruitment of employees for South African mines in the SADC region and assists miners and ex-miners in accessing social benefits has an office in Maputo.

A long standing partnership from 2005 has been developed between VSO RAISA, AMIMO and TEBA. In the partnership, VSO RAISA works at a programmatic level with AMIMO to focus on HIV and AIDS related issues. Another joint project between the AMIMO, the South African National Union of Mineworkers (NUM), TEBA, and the Southern African AIDS Training (SAT) Programme is underway to control the transmission of HIV along the Maputo corridor. It aims to prevent the spread of HIV by miners to their families. It also assists in income and employment generating activities for ex-miners.

In a third project the US department of labor, International Labour Organisation (ILO), HOPE, Mozambican Association for the Development of the Family (AMODEFA), TEBA, and AMIMO are implementing a project called Khluvuka (Corredor da Esperanca) in Gaza and Maputo province. Its aim is also to prevent the spread of HIV by miners to their families and assists families with infected members.

Policies and Legal Framework

[14] IOM Baseline, 2015

National policies that were formulated by the state relevant to TB related issues affecting current and ex-miners were not identified in the documents provided.[15] During the endline evaluation it emerged that the National Strategic Plan for HIV and AIDS PENIV has made important provisions for migrant mineworkers and ex-mineworkers. Mozambique has not ratified International Conventions that have the ability to provide individual rights, if domesticated, to migrant mineworkers as well as other relevant employees.

Table 7: National legislation & policies and International conventions to which Mozambique is a signatory

National Legislation and policies	International Conventions
• National Strategic Plan HIV & AIDS PEN IV • Please add the name of this plan	• International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families, 1990 * • African Charter ratified 22 February 1989 • International Covenant on Civil and Political Rights, 1966* • ILO Migration for Employment Convention (Revised), 1949 (No.97) * • ILO C143 Migrant Workers (Supplementary Provisions) Convention, 1975 (No.143) * • ILO C189-Domestic Workers Convention, 2011, (No.189) * • UN Declaration on the Human Rights of Individuals Who Are Not Nationals of the Country in Which They Live (1985) *

Conventions marked * have not been ratified

Regional Conventions and Policies

The only source of national TB policy is the domestic application of the SADC Declaration and Code of Conduct on Tuberculosis in the Mining Sector in 2012. The SADC Declaration on TB is the main regional guiding policy for a coordinated response to the management of TB among miners and ex-miners within SADC. The success of the SADC declaration on TB in nation states requires the full cooperation of the other signatory states and most importantly South Africa, the significant employer state.

[15] ibid

Project Components and Partners

Table 8: Project Component and Partners

PROJECT COMPONENT	KEY PARTNERS MOZAMBIQUE
Research and information dissemination	
Advocacy and policy development	*Development partners:* International Organization for Migration (IOM) *Government*: Ministry of Health (MOH), Ministry of Work, Employment and Social Safety (MWESS) *Private sector:* SAICOM
Service delivery and capacity building	*Implementing partners:* PfukaLixile and Coalizão *Government: District Health Directorate of Moamba and Ressano Garcia Health center* *Civil society:* AMIMO
Regional coordination	VSO and IOM

VSO and IOM were responsible for the regional coordination of the project. VSO and IOM implemented the project with the partnership of AMIMO, Coalizão and Pfuka Lixile. AMIMO, Pfuka Lixile and Coalizão played key roles as implementing partners as they worked directly with the target group and communities where the beneficiaries live. IOM and VSO provided support in terms of providing financial capacity, technical capacity as well as support with monitoring and evaluation.

AMIMO was responsible for economic issues such as: rent generation through agriculture and production, informal business, and public cellphones called Onecell given to the beneficiaries (miners, ex-miners and their families).

Coalizão was linked to the project for a one-year period in 2014/15 after which they left the partnership. They worked in the areas of subsistence mountain agriculture for the target group of beneficiaries and trained students from local schools /change agents in the matters of sexual and reproductive health, violence, risky behaviors and HIV/AIDS.

Pfuka Lixile is a community based organization, working specifically and exclusively at Ressano Garcia Administrative Post at Moamba district. It has worked with the project from 2015 to 2016. Pfuka Lixile traditionally worked in the area of home based care in the HIV and AIDS context. As treatment became more available for the population in Mozambique, Pfuka Lixile started widening their work to include health education and delivered health talks about HIV, TB and Sexual and reproductive health and other contagious and non-contagious diseases. Pfuka Lixile was responsible for implementation of this project with the financial and technical support of IOM in Mozambique-this was the first time that this association had a donor and had to learn the procedures of financial management and accountability.

Project Governance and Management

The IOM country project manager (PM) provides oversight, guidance and input regarding the project direction and activities in line with the regional framework. Government partners at National and local levels also provide inputs. From inception in 2013 until early 2015 the IOM regional coordinator managed the project. The project does not have an official oversight or advisory body such as a Steering Committee (SC) or Advisory Board (AB).

The entry point of the project has been through the National Ministry of Health, and is then cascaded to the Provincial Directorate, District Directorate and its institutions (health) at lower levels. At the level of the health service, there was enagement between the change agents (activists) and the health system referrals, forms and procedures to ensure that the project operated within the existing sytem.

Major Achievements

National level

IOM through the Mining Sector Project supported the integration of AMIMO into the National HIV/AIDS Combat Council and assisted them to take an important step passing migratory groups from vulnerable to priority groups according to PEN IV. According to PEN IV, in the context of the national combat response to HIV the priority population of the mobile and migrant workers' group it includes mine workers, long distance truck drivers, and seasonal workers from the extraction industry, in gold-digging, in public buildings and in agricultural properties.

IOM/the Mining Sector Project helped AMIMO to be acknowledged throughout the country as the national association that defends the interests of the migratory mineworker groups in the advocacy campaigns. During the implementation of the project AMIMO was acknowledged as an organization that fights for rights of the miners related to compensation, the right to access treatment, social integration of the former mineworkers and mitigating the impact of poverty among the widows of ex-miners through the POPA project (refer to POPA report).

At the national, provincial and district level the resolution of unpaid compensation payments to ex-mineworkers for occupational disease remains a priority and progress was made towards this during the implementation of the Mining Sector Project. Presently the Mozambican government has information that about 3 000 former miners should benefit from the referred compensation funds for occupational diseases contracted while working on South African mines. For the case of deceased miners, the benefits will be directed to their relatives, like children and widows, among others who are considered legitimate members of family. Data collection in the endline evaluation highlights the continued precarious situation of miners (mostly former miners and their families), and the consequent need for the Mozambican government to prioritise this population group. The Ministry of Work, Employment and Social Safety (MWESS) has received

the first list of ex-miners to be compensated for occupational diseases contracted while working for mining companies in South Africa.

In the first phase, a group of 467 registered beneficiaries was listed by the entity responsible for the retroactive payment. The Compensation Commission for Occupational Diseases with its headquarters in South Africa was identified as the system to deal with compensation in South Africa, while the Mozambican side dealt with issues of document certification due payment.

The registration process is running simultaneously at MWESS central services, through the Migratory Work Direction, in coordination with the provincial and district government who are assisting with providing compensation for this group, by ascertaining important information related to the miner, date of contract cessation or death of miner, as well as details of family members in the case of a deceased miner.

Site level

IOM/ the Mining Sector Project, also referred to as the Pfuneca project, helped in the institutional capacitation of Pfuka Lixile which is a community organization based in Ressano Garcia, a frontier zone, that has helped in raising awareness of people living with HIV and TB from the community and increasing access to national health services. IOM supported the Juvenile Coalition association in the sexual and reproductive health programs directed at young people from Ressano Garcia schools. In the Pfuneca project with Pfuka Lixile, the goal was institutional capacitation of this organization in the areas of health education, and access to health services. The capacity building effort was also intended to increase awareness about the organization itself in Ressano Garcia, with its high mobility and highly dynamic corridor between Mozambique and South Africa. The project was implemented at a community level by change agents (activists) who conducted the following activities in the communities: health lectures; door to door visits, health information included prevention and sharing of information on HIV, STI and TB; working directly with heath facilities by conducting initial screening of patients and then referring on to the relevant health centre; counselling and dealing with issues of stigma and discrimination.

> *"All bad conceptions that have existed around HIV were the major barriers for the implementation of these projects and this implies that the activist informed, educated and this takes some time because we are talking about aspects of behavior change and they do not happen immediately, it takes many years." (KII)*

Monitoring reports indicate that a total of 78 CAs were trained to facilitate community dialogues and 219 change agents were trained to provide other health information. The field visit to Resano Garcia indicated that there were 16 agents currently working with Pfuka Lixile. Change agents at Pfuka Lixile reported receiving a monthly stipend of 12 000MT a month.

The Table below provides an overall synthesis of the overall project performance.

Table 9: Performance against targets and indicators

Outcome or Output	*Indicator*	*2014 - 2015*	*2016*	*Total*	*COMMENT*
Monitoring migrants' health	*Number of key national routine data collection instruments that incorporate questions on migration and health*	*0*	*-*	*0*	
	Number of research studies conducted focused on migrants' health and migration-related health issues	*2*	*-*	*2*	
	One operational migration health knowledge sharing platform	*0*	*-*	*0*	
Policies and legal frameworks	*Proportion of policy makers and stakeholders with increased knowledge on migration health related issues and the importance of migration and health in health policies*	*1*	*-*	*1*	
	Number of non-health sectors that have incorporated migration and health in their policies, legislations and strategies	*1*	*-*	*1*	
Increased knowledge	*Number of individuals reached through community education*	*78 946*	*27 818*	*106 764*	*Number of individuals reached went down in 2016*
	Number of reproductive age individuals (15-49 years) reached with education on sexual and reproductive health	*39 162*	*3596*	*42 758*	*Number of individuals reached went down in 2016*
	Number of community led initiatives to address the social determinants of health	*108*	*5*	*113*	*Less initiatives took place in 2016*

Strengthening service provision	*Number of change agents trained to facilitate community dialogue*	*-*	*78*	*78*	
	Number of change agents trained who demonstrate skills and capacity to facilitate community dialogues and education on the social determinants of health	*219*	*-*	*219*	
	Number of individuals from key stakeholder organisations capacitated on migration and health	*0*	*50*	*50*	
	Number of health workforce members capacitated on migration and health	*534*	*10*	*544*	
Improved service provision	*Number of individuals referred for health and other services*	*10 368*	*636*	*11 004*	
	Number of individuals referred for health and other services who received services at the referral destination	*10 366*	*497*	*10 863*	
	Number of individuals referred for HIV testing	*0*	*3626*	*3626*	
	Number of individuals referred for HIV testing who received their HIV results at the referral destination	*1 298*	*3523*	*4821*	*Number of individuals referred is 0 in 2014 – 2015 and yet number of individuals referred who received treatment is 1 298*
	Number of individuals screened for TB	*2406*	*8067*	*10 473*	
	Number of individuals with TB symptoms referred for diagnosis and treatment in migration affected communities	*80*	*242*	*322*	
	Number of referred individuals with TB symptoms who receive diagnosis and treatment at referral destination	*80*	*170*	*250*	

	Number of SGBV survivors identified and referred to service providers for support and protection	*0*	*0*	*0*
	Number of SGBV victims identified and referred to service providers for support and protection who received services at the referral destination	*0*	*0*	*0*
	Number of condoms and lubricants distributed	*-*	*-*	*-*
Multi-sectoral partnerships and networks	*Number of initiatives that received technical support from IOM*	*5*	*-*	*5*
	Number of multi-country and/or multi sectoral partnerships and networks established/strengthened for effective coordinated response to migration and health	*3*	*-*	*3*
	Number of partnerships with relevant stakeholder organizations formalized and/or strengthened	*5*	*-*	*5*
	Number of tools, guidelines and technical briefs on migration and health disseminated	*2*	*-*	*2*
	Number of relevant forums, dialogues, campaigns and conferences that include migration and health.	*0*	*-*	*0*

Relevance

Key Informants and Change Agents reported that the project was well received by the local government authorities and communities. The health sector commented that the project's relevance was because it was because the activities were aligned with the focus areas of the Health Ministry, including disseminating health information, supporting community level health events eg. working with health on commemorative days (health fairs on 1st December-International AIDS Day); and focusing on adolescents and young people, particularly girls who are a priority for the Ministry of Health. Change agents reported working closely with the local health system.

> *"We have access to the hospital`s list that display the quitters and lacking ones. Based on this list we would go after those people so that they can go back to the treatment." (FGD, Change Agents)*

They also reported working closely with other community based structures outside of the health system.

> *"Here we work with neighborhood secretaries and block chiefs. The structures help us in our job identifying the cases that need support, mobilizing people for organizing the lectures and fairs we bring. That's how our involvement has been." (FGD, Change Agents)*

> *"All the neighborhood structures know us and know how important our work is and they are smoothing it for us." (FGD, Change Agents)*

The focus group discussions with miners and ex-miners revealed that the majority of them did not know of the existence of the Pfuke Lixile project in Ressano Garcia and had never heard about it, and were not accessing health care provided by the project. They expressed discontent with this.

> *"This is the first time I personally hear about the project." (FGD Miners and ex-miners)*

> *"I only hear about people who help miners but I don't know them. They tell me about a work institute but I don't know where it is." (FGD Miners and ex-miners)*

However, in a focus group discussion with ex miners, it was reported that many were aware of the existence and work of AMIMO and VSO (refer to the POPA report).

> *"I am not direct beneficiary but an indirect one, as my father was ex-miner and a member of AMIMO, he also stopped working due to illness, and he did not receive his pension. So when there were opportunities of being helped by AMIMO he had the benefit of working in the farm here in Moamba. I was the one going behind of his benefits. And from VSO he received public cellular phone called One Cell I was the one using to make business." ((FGD Ex-miners)*

Respondents noted that there is a great number of orphaned and vulnerable children (OVC) in the communities, and it is difficult to assess whether the child is a child of an ex-miner or not. One of the concerns of Pfuka Lixile is that OVC's need to become beneficiaries of this project if it continues.

Nevertheless, even though OVCs were not direct beneficiaries of the project, IOM made programmatic changes in order to enroll OVC by providing them with school material. However, they were not able to sustain this initiative.

Effectiveness

On project initiation, effectiveness was achieved by working with 2 civil society organisations that ensured access to the relevant target groups viz. Pfuka Lixile to deal with health related issues for the broader community, and through AMIMO in accessing miners, ex-miners and their widows.

Being a CBO, Pfuka Lixile were able to form small support groups who facilitated the taking of medicines from the hospital to individuals who were unable to go to hospital. There were also home visits. Change agents used the manuals provided by IOM, about gender, migration, and HIV. It also included a module called "one man" which deals with the participation of men in heath matters in order to increase men's participation in health related issues and with accessing treatment and services. Change agents reported that they were seeing changes in the community due to the activities of the project.

> *"Now it is starting to change, a lot. Men are now understanding and following advices from their wives and from us, the activists. Now they see that it is a matter of health and not about having us pocking our fingers into their lives. That they own their lives and that they run their families, but they have to pay attention to health issues that may emerge in the community or in their families or even in themselves. Things are really changing. This is not something that did not happen in the previous years." (FGD, Change Agents)*

In Ressano Garcia, Pfuka Lixile works with youngsters grade 8 to grade 12 in the dissemination of information connected with HIV and sexual and reproductive health. Male and female students are reached during the school day shift. 20 students were recruited as Change Agents of the school to proceed with sensitizing and delivering health information to school going children.

In addition to the regular project management and supervision of implementation activities, there were monitoring and evaluation visits. The M&E instruments were designed by IOM and adopted by the implementers together with the Change Agent managers. The teams were trained on monitoring and evaluation which included information on why and how to monitor and on the relevant indicators for the projects. Monitoring activities occurred twice or four times per semester depending on the agreement established. Monitoring was consistently cited by respondents as being one of the biggest challenges, and discrepancies and anomolies in data, as illustrated in Table 3, are indicative of this.

Exisiting monitoring data reports that a total of approximately 106 764 individuals were reached through community education activities. A total of 11 004 community

members were referred for health and other services and 10 863 (98%) received services at the referral site. This is an extremely high rate of successful referral to service and it was not possible to test the veracity of these reported numbers during the field visits. Of the 3 626 persons referred for HIV testing it was reported that 4 821 received their results at the testing facility. This exceeds the number of people referred and calls to question the validation of the data.

On reflection, IOM commented that there was room for greater effectiveness through increasing the number of change agents, and by increasing the number of beneficiaries. It was noted that the number of beneficiaries did increase with time-what started as a snowball effect increased as more and more people became aware of the work of the project through neighbours, friends and colleagues.

The local health service reported the appointment of change agents or activists as supporting their work in the communities.

> *"The health sector has also benefited from change agents not only for IOM activities but also for Ressano Garcia and Moamba district services for disseminate information about the health network (cleaning, preventive medicine aspects, water treatment) and other things related to Community health." (KII, District)*

Collaboration between TEBA and IOM allowed for diagnosis of miners with TB-although this happened in Mozambique the collaboration allowed for prescription to be translated into English and sent to the employer in order to carry on with the treatment in South Africa.

Efficiency

The intervention of the Mining Sector Project included building and strengthening the capacity of the organisations that were implementing activities. This institutional capacitation did not only result in training people, but also in the registration of the associations in order to make them official. Support to the organisations was also provided through provision of electronic equipment for their offices, also the payment of rent (Pfuka Lixile and Coalizão in Ressano Garcia and AMIMO in the village of Moamba and Maputo city), as well as payment of subsidies of the board of the project and Change Agents.

Change Agents played an important role in the implementation of activities and contributed to the overall efficiency and reach of the project. Change Agents worked closely with local health care facilities and would also conduct general evaluation of the patients.

In all areas in relation to project activities, the biggest barrier remains stigma and discrimination. This continues to be the most significant barrier to implementation of this project. It was reported that this more prevalent in Ressano Garcia and is one of the reasons why people leave Ressano Garcia to seek treatment in Maputo or Matola in order not to be seen in Ressano. The Mining Sector Project tried to sensitize people to prevent this stigma and discrimination and this was done through talks,

discussions and distribution of condoms in private spaces, markets, and festive days like Christmas.

"We worked more intensively during the high migration and people`s movement periods at Ressano Garcia border, we are talking about Easter time, Christmas and at the end of the years. During this time, we worked more in either border and trains the transported many miners who travel between Mozambique and South Africa." (FGD, Change Agents)

"Because the population is mobile, the IOM and health ministry have established partnerships mainly during two periods of the year, Easter and Christmas and New Year (March, April, December and January) which is a time of particular movement at the borders and in these two periods organize a wider health fair to reach those returning home and in this period still contact the migrants who return home to the maximum trying to sensitize them about these things, make a small assessment, refer to the health center and try to perceive their Final destination and get in touch with VSO to try to follow up these people in their destination." (KII)

Impact

At a national level progress had been made in the national policy document PEN IV to identify migrant mineworkers as a key population. Noteworthy strides have also been made to resolve the compensation issues affecting thousands of ex-mineworkers though government efforts to register qualifying individuals and liaison with the Medical Bureau of Occupational Disease (MBOD) in South Africa through the Mining Sector Project.

Stakeholders at the local level commented that it was difficult to assess impact with projects like this with short lifespans, and particularly because behaviour change is difficult to measure over a short period. However, it was felt that the work of the change agents in reaching beneficiaries, as well as the POPA success stories were illustrative of the project impact. During the implementation of POPA stories were collected of small business that had succeeded despite the overwhelming poverty of mining affected communities in Mozambique.

In addition, the increased capacity of local organisations was seen as one of the most significant impacts, both in terms of the organisations overall capacity, and on the individual capacity of change agents.

"IOM has created local capacity, I think this is the big impact." (KII, National)

I think all of us, learned a lot and turned into better activists and health agents. We received more training and got more work experience as we worked in the communities. (FGD, Change Agents)

In particular, change agents, who worked directly with beneficiaries, had the following to say in terms of the impact of the project:

"Indeed, men were very stubborn. In their opinion, they could not get advices from women or even give their opinion about their health or about how they should proceed with their families. This is changing now." (FGD, Change Agents)

"The impact in the beneficiaries and the communities was very positive. People`s behavior, mainly men`s behavior is changing due to our work." (FGD, Change Agents)

Sustainability

The issue of sustainability was cause for concern and was raised by respondents. However despite concerns over funding and the future of the project, the Mining Sector Project and its partnerships did open key stakeholders to the possibility of future programmes. Respondents hoped that AMIMO and Pfuka Lixile will continue the project, and that their capacity had been enhanced to enable this.

"We left them with the necessary mechanisms and materials so that they could govern themselves administratively and financially, I know they have the motivation to do some projects and proposals of projects to submit". (KII, National)

"Now, after the project, we have a better preparation for helping people." (FGD, Change Agents)

For future development of this project, there was a request that the Mining Sector Project should cover more beneficiaries and that it must be holistic and include OVC, education, economic activities, agriculture, reproductive health. There was a feeling that for the future the beneficiaries should participate in the design, planning, implementation and monitoring of the project activities.

"The direct people involvement at the beginning I think this creates more value in the identification of space, in the accountability of their actions and undertakings." (KII, National)

POPA was felt to provide a good example of this.

District level key informants suggested that it is important for IOM to share their findings and evidence generated through this work to inform future interventions and whether it is worth investing in the health of miners and ex miners as a specific target group.

"We must know what IOM does, work with miners, but what are they looking for? What do they want more? What do they want to achieve? They have to share with us, we want to know, what they did in that long time, what conclusions did they draw? Is it worth it or not to accompany the miner?" (KII, District)

Conclusion

The mining sector project is aligned with national priorities in terms of dealing with the specific challenges faced by mining and migrant communities. However, systemic poverty is endemic in Mozambique and issues related to HIV and TB affect all sectors of the population, making it difficult to focus exclusively on miners, ex miners and their families. The project supported the capacity development of Pfuka Lixile which is embedded in the community, and their change agents, to work more closely with the existing health system and other community based structures. Overall success in relation to HIV and TB prevention and treatment was largely hindered by stigma and discrimination, which is still persistent in many of the communities. There was little evidence from the field visits of support to miners and ex-miners in the form of mining related compensation of any kind.

Table 4: Summary of Mozambique findings against the OECD-DAC project criteria

OECD-DAC criteria	Key findings Mozambique
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
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 Change Agents was supported • Change Agents hampered by high levels of stigma and discrimination
Efficiency	• Working with Change Agents assisted reach • Hampered by high levels of stigma and discrimination
Impact	• Migrant and mining related concerns and health issues highlighted in local communities • Increased capacity of local community based organisations and Change Agents
Sustainability	• Existing community based organisations have greater awareness of migrancy and mining related issues • Work within existing health system

APPENDIX 4
South Africa (SA) Report

Country context

South Africa (SA) is the southernmost country in Africa and has a population of close to 56 million inhabitants. It is divided into nine provinces and 52 districts. The World Bank (WB) classifies South Africa as an upper-middle-income economy, and a newly industrialised country; its economy is the second largest in Africa, and the 34th-largest in the world. In terms of purchasing power parity, SA has the seventh-highest per capita income in Africa. However, poverty and inequality remain widespread, with about a quarter of the population unemployed and living on less than US$1.25 a day. The country is endowed with the world's largest reserves of a number of minerals, such as gold, platinum and titanium, hence it has a large mining sector which directly employs nearly half a million employees. Between 5-8% of the national GDP comes from mining.

The health sector

According to the 2015 UNAIDS Report, SA has an estimated 7 million people living with HIV – more than any other country in the world. Mining areas have HIV and TB rates that are higher than communities that are not impacted by mining in any way. The HIV prevalence is 19.2% in the general population of 19-45 year olds and ranges from 12-47% in miners and mining communities. The TB prevalence rate is also higher in miners at 3 000 per 100 000 population compared to 834 (range 737-936) per 100 000 persons in the general population.[16] The large mining houses provide in-house or outsourced medical services to employees but these medical benefits often do not extend to the family members of miners.

Results of a 2015 situational analysis conducted in 710 households in Smashers Block (SB) – a mineworker receiving community in the Waterberg District of Limpopo Province (LP) reported that more than 10% of households had members who were sick and 5% had terminally ill people; most of these were attributable to AIDS and TB. The single community health centre in SB is geographically easily accessible, but long waiting times for medical attention make people reluctant to attend this public health facility. Therefore, even though primary health care is provided free of charge, long patient queues are an obstacle to early presentation for diagnosis and treatment especially during the initial stages of illness. Forty five percent of households had no medical aid cover and the high financial costs of private health care also present an additional barrier to appropriate health seeking behavior. The study found that there were no organisations providing information, education and communication (IEC) programs related to HIV&AIDS and TB in Smashers Block and very few individuals were aware of organisations running programmes to address these conditions.

Policies and Legal Framework

Mineworkers in South Africa currently have the highest TB rate in the world. As a result of employing nearly half a million direct employees, and with the mining sector

[16] 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

accounting for one-third of all TB infections in the Southern African region, the need for legislation and policies became imperative. The first column in table 1 below lists the most important pieces of national occupational legislation and policy. In the main these provide for the welfare of workers in general, while some e.g. Mine Health and Safety Act (MHSA) and Compensation for Occupational Injuries and Diseases Act (COIDA) do have a particular focus on miners.

SA is a signatory to several international conventions as listed in the second column in the table below, but has not ratified International Conventions that have the ability to provide individual rights, if domesticated, to migrant mineworkers as well as other relevant employees.

Table 10: National legislation & policies and International conventions to which SD is a signatory

National Legislation and policies	International Conventions
• **Employment Equity Act, No. 55 of 1988** • **Labour Relations Act, No. 66 of 1995** • **Occupational Health and Safety Act, No. 85 of 1993** • **Mine Health and Safety Act, No. 29 of 1996** • **Compensation for Occupational Injuries and Diseases Act, No. 130 of 1993** • **Basic Conditions of Employment Act, No. 75 of 1997** • **Medical Schemes Act, No. 131 of 1998** • **Promotion of Equality and Prevention of Unfair Discrimination Act, No. 4 of 2004**	• International Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families, 1990 * • African Charter ratified 09 July 1996. • International Covenant on Civil and Political Rights, 1966 ratified 10 December 1998. • ILO Migration for Employment Convention (Revised), 1949 (No.97) * • ILO C143 Migrant Workers (Supplementary Provisions) Convention, 1975 (No.143) * • ILO C189-Domestic Workers Convention, 2011, (No.189) * • UN Declaration on the Human Rights of Individuals Who Are Not Nationals of the Country in Which They Live (1985) *

Conventions marked * have not been ratified

Regional Conventions and Policies

South Africa is a signatory to the SADC Declaration and Code of Conduct on Tuberculosis in the Mining Sector in 2012. Under the auspices of the SADC Declaration, in 2014 South Africa convened a TB and Mining High Level Ministerial Conference in Johannesburg aimed at developing a coordinated, multi-sectoral response to TB in the mining sector. In 2014 SADC developed the Framework for the Harmonised Management of Tuberculosis in the Mining Sector.

Project activities

The project activities are summarized below according to the four project components:

Research and information dissemination – A baseline survey, conducted in Smashers Block, Waterberg District, was completed in early 2015. The results were utilized to inform programming.

Advocacy and policy development – This component was closely linked to regional coordination. IOM provided funding and technical assistance (TA) for two high level meetings led by the Department of Mineral Resources (DMR) with the participation of other key government departments such as the Department of Labour (DOL) and Department of Health (DOH) as well as for the work produced by the technical working groups that emanated from these. This is described in the section of the report entitled major national level achievements.

Service delivery and capacity development – consisted of raising awareness on issues related to health (HIV and TB) and health services. This component was outsourced to a local country-implementing partner. The model used change agents (CAs) on the ground to provide peer education. CAs were drawn from local community based organizations (CBOs) and received a stipend from the home-based care (HBC) unit in the LP Department of Health (DOH). CAs used resources (health education and screening materials) aligned to DOH protocols and procedures to carry out their work. Potential patients identified during screening were referred to health services for definitive diagnosis and treatment. On the supply side, health workers (professionals working in the facilities and lay health workers in the facilities and community) were trained on heath and migration. There was a paper-based up and down referral system from community to health facility and back. The VSO livelihoods component of the project was not implemented in SA.

Country coordination – The Waterberg Municipality, the Office of the Premier of Limpopo, and NGOs working in the district have established a migration and health forum. IOM was as active participant on the forum, which provides a useful platform to discuss and share knowledge as well as monitor progress and challenges encountered during the course of implementing HIV&AIDS and TB interventions.

Project partners by component

Table 11: Key country partners by project component

PROJECT COMPONENT	KEY PARTNERS SOUTH AFRICA
Research and information dissemination	
Advocacy and policy development	*Development partners:* International Organisation for Migration (IOM), Department for International Development (DFID), World Bank (WB) *Government*: National Department of Health (NDOH) especially Medical Bureau for Occupational Diseases (MBOD), Department of Mineral Resources (DMR), Department of Labour (DOL) *Private sector:* Chamber of Mines (COM) *Organised Labour:* 5 mining unions Government and ex-mineworker unions from Lesotho, Mozambique, Swaziland (and Botswana)
Service delivery and capacity building	*Implementing partners:* CARE SA from 2013-2015 and Centre for Positive Care (CPC) from 2015-2017 *Government:* Limpopo (LP) Office of the Premier (OTP), Department of Social Development (DSD), Department of Health (DOH), Waterberg District Municipality (WDM), Local municipalities of Thabazimbi and Lephalale (councilors) *Civil society:* Waterberg District Migrant Health Forum (DMHF)
Regional coordination	Refer to regional report

Project management and governance

The IOM country project manager (PM) provides oversight, guidance and input regarding the project direction and activities in line with the regional framework. Government partners at provincial and local (municipal) levels also provide inputs, as does the District Migrant Health Forum (DMHF). The DMHF is a partnership between the Waterberg District Municipality (WDM), Office of the Premier (OTP) and nongovernmental organisations (NGOs) such as IOM that work in the district. Government stakeholders that have played an active role towards realising the project objectives include the Limpopo provincial departments of Health, Social Development, Home Affairs and Basic Education as well as the municipalities of Waterberg, Lephalale and Thabazimbi.

From inception in 2013 until early 2015 the IOM regional coordinator managed the project. At this point the SA country coordinator took on the PM role in addition to a host of other responsibilities outside of the project. During 2015 a consultant was brought on board to provide project management support and technical assistance. In

September 2016 IOM employed a migration project assistant (not specifically for this project) who assisted in identifying bottlenecks and negotiating a no cost extension for the project.

CARE-SA was the implementing partner (IP) from project initiation in late 2013 until the organization withdrew its activities in SA. In September 2015 Centre for Positive Care (CPC) was contracted to replace CARE as IP, but due to problems with contractual arrangements only began activities on the ground in February/March 2016. The project obtained a 6-month no cost extension and will close in April 2017.

The project does not have an official oversight or advisory body such as a Steering Committee (SC) or Advisory Board (AB).

Major Achievements

National level

In South Africa, the advocacy and policy development component of the project gained most traction. The project played a significant role in facilitating a year long process of intense dialogues centred around reforming the compensation system in SA and extending services to the neighbouring countries of Botswana, Lesotho, Mozambique and Swaziland, which are the countries of origin of many ex-miners. 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[17], and mining houses. The SA Deputy Minister (DM) of Mineral Resources chaired the SC, which provided oversight to the work of six technical working groups (TWGs)[18]. 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, SA. Further work after the Summit resulted in a report that was delivered to the SA Ministers of Health and Labour in October 2016 and forms the basis of ongoing efforts in this area (compensation for ex-miners).

> *"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…" (National KII, DOH)*

> *"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…". (National KII, DOH)*

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

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

The compensation systems work capitalized on research conducted in neighbouring countries, provided by IOM, on the situation of ex-mineworkers, lessons in tracking and tracing patients as well as good practices in awareness training and sensitisation.

Site Level

There are 18 change agents (CAs) split between 6 sites; 6 CAs work in the 2 Lephalale sites and 12 CAs in the 4 Thabazimbi sites. The project works mainly with the families of miners and mineworker communities because mines provide health benefits to workers and many ex-mineworkers return to their countries of origin when they stop working. CAs therefore interact mainly with the wives and young children of miners. Whilst HIV and TB education and prevention activities were maintained throughout the lifecycle of the project, in 2015 there was a shift to incorporate sexual and reproductive health and rights (SRHR). According to project monitoring data 40 victims of sexual and gender based violence (SGBV) were identified in the community and referred for care and 25 (63%) of these received services.

> *In Vakansie they* (CA) *teach women about abuse from their husbands since most migrant men abuse their women emotionally and physically, now their women are free to speak out since Change Agents have taught them to speak out and consult them if necessary, CA work hand in glove with Social workers and SAPS in such cases. (FGD, Beneficiary)*

> *They help children who are not attending schools because of lack of documents like birth certificates to attend school since they have a good working relationship with schools and home affairs people. (FGD, Beneficiary)*

Table 3 below presents, in tabular format, a summarized version of the routine project monitoring data that was collected and collated on the IOM project M&E system.

Table 12: Performance against targets and indicators

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
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	-	-	-	-	-	-	
	One operational migration health knowledge sharing platform	-	-	-	-	-	-	
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	-	-	-	-	-	-	
	Number of non-health sectors that have incorporated migration and health in their policies, legislations and strategies	-	-	-	-	-	-	
Increased knowledge	Number of individuals reached through community education	10 000	27 694	41 400	22 813	51 400	50 507	Target achieved
	Number of reproductive age individuals (15-49 years) reached with education on sexual and reproductive health	-	-	6 210	9 407	6 201	9 407	Target exceeded
	Number of community led initiatives to address the social determinants of health	-	0	12	6	12	6	Target not achieved – IP changes delayed implementation

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
Strengthening service provision	Number of change agents trained to facilitate community dialogue	150	-	20	17	170	17	
	Number of change agents trained who demonstrate skills and capacity to facilitate community dialogues and education on the social determinants of health	0	223	20	11	20	240	Total figure exceeds number of CAs trained. Totals for 2014/15/16 do not tally
	Number of individuals from key stakeholder organisations capacitated on migration and health	100%	7	124	6	?	13	
	Number of health workforce members capacitated on migration and health	60%	0	16	13	??	13	
Improved service provision	Number of individuals referred for health and other services	4 000	687	1 380	2 181	5 380	2 868	Ambitious target partially achieved
	Number of individuals referred for health and other services who received services at the referral destination	2 400	923	1 311	1 180	3 711	2 103	73% of referrals received services
	Number of individuals referred for HIV testing	4 000	1 071	414	271	4 414	1 342	Ambitious target partially achieved

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
	Number of individuals referred for HIV testing who received their HIV results at the referral destination	2 400	85	414	505	2 814	590	44% of referrals received HIV test results
	Number of individuals screened for TB	5 000	1 560	6 900	209	11 900	1 769	Target set too high
	Number of individuals with TB symptoms referred for diagnosis and treatment in migration affected communities	100%	99	414	103	-	202	
	Number of referred individuals with TB symptoms who receive diagnosis and treatment at referral destination	60%	0	414	103	-	103	51% of referrals received treatment
	Number of SGBV survivors identified and referred to service providers for support and protection	50	0	138	40	188	40	
	Number of SGBV victims identified and referred to service providers for support and protection who received services at the referral destination	30%	0	-	25	-	25	63% of referrals received treatment
	Number of condoms and lubricants distributed	2000	-	50 000	144 410	52 000	144 410	Total target exceeded (3x) in 1 year
Multi-sectoral	Number of initiatives that received technical support from IOM	-	-	-	-	-	-	

Outcome or Output	Indicator	2014 - 2015		2016		TOTAL (2014-2016)		COMMENT
		Target	Actual	Target	Actual	Target	Actual	
partnerships and networks	Number of multi-country and/or multi sectoral partnerships and networks established/strengthened for effective coordinated response to migration and health	-	-	-	-	-	-	
	Number of partnerships with relevant stakeholder organizations formalized and/or strengthened	-	-	-	-	-	-	
	Number of tools, guidelines and technical briefs on migration and health disseminated	-	-	-	-	-	-	
	Number of relevant forums, dialogues, campaigns and conferences that include migration and health.	-	-	-	-	-	-	

Relevance

Most mineworkers are covered by health services provided by the mining houses. However, they and their families live in an environment that is not conducive to their health and wellbeing i.e. underlying structural issues and the social determinants of health – lack of water and sanitation, no documentation to access schooling or social grants, police harassment, xenophobic attitudes etc. They live in situations of extreme poverty and therefore food security is a more immediate imperative than HIV education.

> *"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" (National KI).*

> *"… 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)*

The project was well received by government partners and the community. A total of 1 342 people were referred to health facilities for HIV testing over the course of the project and 44% (n=590) received their results at the referral facility. This difference between the number of referrals and those who received results might indicate a problem in the project monitoring data as SA uses rapid testing for HIV screening which yields immediate results. CAs referred 202 persons with symptoms suggestive of TB for testing; a definitive diagnosis of TB was made in 53% of referrals resulting in 103 patients being put on anti-TB treatment.

> *"In Smasher we are welcomed and work well with our clinic, we even meet weekly with the sister in charge, former councilor was very supportive…." (FGD, CAs)*

> *They (CAs) do door to door in migrant houses and educate them about health and that they have a right to treatment in the clinic….It's very good since we are now seeing a lot of them (patients) coming for treatment…" (KII, DOH)*

However, there were issues that had to be dealt with regarding raised expectations amongst project beneficiaries where the community had hopes/expectations of employment opportunities beyond what the project could deliver. This caused frustration, which had to be managed, but 'could have been dealt with better at the beginning of the program' (National level KII). According to the routine project monitoring data 240 CAs were deemed competent at facilitating community dialogues and to provide HIV education whereas the site visit revealed that 18 CAs were active on the programme. This suggests an extremely high level of attrition or that many community members were trained (and might have expected to be employed) but could not be accommodated on the project. Only 50% (6 against a target of 12) of the community led initiatives to address the social determinants of health were conducted.

"We can see the difference in the 3 (out of 10) *facilities but if the change agents could be funded and extend their services to the other facilities, Thabazimbi would win." (Site level KII)*

"There is a need for more money for change agents or appraisals because this is a full time job everyday but the stipend is not enough for cost of living. There is a need for incentives." (Site level KII)

Effectiveness

Beneficiaries were reached through change agents (CAs) sourced through local structures and carers employed by local CBOs who were already conducting home based care (HBC) activities. A total of 50 507 individuals were reached with community education activities; close to the project target of reaching 51 400 people. The carers are linked to the local clinics and receive a stipend from the DOH. This arrangement facilitates referrals from community to facility levels. CAs referred a total of 2 868 persons for health or other services. This represents 53% of the project target for referrals which was probably set too high at 5 380 referrals. Seventy three percent (n=2 103) of people referred received services at the referral site.

"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, CAs)*

There was no defined 'package of services' that the CAs provided. Their main activities included health education (HIV and TB), counselling, condom distribution as well as symptom screening for TB and referral where necessary. Informants representing the IP, DOH, CAs and beneficiaries all reported these as key project activities. Information was shared through small group discussions and dissemination of printed IEC materials on health conditions provided by DOH complemented by posters and pamphlets printed by IOM. The program also provides referrals to government departments (outside of DOH) and NGOs working in the district, depending on the need identified. In 2015 the project commissioned a detailed situation analysis of households and services in Smasher's Block, Thabazimbi. Organisations working in the district include: Bakoni (condom distribution), Care Works (HIV and TB Testing), Red Cross (HIV and TB Testing), Home Based Care, Isibindi (Drop in centre for orphans and vulnerable children) and the Waterberg Environmental Justice Forum. The working relationship with any of these organisations is ad hoc and not formalized through a memorandum of understanding (MOU); when the project holds community group discussions they are invited to address the community on services that these stakeholders specialise in. The project condom and lubricant distribution statistics – 144 410 condoms distributed in 2016 alone (278% of the 3-year project target of 52 000 condoms to be distributed) might be indicative of the collaborative working relationship between the CAs and the other community health workers covering the same area or that large numbers of condoms were distributed during mass campaign drives rather than during the course of the day-to-day duties of the CAs.

"We do door to door, health campaigns and teach them about health, TB and HIV. We encourage them to take their treatment and not to default, in our FGDs if we encounter OVCs we refer them to other home based care like Isibindi and Thabang which works with social development." (FGD, CAs)

The central role of IOM was to build the capacity of implementing partners. Training was provided on implementing the community capacity enhancement (CCE) methodology to build competent communities. However, because of time constraints this training was piecemeal rather than the recommended approach of a structured training programme with onsite mentorship and support. The IP in turn trained CAs on technical and programme issues such as basics of HIV, treatment literacy, M&E and to provide mentorship and support. IOM provided migrant health and rights training to health workers and security guards at health facilities. The latter would turn migrants away at the facility gates if they did not have SA identity documents, but reportedly no longer do so since the sensitisation training. A total of 13 individuals from key stakeholder organisations were capacitated on health and migration. This figure excludes members of the health workforce.

"With the methodology (CCE) *we can identify concerns, explore the historical nature of the community such as using tree diagrams to get to root issues in the community then get to decision making – thinking about what does the community need, who do you need, how do you approach them, what worked, what did not, solutions did." (Site level KI, IP)*

The continuous support and oversight on the part of both IP and project management structures was not consistent throughout the project because of issues surrounding the change in IP and human resource (HR) constraints and conflicting priorities on the part of IOM staff. This means that while monitoring data provides an indication of the number of contacts between CAs and beneficiaries it is not possible to assess the quality or 'depth of the reach' of these interactions. Nonetheless respondents working in local health facilities report that patients referred by CAs 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." (Site level KII, DOH)

Project activities were affected by contextual factors outside the control of the project. As a site level example, politics in Thabazimbi temporarily affected the work of change agents. The project started when the local councilor was a member of the African National Congress (ANC). The new councilor is an Economic Freedom Fighters (EFF) member and many people in the community support the EFF, which meant that some people were not welcoming to change agents as they saw them as ANC employees/members. On the other hand at the national/regional policy level the project succeeded in bringing together multiple stakeholders operating in a very complex environment fraught with difficult dynamics and produce a positive output.

"The success was that we could bring them together around a central theme which was integration of compensation systems and improve service delivery to mine workers and ex-mineworkers." (National KII, MBOD)

Efficiency

Implementation delays and service delivery interruptions occurred during the changeover period from CARE-SA to CPC as IP. This was due to contractual issues as well as a remapping and redesigning exercise which affected the number (reduced) and areas in which CAs operate. The project aimed to conduct 12 community-led initiatives to address the social determinants of health and was only able to do 6 events (50% of target).

IPs reported quarterly on a set of indicators and also provided a narrative report documenting challenges encountered and steps taken to overcome these. It is difficult for the evaluation to comment on the efficiency of activities as reports were not always submitted on time, data were incomplete and data verification and monitoring site visits did not routinely occur to schedule.[19] This not only led to 'communication breakdowns' that necessitated 'firefighting visits' and 'crisis management' but also meant that there was suboptimal use of monitoring data for timely intervention and/or to adapt and redirect activities where necessary. The latter was largely as a result of under-resourcing in terms of IOM country staff dedicated to work on the project.

In terms of cost efficiency, all respondents interviewed were not in a position to comment on the budget or the efficiency of resource allocation per activity. It was pointed out that no salaries were paid out and that CAs received only a small travel allowance. Country partners 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, 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... (Site level KII, Local government)*

Respondents at implementation level cited the following issues as having a negative impact on operational efficiency: Lack of an office space from which community level workers can conduct their administrative tasks, the level of compensation, lack of transport, lack of incentives and late payments.

> *"The funds need to be disbursed on time. IOM gave us funds very late which affected operations, especially because we now had to spend the money quickly as we had very short time left in the financial year." (Site level KI)*

[19] No data reported for 2013 & 2014. **In 2015** - Different version of reports submitted for Q1(Jan-Mar). Submitted data not verified. Data quality gaps and incomplete data; disaggregation not done correctly in some indicators numbers do not tally. Duplicates in data entries on the Q2 report. **In 2016** – Q2 reported. Reported data not verified. Data not disaggregated by site.

Impact

The project has sensitized the district to issues of migrant health and rights although these have not yet been mainstreamed. According to the routine monitoring data a total of 13 health workers were trained on health and migration. 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, there were anecdotal reports from SA and labour sending countries of improved systems of referral and continuity of treatment when miners travel between countries e.g. for periods of home leave. There is also documented evidence of increased compensation payouts.

> *"I as a migrant CA from Lesotho live in Vakansie, I don't have any problems accept when it comes to issue of schooling, my child don't attend school because of legal papers they need, but health facilities we are welcomed". (FGD, Beneficiary)*

> *"…Improved on payments and certifications. 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" (National KI, MBOD)*

There were anecdotal reports from health workers regarding improved retention in care and improved antenatal care attendance amongst migrants attending the clinics in Thabazimbi. However, this information (nationality) is not recorded and therefore these reports could not be verified.

> *"We had the highest PCR positive and lowest with antenatal bookings in the sub district but now we are above the target. With PCR we are now 1/71 which gives us 1.4 but previously we were around 3.4." (Site level KI, DOH)*

> *"We have more TB patients who receive treatment in our clinics due to transfers from CAs." (Site level KI, DOH)*

Sustainability

Public health facilities will continue to provide services to migrants who visit them. The foundation has been laid for mainstreaming migrant health services although this is not yet happening. The DMHF will continue to engage on migrant health issues. IOM's participation in the LP development partners' meetings has also served to raise awareness regarding migrant health and rights amongst other partners working in the province.

> *DoH also wants to check how they will incorporate migrant issues in their own work – so the nurses want to help. (Site level KII)*

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)

> *"Then the wider agenda we are looking at through the GF to deal with services outside SA in 10 SA countries and different policy interventions that does not replicate the problem of the past 120 years in SA – bad work practices, exposure to hazardous substances like dust etc." (National KI, DOH)*

Conclusion

Respondents perceive the project as relevant because HIV and TB are serious health concerns in this mining affected community as in others. However, the income generation component of the Mining Sector Project, which was not implemented in SA, would have added significant value to the intervention because of the extreme poverty experienced by community members. Contractual delays with the changeover of IPs hampered smooth and efficient project implementation. The CAs are employed by local CBOs and receive a stipend from DOH making it cost effective for the project and increasing the likelihood that their work will continue after project close-out (sustainability). The relatively small stipend does mean that these CAs are continually on the lookout for better employment opportunities leading to staff attrition and the need for frequent training of new members. The project was effective in making a large number of referrals and 73% received services at the referral site i.e. improving access to health services. However the evaluation was not able to assess the effect on improving the health of migrants (health outcomes) as these details (nationality) are not captured on the DHIS.

Table 13: Summary of SA findings against the OECD-DAC criteria

OECD-DAC criteria	Key findings South Africa
Relevance	• 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	• 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	• 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	• Potential for mainstreaming of migrant health services
Sustainability	• Public health facilities will continue to provide services to migrants

APPENDIX 5
Regional Report

Country context

The scramble for Africa under colonialism was a scramble for the control of natural resources by large scale miners from Western powers. Under British rule, mining centres such as the Zambian Copperbelt, South African West Rand and the Great Dyke Region of Zimbabwe advanced. In South Africa, with its large white settler population, colonialism was experienced as both early and late conquest that only ended with the adoption of constitutional democracy, as recently, as 1994. As a consequence, mining history in the region is profoundly shaped by the injustices of colonial rule and South Africa's apartheid years. Specifically the migrant labour system associated with South African gold mining. Under this system labour was drawn for decades from *"labour sending areas"* in Malawi, Mozambique, Lesotho, Swaziland and South Africa.

Mining under colonialism and apartheid was hazardous and many mineworkers lost their lives. Towards the end of the apartheid era South African gold mining alone claimed the lives of between 500-700 mine workers per annum, and estimates at the time were that 66 000 mine workers had died in mine accidents and more than a million had been seriously injured since the turn of the century.[20] The 1995, Commission of Inquiry into Safety and Health in the Mining Industry (Leon Commission) also concluded that tens of thousands of miners had contracted silicosis in the South Africa mining industry without the disease being diagnosed and without receiving the compensation to which they were entitled.[21] Later research estimates were that two hundred thousand mineworkers in South Africa and around eighty thousand in neighbouring states were entitled to awards.[22] The racism, discrimination and exploitation meted out to southern African mine workers, their families and communities still has resonance today.

The Regional focus of the Mining Sector Project was an important contribution to addressing the Southern African migrant mineworker legacy. The regionality of the Mining Sector Project was considered to be unique involving the traditional labour sending countries of Swaziland, Lesotho and Mozambique, as well as, mining destination country, South Africa.

The health sector

Mining areas have HIV and TB rates that are higher than communities that are not impacted by mining in any way.[23] 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

[20] Leger, J.P. 1991. Trends and causes of fatalities in South African mines. *Saf Sci.,* 14(3-4): 169-85

[21] Report of the Commission of Inquiry into Safety and Health in the Mining Industry (Pretoria: Department of Minerals and Energy Affairs, 1995)

[22] Murray, J. 'Development of Radiological and Autopsy Silicosis in a Cohort of Gold Miners Followed up in Retirement' paper presented at the Research Forum, National Institute for Occupational Health, Johannesburg 26 May 2005

[23] 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

place miners at risk of contracting HIV and TB. 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.

At its inception HIV was considered an entry point to health issues for the Mining Sector Project rather than the only focus. Respondents described the HIV focus of the Mining Sector Project being overwhelmed by TB, after the adoption of the 2012 TB in Mining SADC declaration. To a very large extent the focus of the Regional component of the Mining Sector Project has been shaped by the implementation of this declaration.

Mining associations

VSO, through POPA focused on building the 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.

Regional conventions and policies

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).

Project activities

Research and information dissemination – The Regional programme of the Mining Sector Project had oversight of the delivery of four baseline studies. One for each participating country, delivered over a two year period 2014-15. An Integrated Bio-Surveillance Survey (IBSS) is still for completion in 2017.

Advocacy and policy development – Evidence generated within SADC under the title *'Developing Financing Mechanisms for Mobile Populations,'* concluded that the investment return out-weighed inaction on migrant people's health. 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 for ex-mineworkers, and extending related 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, including ex-mineworker associations, labour unions, the South African Mine Health and Safety Council, various government departments[24], 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)[25]. Papers presented by the TWGs were deliberated during a

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

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

Summit on the 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.

In addition to the above there were several other regional workshops including workshops in Tanzania and Zambia to align the Mining Sector Project activities with SADC more broadly. The Regional programme also supported SAT (Southern Africa AIDS Trust) with respect to social benefit portability.

Service delivery and capacity development – at the regional level the service delivery and capacity development component was supported primarily through the M&E function. Tools aligned with Mining Sector Project results matrix were shared with implementing partners (IPs) in all countries. Training was also provided to IPs. IOM also supported in country work with training to health service providers on issues related to migration.

Country coordination – The regional programme held responsibility for overall project oversight and implementation including the co-ordination with POPA activities. At the national level the regional programme sought to influence the national TB Programme first, and thereafter HIV, occupational health services and Ministries of Labour specifically in relation to the implementation of the SADC 2012 TB in Mining Declaration.

Project partners by component

Regional 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 mineworkers associations (MWAs), Mine Health and Safety Council, TEBA Development, private sector companies e.g. Mcel, Coca-Cola, United Nation (UN) agencies (UNAIDS, WHO, ILO), as well as international and local nongovernmental organisations (NGOs) including the Southern Africa Trust (SAT).

Table 1: Key country partners by component

PROJECT COMPONENT	KEY PARTNERS REGION
Research and information dissemination	Baseline completed by Impact Research International
Advocacy and policy development	*Development partners:* International Organisation for Migration (IOM), Voluntary Service Overseas (VSO), World Bank (WB), UN agencies *Government*: Ministry of Health (MOH), Ministry of Labour(MOL), Medical Bureau for Occupational Disease (MBOD), SADC, Mine Health and Safety Council *Private sector:* Cell phone providers and other private sponsors *Organised Labour:* SAMA and affliates
Service delivery and capacity building	*Implementing partners in each country* *Government departments in each country*
Regional coordination	As above

Project management and governance

Governance of the Mining Sector Project at the regional level was through the Regional Project Steering Committee (RPSC), set up at the start of the Mining Sector Project in 2013. VSO was a member of RPSC. However, this dissolved within a year once the World Bank established the Programme Implementation Committee (PIC). The PIC was an important mechanism through which to liaise with other key stakeholders across the region. Up to 80 roleplayers attended gatherings of the PIC for 2-3 days, to report back on progress. VSO also participated in the PIC. In total, there were 5 PIC meetings during the lifetime of the Mining Sector Project. Since the close of the Mining Sector Project the PIC has been absorbed into the Regional Co-ordinating Mechanism (RCM) required under the Global Fund with respect to the new grant provided for funding with respect to TB in mining. IOM was considered an important member of the PIC.

"I don't have the full details of the Dutch Project (Mining Sector Project), but IOM was a key stakeholder in the PIC." (KII stakeholder)

IOM South Africa Country Representative held formal accountability for the oversight and implementation of the Mining Sector Project from 2014. Project management was appointed by IOM and worked from the Pretoria office (South Africa country office). The first project manager was moved to the IOM Regional Office at the start of the Mining Sector Project, the second project manager was appointed in June 2014.

The Mining Sector Project was a component of the wider initiative Partnership on Health and Mobility in East and Southern Africa (PHAMESA). A management decision within IOM to move PHAMESA to the IOM Regional Office in 2014, but to leave the Mining Sector Project in the South Africa country office had a marked effect on capacity for the Mining Sector Project roll out. For one, this prompted the necessity for a Mining Sector Project Manager in the South African office, hence the appointment of a second project manager in 2014. Secondly, individuals who had been key to the design and vision of the Mining Sector Project were then moved to the IOM Regional Office and were restricted to holding a technical advisory role rather than a direct line function. Although IOM had a technical specialist available for each pillar of the Mining Sector Project this arrangement was not always effective. The key monitoring and evaluation (M&E) specialist for the Mining Sector Project was in the Regional Office too and M&E in particular suffered as a consequence of this.

Project performance

Major achievements-

Relevance

In practice, the Mining Sector Project at a regional level primarily aimed to support the operationalisation of the SADC 2012 TB in Mining Declaration. The evidence for this focus was not to be found in the baseline studies commissioned as part of the Mining Sector Project, but in the studies that preceded this initiative, such as academic epidemiological studies that showed the biological nexus between silicosis, HIV and TB in the mining sector. One respondent stated,

….really the SADC declaration was catalytic.(KII stakeholder)

Thus regional activities were described as *'needs based'*. Respondents in this evaluation spoke to the political opportunity at the time of the project start up, as stakeholders challenged South Africa with, *"You are spreading TB in our countries"* (KII stakeholder). The rollout of the regional activities was described as *"riding a wave" and "you take opportunities as they come"*. At the time of implementation there was a lot of interest amongst donor/development agencies to be involved with TB in mining. Dfid and the World Bank were two of the major players in this respect. The regional nature of the Mining Sector Project helped give the project status in the IOM office

At a Regional level the Dutch Project has been subsumed by developments to address TB in mining. However at its outset it was primarily an HIV project and was funded as one of a basket of projects addressing HIV priorities in the Region funded by the Dutch Ministry of Foreign Affairs in Southern Africa. Respondents on the whole stressed that the Mining Sector Project was not a TB project and therefore at a Regional level was also interested in the harmonization of services across borders related to TB, HIV and was also committed to the provision of guidance, protocols and awareness raising related to SRHR. Harmonisation of policies and treatment protocols for TB and HIV and the portability of social benefits and access to compensation were all regarded as critical for migrant mineworkers by respondents.

"This is a health project not a TB project"(KII stakeholder)

The Regional mandate to work at a policy level was easy in South Africa which is policy oriented. Swaziland, Lesotho and Mozambique were considered by respondents as more conservative. There were also capacity problems and in-country counterparts were naïve about the process of policy review. The SADC declaration on TB in Mining helped enormously to establish a role for the regional project at the level of both the Minister, and related Ministries, especially with respect to health and labour. In general IOM respondents spoke about being responsible to ensure the migrant voice was heard and to complement processes in the mining sector to address mining legacy issues. Respondents were well aware of the importance of resolving the backlog of compensation and pension payouts owed to ex-mineworkers in the Southern Africa region. However they were also aware this was not the focus of the Mining Sector Project.

"Our role was to bring in the migrant voice."(KII stakeholder)

In this respect IOM was a follower rather than a leader in the resolution of legacy issues for mineworkers. Although having said that the other key stakeholders were very aware that progress could not have been made as effectively in the absence of IOM. The Johannesburg Summit on integration of compensation systems in Southern Africa, convened in May 2016 is an example of this, both because of the multi-lateral nature of IOM and because the Mining Sector Project could support the initiative with resources.

"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)

Effectiveness

The translation of IOM outputs to outcomes at the Regional level such as research and policy developments was insufficiently supported by effective communication/branding, M&E and insufficient research expertise.

The design of the Mining Sector Project relies on a combination of Regional, national and local level activities was shaped by the PHAMESA approach. Respondents liked this approach because advocacy works better when examples can be cited from the ground. It supported the Mining Sector Project having a bottom up feel. It was felt that this had created opportunities for communication work that was planned for at the start of the Project but eventually didn't materialize. It was believed there was an opportunity for the voices of mineworkers to be profiled.

"We did not finish putting a positive spin on migration and the contribution of migrant mineworkers to development. It is not just HIV, TB and silicosis." (KII stakeholder)

Coupled with the missed opportunity for communication opportunities, the Mining Sector Project was poorly branded. One respondent stated that this was because the donor didn't have a requirement for visibility. However on a day to day level the Mining Sector Project was referred to as the "Dutch Project." Although on the ground respondents in key informant interviews generally referred to IOM or VSO when talking about activities at a local level.

Data generated through the M&E should be central to the decision-making associated with a project of this size and with 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. At that time the IOM Country teams made a complaint about double reporting associated with PHAMESA and the Mining Sector Project and thus a decision was made for joint reporting for PHAMESA II and the Mining Sector Project to which the donors agreed. Coupled with inadequate technical expertise at the centre of the Mining Sector Project because of institutional reorganization in IOM 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.

The evaluation team found many difficulties with the quantitative M&E data. These are also listed in the front section of the main endline evaluation report and are as follows:

- Missing data for some quarters in years 2014, 2015 and 2016. This was compounded by missing disaggregation 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.

The evaluation team also found that M&E reports were not shared with partner organisations or with national health and migration forums so respondents were unable to cite evidence of Project success, unless that had been members of site visits to see either the Change Agents or POPA businesses being implemented. Therefore respondents may have had no knowledge of whether the Mining Sector Project was indeed reaching stated outcomes. M&E reports had only ever been shared with the donor, and no other stakeholders associated with this Project at either the regional or national level could state any figures or findings associated with the Mining Sector Project. Respondents in this evaluation commented that they had been part of other such studies but, have never been given a report.

There was no dedicated M&E capacity for the Mining Sector Project at the country level. The approach to M&E at the country level was to grow the capacity of the in-country IPs and in the case of VSO the mineworker associations through support offered by IOM at the regional level. Mozambique and South Africa did have some M&E capacity in the IOM country offices, but Swaziland and Lesotho had no capacity. Although it was acknowledged that a lot of hard work related to M&E did happen at a regional level, the team faced many problems and the data that was collected wasn't adequately used, …*"we tend not to analyse the information." (KII stakeholder)*

In all countries there were major problems with data collection and capture, suggesting that the approach to M&E was only partially successful. One respondent commented that the site visits proved the best insight into change,

"We had hoped the MTR would provide data but this did not happen. The site visits were actually the best insight into change. There were emotional stories from beneficiaries." (KII stakeholder)

Problems with data collection and capture included:

- IPs not collecting data despite service level agreements
- No or very poor implementation on the ground that could be reported on
- Data was unreliable, incorrect and no back data for verification
- Transition to new IPs proved very difficult (no transfer of data set)
- IPs used their own tools, there was too little money in the project to warrant them doing data collection properly
- Change Agents used by IPs in Lesotho and Swaziland worked as volunteers and therefore there was no formal accountability to complete monitoring tools.

The commissioning of research did not happened to plan. The original intention to collaborate with KIT in the Netherlands collapsed and the rollout of research was seriously hampered by both a lack of capacity in IOM in the line function management of the Mining Sector Project and in the appointed service providers. The baseline studies were both delayed for these reasons and the IBBS study is not yet complete despite funds being allocated in 2014. Observations and comments about the research included;

- The baseline reports did not provide useful baseline indicators for the Mining Sector Project as a whole, rather they were detailed situation analyses in selected communities. (It took 1.5 years to sign off on the baseline reports)
- There was insufficient technical capacity in the Mining Sector Project team to manage the IBBS. Research and demographic expertise sat in the IOM Regional Office. It has been delayed because the research officer was overloaded and there have been other commitments

Efficiency including cost efficiency

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. (Refer to Table 2) At a regional level research was felt by respondents to have been expensive.

Respondents reported that the resourcing of the Mining Sector Project was inadequate in the areas of M&E, and IOM and POPA local level activities. The country and POPA reports detail the comments about the budget with respect to local level activities. Although respondents often spoke about time rather than money being the challenge at a local level. One respondent stated,

"We needed more time to reach more beneficiaries. It took the first year to set up the momentum is at the 4th year. We need to educate donors you cannot cut when you are at your peak." (KII stakeholder)

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 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.

Table 2: 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

Impact

The impact of policy, research and advocacy activities in the Mining Sector Project is inadequately captured in project documentation and in the monitoring indicators. Output indicators such as, the # of research projects complete or proportion of policy

makers and stakeholders with increased knowledge of migration and health in health policies resulted in the overall objective of the Mining Sector Project, to improve the lives of 20 000 migrant mineworkers, ex-mineworkers, their families and communities, became the business of Outcome 3 and chasing numbers on the ground. For example, policy changes at the country level that saw migrant mineworkers move from vulnerable to priority groups in PEN IV (government National Strategic Plan HIV/AIDS) in Mozambique will have a lasting impact for very many mineworkers if actioned. Many more than the Mining Sector 20 000 mineworkers will be impacted by this change. The South African Medical Bureau for Occupational Disease (MBOD) report that many more beneficiaries are being paid because of the developments and progress that is happening in collaboration with 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)

Improved compensation payouts is essential restitution work within the Southern African community if the legacy of mining is to be addressed. Interestingly not all respondents reported being happy with the original results framework for the Mining Sector Project and one limitation was the lack of rationale for the selection of 20 000 beneficiaries. The regional partnership work through the compensation summit and with the Mozambique Combat (AIDS) Council and with the Migration and Health Forums in Swaziland and Lesotho will impact on very many more than 20 000 migrant mineworkers. In relation to impact the results framework was not aligned with indicators that may already be reported on in-country such as district HIV prevalence and TB incidence.

"Theory of change, I can't say I know much about it. To my knowledge we don't have one."(KII stakeholder)

The Mining Sector Project did not have a theory of change. Change was captured according to the results matrix. Respondents in this evaluation provided their personal observations about change which for some was very focused on an individual behaviour change paradigm. Thus change started with awareness raising amongst beneficiaries, having access to treatment, enjoying improved health status and behaviour change, thus reducing HIV and TB prevalence and increasing the likelihood of healthy migrants. Although in some cases other respondents saw that the environment must change to assist local projects to succeed, if systems don't change then local projects will always struggle. The timeous payment of compensation was given as an example of this, because it can keep ex-mineworkers from the trap of poverty.

Sustainability

At the regional level partnership was key to sustainability. Significant funding secured through the Global Fund and World Bank from 2017 will sustain TB related work initiated with the support of the Mining Sector Project in two or the three labour

sending communities. Global Fund commitments are to strengthen TB management (through health systems strengthening) in four countries Zambia, Lesotho, Malawi and Mozambique. It will remain important to engage with IOM in this process**.** Partners such as World Bank are still, for example, to mainstream migration. PHAMESA II is to take over the funding of some of the Mining Sector Project Change Agents especially in South Africa and Mozambique from 2017.

There is still significant fragmentation of health and related services for mineworkers and ex-mineworkers. For the future, treatment guidelines, bilateral agreements on compensation and access to health care services still remain priorities for finalisation. For the future IOM may play a key role in the development and roll out of the regional data base of migrant mineworkers.

Capacity building of mineworker associations, and participation in regional fora has resulted in their leadership speaking on international platforms and therefore contributing to consultation at the highest levels. Although the Mining Sector Project didn't have the relationships to engage with the mining industry itself, IOM and VSO have been made visible to the industry through the Compensation Summit and other regional gatherings. However for the future, one respondent noted that communities remain fragile and thus likely to migrate, underpinning the importance of sustaining work in the area of migration.

"The elephant in the room is the fragility in communities which causes communities to migrate…migration is a key determinant of health" (KII Stakeholder)

Conclusion

The regional component of the Mining Sector Project was extremely timely and played a very constructive role in supporting the developments at a regional level to respond to the SADC 2012 Declaration on TB in Mining and in supporting the regional Compensation Summit held in Johannesburg in May 2016. The impact of this 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.

The translation of IOM outputs to outcomes at the Regional level such as research and policy developments was insufficiently supported by effective communication/branding, M&E and research expertise. Research outputs were all delayed in the implementation of the Mining Sector Project.

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 this across four countries and sixteen districts. The internal reorganization at IOM during the start-up of the Mining Sector Project contributed to there being insufficient research and M&E expertise with direct line function responsibility for implementation.

Partnerships secured through policy and advocacy work at the regional level have ensured that 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 Change Agents especially 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 therefore contributing to consultation at the highest levels.

Table 3: Summary of Regional findings against the OECD-DAC project criteria

OECD-DAC criteria	Key findings region
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.
Effectiveness	• Research and policy developments were insufficiently supported by effective communication/branding, M&E and research expertise. • Research outputs were all delayed.
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.
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.
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 Change Agents especially 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.

APPENDIX 6
POPA Report

Country Context

Phone Out Poverty and AIDS (POPA) was first piloted in Mozambique prior to the launch of the Mining Sector Project in 2013. This is an income generating initiative that involves a partnership with private sector cellular phone companies to provide business opportunities in traditional labour sending communities in Mozambique, Lesotho and Swaziland. POPA focused on reaching the most vulnerable in mining affected communities and targeted widows of ex-mineworkers and in Mozambique orphans and vulnerable children (OVC). In this capacity VSO made an important contribution to address gender inequity in mining affected communities, where women have for centuries borne the brunt of child care in the absence of fathers, who worked away on South African mines, and bore the burden of care, when sick ex-mineworkers returned home. Alongside the provision of start up support for a local business, POPA beneficiaries were supported with education and information about HIV and AIDS and SHRH. In total, POPA was implemented in 13 districts across three countries as shown in Table 1 below. Eight sites overlapped with IOM local level peer educator activities as described in the country reports.

Table 1: POPA implementation sites in three countries

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	5	Mabucuane	Labour sending	VSO
		Manhica	Labour sending	VSO
		Maputo City	Sending/transit	IOM and VSO
		Matola	Labour sending	VSO
		Maxaquene	Labour sending	VSO
Swaziland	3	Lubombo	Labour sending	IOM and VSO
		Manzini	Labour sending	IOM and VSO
		Shiselweni	Labour sending	IOM and VSO
TOTAL	**13**			

Note: Some VSO activities extended into Moamba, Gaza Province. In this area POPA interfaced with the MWA , Kindlimuka.

The POPA pilot project focused on the provision of phone booths to women who were HIV+. In this way women had the opportunity both to earn some money and to be less isolated in their community. By the time POPA was being implemented in Swaziland and Lesotho technology had moved on and phone booths were less useful, even poor communities where many individuals may have mobile phones. In practice, although POPA was initially focused on income generation through the sale of phone technology and services, in practice POPA on the ground was associated with a range

of livelihood activities. These included the selling of groceries, hardware supplies, poultry and piggery enterprises. The findings discussed here therefore include a range of observations about income generating activities (IGAs) in general rather than those only associated with the mobile phone business.

Project activities

Research and information dissemination – A baseline survey was conducted.

Advocacy and policy development – Key informants interviewed as part of this endline evaluation appreciated the link between health and livelihood activities in the design of the Mining Sector Project. Although VSO did not play a specific role in regional advocacy and policy activities their participation at this level did make an impact. The extent of poverty in mining affected communities was made very tangible to other regional stakeholders because of the work of the POPA project.

Service delivery and capacity development – At a country level POPA has been implemented by VSO international volunteers working in partnership with national level membership associations addressing the interests of current and ex-mineworkers. Representatives of these associations were trained and supported to assist in the selection, set up, monitoring and support to POPA IGAs. VSO, through POPA, implemented an extensive capacity building programme for each association. The key country partner associations were:

- The Ex-Miners and Allied Workers Association of Lesotho (EMAWA)
- Association of Mozambican Mine Workers (AMIMO) (national) and Kindlimuka (Moamba in Gaza)
- Swaziland Migrant Miners Workers Association (SWAMMIWA)

VSO and country partner organisations identified districts and beneficiaries to receive support from POPA. Widows of ex-mineworkers were the primary target for POPA support, however in some cases, especially in Mozambique young people left orphaned also benefited.

By entering into a partnership with a local cellular phone provider, VSO and country partner organisations were able to provide a livelihood opportunity for an individual beneficiary or group of beneficiaries (up to 6 members per group) who took on the responsibility of managing a container leased from the mobile phone provider. The private sector partners were Econet(Lesotho), Mcell/One cell/SAICOM(Mozambique) and Vodacom/MTN (Swaziland). VSO and the private sector partner provided training to beneficiaries on how to do this. Profits from the business were then used to either support further business development, or to meet basic needs within the group of beneficiaries, such as buying food and transport money to the local clinic. In this manner, POPA directly supported local people to continue taking medication such as ARVs or TB medication by providing a source of transport money to get to the local clinic and/or money to buy food. Beneficiaries reported in both the baseline studies and in this endline evaluation being affected by poverty. They reported being unable to take medication (TB and HIV medication) on an empty stomach, and not having the means to get to a clinic. POPA also provided training about HIV and AIDS and those benefiting from the containers were assisted to provide education and support in the

community and to distribute condoms. In Mozambique and Lesotho Community Care Givers were trained and given Home Based Care Kits.

Regional coordination – It was VSO who first approached the Dutch funders who consequently requested a regional project and linked VSO with IOM. The regional approach provided VSO with a high profile platform and facilitated working with SADC and regional development partners such as UNAIDS. Exchange visits between country level mining associations participating in POPA, assisted learning and capacity building across the project as a whole.

Project Partners by Component

Table 2: Key partners by component

PROJECT COMPONENT	KEY PARTNERS POPA
Research and information dissemination	
Advocacy and policy development	*Development partners:* International Organisation for Migration (IOM), Voluntary Service Overseas (VSO), World Bank (WB) *Government*: Ministry of Health (MOH), Ministry of Agriculture (MOA) *Private sector:* *Organised Labour:* SAMA
Service delivery and capacity building	*Implementing partners:* EMAWA, AMINO, Kindlimuka, SWAMMIWA *Government:* *Civil society: SAT, URSA* *Private sector:* Econet, SAICOM, OneCell, Mcell, Vodacom, MTN, shoprite
Regional coordination	

Project governance and management

A Regional Steering committee for the Mining Sector Project did convene at the start of the implementation although this was short lived and was replaced by the World Bank convened PIC. VSO RAISA participated in both of these structures.

A project lead for POPA operated from the VSO office in Pretoria. Oversight for POPA activities was provided by the IOM appointed Mining Sector Project Manager. IOM required quarterly reporting and there were periodic joint (VSO and IOM) site visits. Overall VSO reported that they found this collaborative arrangement helpful and were happy with the attention to detail and quality of the support provided by IOM.

At a country level, international VSO volunteers worked with local mining associations to implement activities on the ground. The volunteers were primarily responsible for

building the capacity of local associations to roll out POPA and to participate in regional advocacy and policy developments. VSO had initially appointed an M&E officer (International Volunteer) for POPA to strengthen the capacity of Southern Africa Mineworkers Association (SAMA) and its affiliates in Lesotho, Mozambique and Swaziland to effectively plan ,implement and evaluate their projects that respond to the needs and rights of their members in regard to Health, TB HIV and AIDS and sustainable livelihoods. Specific objectives included developing systems, policies and procedures for effective project management and impact measurement for the POPA (within SAMA and its affiliates). This appointee quickly discovered that it was necessary to strengthen SAMA bottom up and elected to work with EMAWA in Lesotho.

In each of the mineworker/ex-mineworkers associations one volunteer was on placement for up to 2 years. In Swaziland, 3 volunteers worked for shorter periods of about 6 months.

An International Volunteer from Netherlands was placed in Swaziland by VSO for a period of 6 months. Her summary of her role is '*being an agent of change*' . Her work was with SWAMMIWA. As part of her work she was able to offer the partner organization, SWAMMIWA, in Swaziland, a team building workshop and personal profile development. The main outcome of the volunteer position was creating a stronger team within the SWAMMIWA office which enabled the team to work better together and encourage the organization to grow.

The achievements of POPA are summarized in the Table 2.

Table 2: Final reported totals for POPA activities in three countries 2013-15

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	In rands
	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

Relevance

Mineworker and ex-mineworkers associations in the three countries participated in a two/three year programme of capacity building. These were membership organisations that had not had prior experience of implementing a development project. Key informants for this evaluation all commented on their poor capacity for governance and financial management and that the capacity building programme enabled these associations to significantly contribute to processes across the region to address TB and compensation issues affecting current and ex-mineworkers and their families. Inparticular there was significant conflict between the regional structure of SAMA and EMAWA in Lesotho. Key informants point to the extensive learning that has happened across the Region in the last 5 years as evidence of the success of the capacity building activities.

The poverty facing beneficiaries in the Mining Sector Project was stark. All key informants and FGD respondents could point to individuals who had benefited from POPA, even if these benefits were short lived and/or very small. All respondents agreed that opportunities for livelihood are critical for individuals living in mining affected communities.

"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)

"If this (income generating activities) had come before it would have meant mineworkers would be protected." (KII stakeholder)

The response of government to POPA differed across the three countries. In general, Swaziland and Lesotho governments responded more favourably. In Lesotho both the Ministry of Labour (MOL) and the Ministry of Agriculture (MOA) had some engagement with POPA IGAs. Overall this was a high level project for VSO with significant exposure for them at senior levels of government both within countries and in the Region. Key informants report that POPA has certainly assisted in putting livelihood work for mining affected communities on the agenda for other key development role players. The private sector also reported making concessions for POPA beneficiaries in the belief that the *"intention was helping and that the project was sustainable."* (KII stakeholder)

Effectiveness

In total, over three years 657 people were trained in IGAs of whom 511 were widows. Of these, at the end of 2015, 204 widows were reported to be running businesses of which 92 of these were in Mozambique. 5 987 individuals were reached with HIV and TB interventions or whom 4650 were in Mozambique making Mozambique the largest of the POPA sites.

Mineworker and ex-mineworker associations were used to identify beneficiaries for POPA. Whilst this did happen in all countries there were some serious difficulties that arose as a result of this selection and with the role of the mineworker association thereafter. There were also difficulties with the private sector mobile phone contractor, with the ability of beneficiaries to make a profit in the present economic

climate, and with the POPA groups themselves that struggled to manage internal conflicts. Examples of these difficulties are listed on the following two pages.

The fact that there were so many difficulties is not so surprising given the extent of poverty. Rather, these issues are raised because they are an indication that the decision-making in the Mining Sector Project and in POPA specifically was not sufficiently responsive to problems on the ground. As one key informant stated,

"These are very poor communities you can't have a blue print for a development initiative." (KII stakeholder).

Key informants across countries spoke about POPA being overly ambitious and would have benefited from working in a more defined geographical area. Also buy-in of all the key stakeholders at a country level and a country level decision making mechanism would have helped to keep everyone involved accountable.

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
- Additional costs for the business were unforeseen, such as, transport of stock, for security of the container, and providing credit to customers that was 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.

Efficiency (including cost efficiency)

Respondents described IGAs as expensive. One stakeholder went as far as to say three times the amount of resources were needed for a project like POPA to be successful. Troubled relationships between VSO and the mineworker associations in some instances did not help stakeholders believe there was strong financial accountability. The weak capacity of these associations was also felt to hinder efficiency. Basic operational costs for the mineworkers associations were met by POPA. Other key informants commented that international volunteers were expensive.

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) Many beneficiaries needed a lot more support through further training such as business training, building self- confidence, personal branding and team spirit/co-operation, sales and decision making and this was highlighted in field reports. Some beneficiaries were poorly selected for a range of reasons and this hampered project success.

As stated earlier key informants felt POPA was overly ambitious and unable to support beneficiaries across all 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 a co-ordinator in the districts to have oversight on a more day-to-day basis of activities on the ground.

Impact

Both capacitated mineworker and ex-mineworker associations and VSO have made a visible contribution to the processes of policy change at the regional and national levels. One stakeholder commented,

"VSO participated strongly in the country consultation in the development of a framework for managing TB in the mining sector" (KII stakeholder)

The impact of POPA IGAs is not uniformly positive, although there are some very positive stories of local business that had flourished (refer to POPA success stories). Whilst project managers in IOM and VSO generally spoke positively about POPA, other stakeholders were less convinced.

"I never really understood how we can break the cycle of poverty until I met a POPA beneficiary. Her business was flourishing and she was opening other businesses. She said 'now I can see the future. I know my children can go to school and they can go all the way to university.'" (KII Stakeholder)

"In our latest evaluations we could see that now they (beneficiaries) can afford up to three daily meals, they can buy school uniforms for the kids, one of them even bought a TV and managed to build a house at Maputo City. This is the kind of change we aimed for and we can see it everywhere." (KII stakeholder)

"It has changed the lives of people. Women are now retained in Lesotho. They are not going to South Africa to become domestic or farm workers." (KII stakeholder)

"I wouldn't say the Dutch[Mining Sector] Project has achieved much some projects have died. We were not impressed with the livelihood projects." (KII stakeholder)

"The impact was minimum as I said if they had done the things in another way the results would be different. There were lots of mistakes things which we did not like and we did not even realize." (KII stakeholder)

Although POPA had both an economic and a health component it was the economic component that dominated. With respect to the IGAs for every story of success, there is story of failure too. Generally the 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. 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. (Refer to POPA success stories)

The criticisms of POPA centred around the wrong choice of IGA,

"In Leribe and Butha Buthe the land is fertile for agriculture. The projects are not sustainable selling biscuits." (KII stakeholder)

In Lesotho, 19 phone containers were introduced into 5 districts, it was stated by one respondent that of these, 2 had collapsed completely, and 2/3rds were no longer functional. POPA projects were considered by some to have been too small to generate sufficient profits. 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)

As repeatedly stated, it was also felt by stakeholders that working in one district only would have intensified impact. This is because monitoring and problem solving visits may have been more frequent if activities under POPA had been combined into one area. POPA would have saved on transport and fuel costs in this scenario too.

Where health training happened 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)

Beneficiaries also described the psychosocial benefits that ensue when working 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)

Sustainability

Neither VSO or IOM had adequately prepared communities for the end of the project. Project managers admitted that they were unsure about what had happened on the ground and/or had endured.

"Now that the life cost increased I feel bad whenever I do a monitoring visit because now they have fewer profits and consequently ….some interrupted the HIV/AIDS treatment." (KII stakeholder)

"You come here often but you say nothing. Are you still going to support us?" (KII stakeholder)

Despite some of the difficulties respondents did see further opportunities for the future. During implementation many youth came over to POPA containers and were asking questions about SRHR. One respondent spoke about looking at youth friendly corners or an internet café next to phone shops. Another respondent spoke about the value of using POPA beneficiaries themselves for further roll out. A site visit to POPA during its period of implementation, in Lesotho concluded that beneficiaries should be more carefully consulted for the future in the design of the programme.

Sustainability for POPA focused on both a strengthened role for mineworker and ex-mineworker associations into the future and on some capacity being left in communities to take IGAs forward. In Lesotho, EMAWA described being empowered to implement its own IGAs (orchard and vegetable projects) specifically with the purpose of creating income to sustain the organization for the future. An approach to their own sustainability that they acknowledged came directly from their exposure to POPA. EMAWA saw IGAs as a means to secure an office and two cars, to facilitate both the work of the association, and from which to potentially to generate further income. The research team in Mozambique observed that for the future AMIMO will need to redefine itself to gain traction as the interlocutor between the government (Ministry of Labor Employment and Social Security, Ministry of Economy and Finance as well as Ministry of Health), International organizations (OIT, IOM), non-governmental organizations, partners of the government, financers of Mozambique and with mining companies in South Africa. To do this, the research team felt AMIMO will need to continue to strengthen their planning processes, their engagement with stakeholders including members on the ground, transparency at a national and local level and extent their reach across all communities in Mozambique affected by mining.

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 the associations to a broader range of development partners such as the World Bank and the Southern African Trust(SAT) and IOM/VSO is providing some support to the preparation of new funding proposals for mineworker associations. EMAWA with the Office of the Prime Minister had approached the South African gold mining group, Harmony Gold for R5 million sponsorship for a diary business. Many key informants proposed that there is a role for further funding. At least another 3 years.

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

In communities it was found that saving schemes made 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 livelihood in traditional labour sending communities. Recent developments facilitated through regional co-operation to resolve the backlog of compensation and pension pay-outs such as the "One stop shops" where mineworkers and ex-mineworkers can be assisted with medical screening and application processes were seen as an important mechanism for the future. Two such facilities are in operation in Swaziland.

Conclusion

POPA made a valuable contribution at the regional and local level by making the poverty of mining affected communities an active focus of the Mining Sector Project. Key informants for this evaluation point to the extensive learning that has happened across the Region in mineworkers associations in the last 5 years as evidence of the success of the capacity building activities.

The poverty facing beneficiaries in the Mining Sector Project was stark. All key informants and FGD respondents could point to individuals who had benefited from POPA, even if these benefits were short lived and/or very small. All respondents agreed that opportunities for livelihood are critical for individuals living in mining affected communities.

At the end of 2015, 204 widows were reported to be running businesses and almost 6000 individuals reached with HIV and TB education. The effectiveness and efficiency of POPA was hampered by a range of implementation challenges on the ground that included being spread too thinly across too many districts, poor selection of IGA beneficiaries and internal conflict in consortiums of POPA beneficiaries, problems with the private sector partner and inadequate resourcing. In Lesotho, the EMAWA split because of POPA district selection that led some members to feel they were deliberately left disadvantaged. However, in general respondents felt that POPA had been overly ambitious.

Of the 657 POPA beneficiaries trained, some met with success in some instances, and failure in others. There is some evidence in the endline evaluation data that the present economic climate is making it yet more difficult for POPA beneficiaries to succeed. IGAs that had a component of saving built into their operation may be more sustainable. Respondents described communities being ill prepared for the end of POPA funding.

Mineworker and ex-mineworker associations (MWAs) benefited from their engagement with POPA. Both because of capacity building and because IGAs provide them with opportunities to sustain themselves as membership organisations. EMAWA in Lesotho have embarked on this journey. MWAs are engaged in raising funds from other sources as a result of their capacity building.

Table 3: Summary of POPA findings against the OECD-DAC project criteria

OECD-DAC criteria	Key findings POPA
Relevance	• 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	• 205 widows running businesses at the end of 2015 • Almost 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	• Resources were considered to be too little for work in 13 districts across three countries.
Impact	• 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	• 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.

POPA SUCCESS STORIES

FOR INDIVIDUALS

POPA success stories focus on individuals who have been able to generate profits that are able to support them to meet some basic needs with respect to food and access to clinics. Many of the beneficiaries have significant numbers of dependents including children, grandchildren and extended family. POPA businesses may have been more sustainable where a saving scheme was involved.

Lesotho

An Evaluation of the IGA undertaken for the Mining Sector Project in 2014 listed the **benefits** among the beneficiaries of the project as:

- Improved living conditions of the beneficiaries in terms of affording 3 meals a day- balanced diet of proteins, carbohydrates, and other energy giving foods including vegetables
  Ability to afford medical care- transport to the nearest health centres
- Supporting their children in school- can afford the lunch box and school fees
  Improved relations/ harmony in the household as the women beneficiaries can contribute to household need- reduced dependence on husbands
- Improved status of the beneficiaries as they are able to contribute to social responsibilities in their communities
- Improved household incomes through savings by the beneficiaries as a results of the project
- All beneficiaries reached and interviewed agreed that the support in health education training, business management and small grants has helped them to see changes in their life.

"In Lesotho, we (monitoring team) *found that women had defaulted on their ARV treatment because they didn't have money to get to the clinic. After POPA all the women were back on ARVs."*

"*This project has inspired my life and given me renewed hope to live. I can go to the nearest clinic or hospital in Maseru. I can also take my ARVs with meals as I should*'.

"*As a man, I have to provide for my family. But without any hope or plan for how to do this, I was always stressed and worried about how to care for myself and my family. It's not good. So being part of the project helps to release stress and have peace of mind*"

Mozambique

Mrs. X who supports 6 people and sells different kind of equipment for the households, like plastic bowls, Tupperware and thermos cans, but also cooks, sweets and "capulana's". She has a little improvised scaffold in the corner of her garden along the road. The business is going but not that well, she hardly makes profits from those

products. Besides the scaffold, she invested the grant in pigs, for the future she wants to increase the pigs, so she can make profit out of that business.

Mrs. Y invested her grant in piggery. She bought one pig, hired a male pig and has had two litters of three and four pigs. Beside the pigs, she started to sell her own vegetables on the market. With this she makes a profit of about 225, 00 meticais monthly. She invests 200, 00 meticais in the save and loan group. She supports three people, 1 adult son and his small boy of 4 years.

"With the help that I got from AMIMO I managed to buy a cow for rearing and right now I have another cow. With the money, I was able to pay for my son to attend a driving school and he is now licensed and at the moment is working in Maputo. He is now adding a great value to our household income as he often sends some money for family expense". Beneficiary Xai-Xai

Mrs. Z who supports 8 people started to sell charcoal, firewood and vegetables. She stopped selling those products, because she ran out of cash, because people took her products, but didn´t pay. There was still an amount of 7.000,00 meticais pending. At this moment she is selling cacana (green leaves, vegetable) at her place, and she is in the poultry association, together with 5 other female entrepreneurs. She also takes part in the save and loan group. She has a monthly profit of about 3.000,00 meticais monthly. In the future she wants to start a poultry in her own garden.

FOR GROUPS AND SAVINGS SCHEMES

Save and Loan group (VSLA), Malehice, Mozambique

A group of 25 people got trained in the methodology of the save and loan group in August 2014, initiated by VSO, who also supplied the group with a saving box, the locks, a notebook for the registration, 25 small handbooks for personal registration and a calculator. They started in the same month, August 2014, and did the whole circle of saving and loaning, from August 2014 till April 2015. Meetings of the saving group started by listing the rules. The second action was the contribution of the social fund, followed by the contribution of the saving and eventually the possibility to get a loan. The group followed independently, the methodology as learned in the training.

The group started it´s activity by a song followed by a prayer, asking the blessing of God to guide them in their activity. Whenever one member contributes then every member claps by way of encouragement. Every member of the group checked the contributed money, and the money that was asked as a loan. So all steps were transparent and every member knew how much was in the saver box.

Village Savings and Loan Associations, Mozambique

According to the VSO RHAISA Experience Sharing Workshop (2014)26, these interventions were successful for the following reasons:

[26] VSO RHAISA Experience sharing workshop Report 23 November 2014

- Money used for start-ups was sourced by the beneficiaries themselves;
- Beneficiaries have since found ways to put funds aside for social benefits such as funerals; and
- Many of the beneficiaries are now able to send their children to school and have improved their nutrition.

FOR PRIVATE PARTNERSHIPS

Troka Aki, Mozambique

The Troka Aki is a good example of a project that has integrated health systems with entrepreneurship. TheTroka Aki voucher system is used to distribute health goods (water purification materials, mosquito nets, condoms) by using Mkesh (mobile money). Twenty five women were trained in this initiative. However, only one woman was able to take the project forward with remarkable results. Her success led to other women taking up the challenges and distributing the health products as well.

Nazareth Masapong Ex-Miners Kiosk Association, Lesotho

VSO-RAISA partnered with Econet to equip beneficiaries with mobile containers. The project is primarily focused on improving the livelihoods of women, though men were also recruited. The community of Nazareth was selected for its high concentration of ex-miners who fit the targeted population of the POPA project, as well as its high market visibility. There was positive partnership interplay on this project as various organisations provided much needed input to ensure a successful outcome of the project. The different roles of the partners are shown below:

- South Africa ex-Mine workers and Allied Workers Association – affiliate of Southern Africa Mineworkers Association (SAMA) – and VSO/RHAISA collaborated with this organisation as it is actively implementing several HIV/AIDS sustainable livelihoods programmes. The organisation also promotes several support groups in the villages and townships.
- Government Ministries- VSO/RHAISA has forged partnerships with government ministries such as the Ministry of Health and the Ministry of Labour who donated an office to the Ex-Miners. The former collaborates with VSO/RHAISA in training the care givers.
- Econet- this is a telecommunications company with an African footprint. Econet provided technical assistance with regards to market intelligence and technical know-how on the use of the mobile carts. The company also provided the mobile carts.
- VSO/RHAISA-The organisation provided general direction in the implementation of the project. In addition, VSO/RHAISA subsidised the mobile carts and provided business training to the beneficiaries. The training was done in collaboration with Econet and Ex-Miners Association and included the following:
    - Books and Record Keeping;

    - Market Skills;
    - Customer Care and Retention;
    - Business Expansion;
    - Specific Business Skills;
    - Pig/Chicken Farming;
    - Home Based Care Training;
    - HIV/TB Prevention Care and Support; and
    - HIV/TB Counseling;
- Community leaders encouraged their members to embark on the various projects and encouraged other community members to emulate the beneficiaries' initiatives.

APPENDIX 7a

End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16)

FOCUS GROUP DISCUSSION

Current and ex-mine workers

Introduction

Good morning/afternoon! My name is: _____ from Sarraounia Public Health Trust. We have been commissioned by IOM and VSO to conduct an End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16).

Background

The **International Organisation for Migration** (IOM) in partnership with **Voluntary Service Overseas** (VSO) has commissioned the Sarraounia Public Health Trust to undertake an End Line Evaluation of the **Partnership on Health and Mobility in the Mining Sector project** (2013 -2016) focusing on Southern African countries. This project is implemented under the auspices of Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The study will provide recommendations about how to further strengthen the work of the project. The study involves interviewing the project staff, local stakeholders and partners, and the beneficiaries of services. The study poses no risk to the individuals, and individual names and positions will not be used in the reporting.

Instructions/Notes to interviewer:

- Adapt terms used in this tool for the project. Use the name of the project throughout the interview. **Simplify language as and when appropriate.**
- Assure respondents that all information is confidential and people will not be quoted by name. Make sure that each respondent signs the informed consent.
- Make sure the register is completed.
- Ask permission to record the FGD. Only record if permission has been granted.
- The questions are open-ended and require probing. Make sure you are well-acquainted with the questions.
- Where respondents have already answered a question previously do not ask the question again but note that the question was answered.
- Accurately transcribe interesting/important **QUOTATIONS (word-for-word)** or note where they occurred so you can transcribe from the recording.
- Ask for copies of any relevant documentation that may be referred to in the interview

Section 0: Information about

Complete the FGD Register

SECTION A: GENERAL

1. **Tell us about yourselves? Tell us about your involvement in mining?**

2. **How did you come to be in this focus group?** (note this provides insight into likely bias in sampling)

3. **Where do you currently live? Where do you come from originally?**

SECTION B: RELEVANCE

4. **What would you say are your biggest challenges as a migrant mine worker/ex mine worker?**

Probe: for health, communication with mines, compensation, continuity of care

5. **Are there any special challenges that only migrant mine workers, ex-mineworkers, their families and communities face?** *Probe: for in relation to health and access to health services*

SECTION C: EFFECTIVENESS

6. **What experience do you have of this project? Have you been assisted by this project?**

Probe: how did you get to know about the project? What happened when you first went there?

7. **Can you tell us about a good experience you have had with this project? Have you had any negative or bad experiences with the project? If yes, please tell us about it.**

8. **Where do you get health services? (HIV, STIs, TB and Primary Health Care)? What challenges do you experience getting to health services? Does the project help address these challenges?**

Probe: government services, other services from other projects such as NGOs, mine health services

SECTION D: EFFICIENCY (INCLUDING COST EFFICIENCY)

9. **Does it cost you anything to access the services of the project?**

Probe: transport, medicine costs, fee for service

10. **What can you tell us about accessing services through this project? How easy or difficult is it?**

Probe: time taken to get support? How efficient are the services? What has been your experience of the CAs?

11. **Do you think that more beneficiaries could have been reached by this project? If yes, please describe how this could have happened?**

SECTION E: IMPACT

12. **Please describe whether this project has made any difference to your life, or the lives of other migrant miners, ex miners and their families? *Probe: Is there a positive story you can share?***

SECTION F: SUSTAINABILITY

13. **Do you know if migrant current and ex-mine workers will be able to continue getting the benefits of project in the future? How will this happen?**

14. **What else needs to be done to improve the health of migrant mine workers, ex-mineworkers, their families and communities?**

15. **Do you have any other comments.**

THANK YOU FOR YOUR TIME!

End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16)

FOCUS GROUP DISCUSSION

Widows (POPA project livelihood support)

Introduction

Good morning/afternoon! My name is: _____ from Sarraounia Public Health Trust. We have been commissioned by IOM and VSO to conduct an End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16).

Background

The **International Organisation for Migration** (IOM) in partnership with **Voluntary Service Overseas** (VSO) has commissioned the Sarraounia Public Health Trust to undertake an End Line Evaluation of the **Partnership on Health and Mobility in the Mining Sector project** (2013 -2016) focusing on Southern African countries. This project is implemented under the auspices of Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The study will provide recommendations about how to further strengthen the work of the project. The study involves interviewing the project staff, local stakeholders and partners, and the beneficiaries of services. The study poses no risk to the individuals, and individual names and positions will not be used in the reporting.

Instructions/Notes to interviewer:

- Adapt terms used in this tool for the project. Use the name of the project throughout the interview. **Simplify language as and when appropriate.**
- Assure respondents that all information is confidential and people will not be quoted by name. Make sure that each respondent signs the informed consent.
- Make sure the register is completed.
- Ask permission to record the FGD. Only record if permission has been granted.
- The questions are open-ended and require probing. Make sure you are well-acquainted with the questions.
- Where respondents have already answered a question previously do not ask the question again but note that the question was answered.
- Accurately transcribe interesting/important **QUOTATIONS (word-for-word)** or note where they occurred so you can transcribe from the recording.
- Ask for copies of any relevant documentation that may be referred to in the interview

Section 0: Information about

Complete the FGD Register

SECTION A: GENERAL

1. **Where do you currently live? Where do you come from originally?**

2. **How were you selected to be part of this focus group discussion?** (Provides insight into likely sampling bias)

SECTION B: RELEVANCE

3. **What are the specific challenges that widows of migrant mine workers and their families face?**

Probe: general challenges and health related challenges

SECTION C: EFFECTIVENESS

4. **What experience do you have of the POPA project? What support does the POPA project offer you?**

Probe: how did you get to know about the POPA project? What happened when you first went there? Describe the nature of the support and how it works. Was there any training or other support offered?

5. **What has worked well in terms of the support you have received from POPA?**

Probe: Can you tell us about a good experience you have had with POPA?

6. **What has not worked well in terms of the support you have received from POPA?**

Probe: Have you had any negative or bad experiences with POPA?

SECTION D: EFFICIENCY (INCLUDING COST EFFICIENCY)

7. **How did POPA support you with resources? What resources were given to you? Is there anything that could have been done differently?**

8. **What information and/or training did you receive from POPA to set up your business? (links to Sustainability)**

Probe: what training? How often? When? For how long?

9. **Do you think that more beneficiaries (widows) could have been reached by POPA? If yes, please describe how this could have happened?**

SECTION E: IMPACT

10. **How has your life and the life of your family changed because of POPA?**
    Probe: Is there a story you can share

11. **How has the income of you family changed because of POPA?**

SECTION F: SUSTAINABILITY

12. **How are you able to continue with the business you started with POPA even though the POPA project has stopped?** Probe: Where do you go to now for support? What sort of support do you need?

13. **Do you have any other comments**

THANK YOU FOR YOUR TIME!

End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16)

FOCUS GROUP DISCUSSION

Change Agents

Introduction

Good morning/afternoon! My name is: _____ from Sarraounia Public Health Trust. We have been commissioned by IOM and VSO to conduct an End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16).

Background

The **International Organisation for Migration** (IOM) in partnership with **Voluntary Service Overseas** (VSO) has commissioned the Sarraounia Public Health Trust to undertake an End Line Evaluation of the **Partnership on Health and Mobility in the Mining Sector project** (2013 -2016) focusing on Southern African countries. This project is implemented under the auspices of Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The study will provide recommendations about how to further strengthen the work of the project. The study involves interviewing the project staff, local stakeholders and partners, and the beneficiaries of services. The study poses no risk to the individuals, and individual names and positions will not be used in the reporting.

Instructions/Notes to interviewer:

- Adapt terms used in this tool for the project. Use the name of the project viz, the Phamesa project or VSO throughout the interview. **Simplify language as and when appropriate.**
- Assure respondents that all information is confidential and people will not be quoted by name. Make sure that each respondent signs the informed consent.
- Ask permission to record the FGD. Only record if permission has been granted.
- The questions are open-ended and require probing. Make sure you are well-acquainted with the questions.
- Where respondents have already answered a question previously do not ask the question again but note that the question was answered.
- The questionnaire is long. Work quickly and effectively through the responses.
- Accurately transcribe interesting/important **QUOTATIONS (word-for-word)** or note where they occurred so you can transcribe from the recording.
- Ask for copies of any relevant documentation that may be referred to in the interview

Section 0: Information about

Complete the FGD Register

SECTION A: GENERAL

1. **Please tell us about migrant mine workers, ex-mineworkers, their families and communities.**

Probe: socio-economic conditions, housing, services, employment/unemployment, where do people work, where do people come from

2. **Describe the work that you do/did for the IOM/Dutch project?**

Probe: for daily activities, roles and responsibilities of the change agents? Are you involved in planning/setting targets?

3. **How do/did you reach migrant mine workers, ex-mineworkers, their families and communities?**

Probe: miners, ex-mine workers men, women, young people?

SECTION B: RELEVANCE

4. **Please describe how migrant mine workers, ex-mineworkers, their families and communities responded to the IOM/Dutch project and your activities.**

Probe: For stories that illustrate good and poor response, specifically ask about miners, ex miners and their families

5. **Please describe how local stakeholders (such as the clinic, local councillor, local mine worker association) responded to the IOM/Dutch project.**

SECTION C: EFFECTIVENESS

6. **As a change agent, what has made your work easy?**

Probe for: availability of stipends, transport money, shoes, umbrellas

7. **As a change agent, what has made your work difficult?**

8. **As a result of your work and activities, how were migrant mine workers, ex-mineworkers, their families and communities helped to access health services (government, NGO or private services)**

*If not, please describe why? How did this project help address the barriers to getting to health services***?**

9. **How are migrant mine workers, ex-mineworkers, their families and communities lives changed because of the IOM/Dutch project?**

Probe: Is there a positive story you can share

SECTION D: EFFICIENCY (INCLUDING COST EFFICIENCY)

10. What information and/or training did/do you receive from the IOM/Dutch project to do the work you do? (links to Sustainability)

Probe: what training? How often? When? For how long?

11. What resources did/do you have available to carry out your project work?

Probe: finances, education materials & tools, organisational support

12. Do you think that more beneficiaries could have been reached by this project? If yes, please describe how?

SECTION E: IMPACT

13. Please describe how you think the IOM/Dutch project has made a difference in the lives of migrant mine workers, ex-mineworkers, their families and communities.

Probe: For stories that illustrate what has been achieved

14. It what ways did the IOM/ Dutch project impact on you personally?

SECTION F: SUSTAINABILITY

15. How do you understand the future of the IOM/Dutch project?

16. How does support continue to be offered to migrant mine workers, ex-mine workers, their families and communities? How are you involved with this?

17. Do you have any other comments.

THANK YOU FOR YOUR TIME!

APPENDIX 7b

End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16)

Key Informant Interview Guide

Site level project implementing partners

Introduction

Good morning/afternoon! My name is: _____ from Sarraounia Public Health Trust. We have been commissioned by IOM and VSO to conduct an End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16).

Background

The **International Organisation for Migration** (IOM) in partnership with **Voluntary Service Overseas** (VSO) has commissioned the Sarraounia Public Health Trust to undertake an End Line Evaluation of the **Partnership on Health and Mobility in the Mining Sector project** (2013 -2016) focusing on Southern African countries. This project is implemented under the auspices of Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The study will provide recommendations about how to further strengthen the work of the project. The study involves interviewing the project staff, local stakeholders and partners, and the beneficiaries of services. The study poses no risk to the individuals, and individual names and positions will not be used in the reporting.

Instructions/Notes to interviewer:

- Adapt terms used in this tool for the project. Use the name of the project viz, the Phamesa project or VSO throughout the interview. **Simplify language as and when appropriate.**
- Assure respondents that all information is confidential and people will not be quoted by name. Make sure that each respondent signs the informed consent.
- Ask permission to record the interview. Only record if permission has been granted.
- The questions are open-ended and require probing. Make sure you are well-acquainted with the questions.
- Where respondents have already answered a question previously do not ask the question again but note that the question was answered.
- The questionnaire is long. Work quickly and effectively through the responses.
- Accurately transcribe interesting/important **QUOTATIONS (word-for-word)** or note where they occurred so you can transcribe from the recording.
- Ask for copies of any relevant documentation that may be referred to in the interview

Section 0: Information about the Interview & the Key Informant

0.1 Date of interview: _____

0.2 Time began:_____Time ended:_____

0.3 Name of Interviewer:_____

0.4 Name of Key Informant:_____

0.5 Organisation:_____

0.6 Title/Designation/Position:_____

0.7 Length of time involved with the IOM/Dutch Project: _____

SECTION A: GENERAL

1. **Please describe the purpose/objectives of the IOM/Dutch project in this area?**

Probe: how long has it been running? Start date? Finish date or still active?

2. **Tell us about the activities of the IOM/Dutch project in this area?**

Probe: project staff roles, change agents and/or volunteers (paid or stipend)

3. **What is the governance/decision making/management structure of this project in this area? Who is involved? What contributions do they make?**

SECTION B: RELEVANCE

4. **What are the priority needs of migrant mine workers, ex-mineworkers, their families and communities?**

Probe: For general health needs, health needs related to the mining sector eg. Compensation for injury/ill health

5. **Please describe the response in this area of local stakeholders (such as local health services/other NGOs/local councillors/mine worker associations) and beneficiaries to the IOM/Dutch project.**

Probe: For stories that illustrate good and poor response

SECTION C: EFFECTIVENESS

6. **How were migrant mine workers, ex-mineworkers, their families and communities reached for the activities of this project. What were the**

challenges of reaching these beneficiaries? What would you do differently if you were to implement this project again?

Probe: Describe the strategies used.

7. **What services and support do/did you offer to migrant mine workers, ex-mineworkers, their families and communities? Tell me about the particular health services you offered. How did beneficiaries access these services? What were the barriers to accessing the services?**

Probe for HIV, STIs and TB, PHC education, testing and treatment programmes

8. **Describe the role of communication, education and training in your project.**

Probe: who was trained? What education materials or campaigns were run?

9. **What are the obstacles to behaviour change faced by migrant mine workers, ex-mineworkers, their families and communities in this project?** *Probe: How did the project address these challenges?*

10. **How effectively was migration mainstreamed into health service delivery in your context?** *What are your reasons for your answer?*

11. **How was the IOM/Dutch project monitored and evaluated?**

Probe for: How often? When monitoring happened? What was monitored? Who monitored? How did you use this data that was collected?

SECTION D: EFFICIENCY (INCLUDING COST EFFICIENCY)

12. **Do you think there was a way that the IOM/Dutch project could have reached more beneficiaries? How could this have happened?**

13. **What was most of the IOM/Dutch Project money spent on in your area? Are there any activities where you needed more resources? In your opinion is the way the project was delivered cost efficient? What could have been done to make improvements?**

14. **How did the community and other stakeholders (such as government) contribute (in cash or kind) to the project?**

SECTION E: IMPACT

15. **How were the lives of migrant mine workers, ex-mineworkers, their families and communities changed because of the IOM/Dutch project? In**

your opinion what is the best evidence you have that shows the impact of this project?
Probe for stories of change

SECTION F: SUSTAINABILITY

16. **Describe any activities that were conducted to strengthen the involvement of local partners of the project (especially local health services)**

17. **Were there any capacity building and/or skills transfer initiatives that happened in this area because of the IOM/Dutch Project?**

18. **What was the vision of the IOM/Dutch project for sustainability?**

19. **How will the health needs of migrant mine workers, ex-mine workers, their families and communities be addressed now the IOM/Dutch project is closed?**

20. **Do you have any other comments.**

THANK YOU FOR YOUR TIME!

End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16)

Key Informant Interview Guide

Site level partner organisations (Government & other partners)

Introduction

Good morning/afternoon! My name is: _____ from Sarraounia Public Health Trust. We have been commissioned by IOM and VSO to conduct an End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16).

Background

The **International Organisation for Migration** (IOM) in partnership with **Voluntary Service Overseas** (VSO) has commissioned the Sarraounia Public Health Trust to undertake an End Line Evaluation of the **Partnership on Health and Mobility in the Mining Sector project** (2013 -2016) focusing on Southern African countries. This project is implemented under the auspices of Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The study will provide recommendations about how to further strengthen the work of the project. The study involves interviewing the project staff, local stakeholders and partners, and the beneficiaries of services. The study poses no risk to the individuals, and individual names and positions will not be used in the reporting.

Instructions/Notes to interviewer:

- Adapt terms used in this tool for the project. Use the name of the project throughout the interview. **Simplify language as and when appropriate.**
- Assure respondents that all information is confidential and people will not be quoted by name. Make sure that each respondent signs the informed consent.
- Ask permission to record the interview. Only record if permission has been granted.
- The questions are open-ended and require probing. Make sure you are well-acquainted with the questions.
- Where respondents have already answered a question previously do not ask the question again but note that the question was answered.
- The questionnaire is long. Work quickly and effectively through the responses.
- Accurately transcribe interesting/important **QUOTATIONS (word-for-word)** or note where they occurred so you can transcribe from the recording.
- Ask for copies of any relevant documentation that may be referred to in the interview

Section 0: Information about the Interview & the Key Informant

0.1 Date of interview: _____

0.2 Time began:_____Time ended:_____

0.3 Name of Interviewer:_____

0.4 Name of Key Informant:_____

0.5 Organisation:_____

0.6 Title/Designation/Position:_____

0.7 Length of time involved with the IOM/Dutch Project: _____

SECTION A: GENERAL

1. **Tell me about your organisation/role in this area? What you do?**

2. **Please describe your role or your relationship with the IOM/Dutch project in the last four years**

Probe: for any changes to this role in the last 12 months

SECTION B: RELEVANCE

3. **What has happened in this area in the last four years to support the health of migrant mine workers, ex-mine workers, their families and communities?**

4. **What was the role of the IOM/Dutch project in bringing about this change?**

5. **Describe the response of your constituency to the IOM/Dutch project?**

Probe: For stories of active support or withdrawal of support, are there differences of opinion amongst your constituency?

6. **As the IOM/Dutch project draws to a close, to what extent has the project met the expectations of your constituency?**

SECTION C: EFFECTIVENESS

7. **What do you regard as the major successes of the IOM/Dutch project in your area?**

Probe for: success stories

8. **What do you regard as the major failures of the IOM/Dutch project in your area?**

Probe for: stories that show failures

9. **Describe the opportunities that the IOM/Dutch project did not act on in your area?**

Probe: For the reasons behind this

SECTION D: EFFICIENCY (INCLUDING COST EFFICIENCY)

10. **Describe how you as a local partner organisation contributed to the governance, planning and/or implementation of the IOM/Dutch project.**

Probe: For examples of specific activities or events

11. **Describe how you as a local partner organisation contributed in cash and kind to the IOM/Dutch project? Describe these contributions.**

Probe: for in kind contributions admin support, venues, representatives at meetings etc

12. **Do you have any comment you would like to make about the resources that were made available to implement the IOM/Dutch project?**

13. **Do you think there was a way that the IOM/Dutch project could have reached more beneficiaries? How could this have happened?**

14. **In your opinion was the way the IOM/Dutch project was delivered cost efficient? What could have been done to make improvements?**

SECTION E: IMPACT

15. **How are the lives of migrant mine workers, ex-mine workers, their families and communities in this area changed because of the IOM/Dutch project?**

Probe: Is there a positive story you can share

16. **How has the work of your organisation been changed because of the IOM/Dutch project? In what ways have you mainstreamed migration in your work?**

17. **What remains to be done for the health of migrant mine workers, ex-mine workers, their families and communities in this area?**

SECTION F: SUSTAINABILITY

16. **How will support for the health of migrant mine workers, ex-mineworkers, their families and communities be delivered now the IOM/Dutch project has closed in this area?**

17. How do you see yourself as a local stakeholder taking forward the vision of the IOM/Dutch project in this area in the future?

Probe: For planned activities 2017 to do this

18. Do you have any other comments.

THANK YOU FOR YOUR TIME!

End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16)

Key Informant Interview Guide

POPA Beneficiary

Introduction

Good morning/afternoon! My name is: _____ from Sarraounia Public Health Trust. We have been commissioned by IOM and VSO to conduct an End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16).

Background

The **International Organisation for Migration** (IOM) in partnership with **Voluntary Service Overseas** (VSO) has commissioned the Sarraounia Public Health Trust to undertake an End Line Evaluation of the **Partnership on Health and Mobility in the Mining Sector project** (2013 -2016) focusing on Southern African countries. This project is implemented under the auspices of Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The study will provide recommendations about how to further strengthen the work of the project. The study involves interviewing the project staff, local stakeholders and partners, and the beneficiaries of services. The study poses no risk to the individuals, and individual names and positions will not be used in the reporting.

Instructions/Notes to interviewer:

- Adapt terms used in this tool for the project. Use the name of the project throughout the interview. **Simplify language as and when appropriate.**
- Assure respondents that all information is confidential and people will not be quoted by name. Make sure that each respondent signs the informed consent.
- Ask permission to record the interview. Only record if permission has been granted.
- The questions are open-ended and require probing. Make sure you are well-acquainted with the questions.
- Where respondents have already answered a question previously do not ask the question again but note that the question was answered.
- The questionnaire is long. Work quickly and effectively through the responses.
- Accurately transcribe interesting/important **QUOTATIONS (word-for-word)** or note where they occurred so you can transcribe from the recording.
- Ask for copies of any relevant documentation that may be referred to in the interview

Selection criteria:

At each site where the POPA project is implemented two key informant interviews are requested with widows who received support through POPA.

These two women will be selected using the following criteria:

1. **Part of the focus group discussion and are willing to share more information about how their income has changed.**
2. **Part of the focus group and whose experience of POPA gives a useful insight into lessons learnt about POPA – both good lessons and/or negative lessons**
3. **Not part of the focus group but meet the criteria in 1 and/or 2 and can meet researchers without the team incurring further cost or interruption to the research schedule.**

Section 0: Information about the Interview & the Key Informant

0.1 Date of interview: _____

0.2 Time began:_____Time ended:_____

0.3 Name of Interviewer:_____

0.4 Name of Key Informant:_____

0.5 What date did you get involved in the POPA project:_____

0.6 What date did you stop receiving support from the POPA project:

_____

SECTION A: GENERAL

1. **Tell me about your home?**
    a. **Where do you stay?**
    b. **Who do you live with?**
    c. **How many people are dependent on you?**

2. **What was happening in your home before the POPA project? (both positive and negative)**
    a. **What sources of income did you have?**

3. **What is happening in your home after the POPA project? (both positive and negative)**
    a. **How has your income changed? What are the reasons for this change**

4. **How are you able to sustain the change brought about in your home because of the POPA project? Is there anything else you would like to see happen?**

5. **Is there anything else you would like to tell me about?**

End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16)

Key Informant Interview Guide

In-country project management (Including IPs)

Introduction

Good morning/afternoon! My name is: _____ from Sarraounia Public Health Trust. We have been commissioned by IOM and VSO to conduct an End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16).

Background

The **International Organisation for Migration** (IOM) in partnership with **Voluntary Service Overseas** (VSO) has commissioned the Sarraounia Public Health Trust to undertake an End Line Evaluation of the **Partnership on Health and Mobility in the Mining Sector project** (2013 -2016) focusing on Southern African countries. This project is implemented under the auspices of Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The study will provide recommendations about how to further strengthen the work of the project. The study involves interviewing the project staff, local stakeholders and partners, and the beneficiaries of services. The study poses no risk to the individuals, and individual names and positions will not be used in the reporting.

Instructions/Notes to interviewer:

- Adapt terms used in this tool for the project. Use the name of the project viz, the Phamesa project or VSO throughout the interview. **Simplify language as and when appropriate.**
- Assure respondents that all information is confidential and people will not be quoted by name. Make sure that each respondent signs the informed consent.
- Ask permission to record the interview. Only record if permission has been granted.
- The questions are open-ended and require probing. Make sure you are well-acquainted with the questions.
- Where respondents have already answered a question previously do not ask the question again but note that the question was answered.
- The questionnaire is long. Work quickly and effectively through the responses.
- Accurately transcribe interesting/important **QUOTATIONS (word-for-word)** or note where they occurred so you can transcribe from the recording.
- Ask for copies of any relevant documentation that may be referred to in the interview

Section 0: Information about the Interview & the Key Informant

0.1 Date of interview: _____

0.2 Time began:_____Time ended:_____

0.3 Name of Interviewer:_____

0.4 Name of Key Informant:_____

0.5 Organisation:_____

0.6 Title/Designation/Position:_____

0.7 Length of time in that position: _____

SECTION A: GENERAL

21. Please describe the purpose/objectives of this project in your country.

Probe: how long has it been running? Set up date? Still active?

22. Tell us about the activities of this project in your country.

Probe: project staff roles, change agents and/or volunteers (paid or stipend)

23. What is the governance structure of this project? Who is involved? What contributions do they make?

SECTION B: RELEVANCE

24. What are the priority needs of migrant mine workers, ex-mineworkers, their families and communities?

Probe: For health needs, needs related to the mining sector eg. Compensation for injury/ill health

25. Please describe the response of local stakeholders including beneficiaries (such as government and/or large and small scale business) to this project.

Probe: For stories that illustrate good and poor response, enquire about evaluations that gauge stakeholder support

SECTION C: EFFECTIVENESS

26. How were migrant mine workers, ex-mineworkers, their families and communities reached for the activities of this project. What were the challenges of reaching these beneficiaries? What would you do differently if you were to implement this Project again?

Probe: Describe the strategies used.

27. **What services and support do/did you offer to migrant mine workers, ex-mineworkers, their families and communities? Tell me about the particular health services you offered. How did beneficiaries access these services? What were the barriers to accessing the services?**

Probe for HIV, STIs and TB, PHC, minimum package of services

28. **Describe the role of communication, education and training in your project.**

Probe: who is trained? For specific education materials, strategies and training, communication campaigns

29. **What are the obstacles to behaviour and social change faced by migrant mine workers, ex-mineworkers, their families and communities in this project? How did the project address these challenges?**
30. **How effectively was migrancy mainstreamed into health service delivery in your context? What are your reasons for your answer?**

31. **How was the project monitored and evaluated? How did you use evidence collected to build on and adapt project activities?**

Probe for: How often? When monitoring happened? What was monitored? Who monitored? The quality assurance of monitoring reports (Ask for monitoring reports)

SECTION D: EFFICIENCY (INCLUDING COST EFFICIENCY)

32. **Do you think there was a way that the project could have reached more beneficiaries? How could this happened?**

33. **What was the majority of cost spend was on? Are there any areas/activities where you needed more resources? In your opinion is the way the project was delivered cost efficient? What could have been done to make improvements**

34. **How did the community and other stakeholders (govt. and the private sector) contribute (in cash or kind) to the project?**

35. **What was the relative expenditure on administration to programme costs?**

SECTION E: IMPACT

36. **How were the lives of migrant mine workers, ex-mineworkers, their families and communities changed because of this project? In your opinion what is the best evidence you have that shows the impact of this project?**

Probe: For stories that illustrate good and poor response **SECTION F: SUSTAINABILITY**

37. **Describe any activities that were conducted to strengthen the investment/involvement of external stakeholders and partners of the project.**

38. **Were there any capacity building and/or skills transfer initiatives that happened in this project?**

39. **What was the vision of this project for sustainability?**

40. **How will the health needs of migrant mine workers, ex-mine workers, their families and communities be addressed now the project is closed?**

41. **Do you have any other comments and questions.**

THANK YOU FOR YOUR TIME!

End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16)

Key Informant Interview Guide

Regional project management

Introduction

Good morning/afternoon! My name is: _____ from Sarraounia Public Health Trust. We have been commissioned by IOM and VSO to conduct an End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16).

Background

The **International Organisation for Migration** (IOM) in partnership with **Voluntary Service Overseas** (VSO) has commissioned the Sarraounia Public Health Trust to undertake an End Line Evaluation of the **Partnership on Health and Mobility in the Mining Sector project** (2013 -2016) focusing on Southern African countries. This project is implemented under the auspices of Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The study will provide recommendations about how to further strengthen the work of the project. The study involves interviewing the project staff, local stakeholders and partners, and the beneficiaries of services. The study poses no risk to the individuals, and individual names and positions will not be used in the reporting.

Instructions/Notes to interviewer:

- Adapt terms used in this tool for the project. Use the name of the project throughout the interview. **Simplify language as and when appropriate.**
- Assure respondents that all information is confidential and people will not be quoted by name. Make sure that each respondent signs the informed consent.
- Ask permission to record the interview. Only record if permission has been granted.
- The questions are open-ended and require probing. Make sure you are well-acquainted with the questions.
- Where respondents have already answered a question previously do not ask the question again but note that the question was answered.
- The questionnaire is long. Work quickly and effectively through the responses.
- Accurately transcribe interesting/important **QUOTATIONS (word-for-word)** or note where they occurred so you can transcribe from the recording.
- Ask for copies of any relevant documentation that may be referred to in the interview

Section 0: Information about the Interview & the Key Informant

0.1 Date of interview: _____

0.2 Time began:_____Time ended:_____

0.3 Name of Interviewer:_____

0.4 Name of Key Informant:_____

0.5 Organisation:_____

0.6 Title/Designation/Position:_____

0.7 Length of time in that position: _____

SECTION A: GENERAL

1. **Please describe the purpose/objectives of this project at a regional level. What problems were you responding to at a regional level when this project was initiated?**

Probe: how long has it been running? Set up date? Still active? Challenges?

2. **Tell us about the activities of this project at the regional level, and how they were streamlined across the countries.**

3. **What is/was the governance structure of this project at a regional level? Who was/is involved? What contributions do they make?**

4. **What have been the benefits working in partnership at the regional level?**

5. **What have been the obstacles of working in partnership at the regional level?**

SECTION B: RELEVANCE

6. **How does/did this project address the priority needs of migrant mine workers, ex-mine workers, their families and communities in the region?**

Probe: For health needs, needs related to the mining sector eg. Compensation for sick/injured workers

7. **How were migrant mine workers, ex-mine workers, their families and communities identified as beneficiaries of this project? What are the challenges with this across the region?**

Probe for primary and secondary beneficiaries

8. **Please describe the response of regional stakeholders (such as governments, donors, the mining sector) to this project.**

SECTION C: EFFECTIVENESS

9. **How was the project monitored and evaluated across the region? How did you use evidence collected to build on and adapt project activities?**

Probe for: How often? When monitoring happened? What was monitored? Who monitored? The quality assurance of monitoring reports (Ask for monitoring reports)

10. **What evidence is there over the last 3 years that this project has addressed the priority needs of migrant mine workers, ex-mine workers, their families and communities in the region?**

SECTION D: EFFICIENCY (INCLUDING COST EFFICIENCY)

11. **Do you think there is a way that this project could have reached more beneficiaries? How could this have happened?**

12. **Can you tell us a bit about what the majority of cost/spend was on? Are there any areas/activities where you needed more resources?**

13. **In your opinion is the way the project was delivered cost efficient? What could have been done to make improvements?**

SECTION E: IMPACT

14. **At a regional level, how were the lives of migrant mine workers, ex-mine workers, their families and communities changed because of this project? What is the best evidence you have that shows the impact of this project?**

15. **What evidence is there that partner organisations have mainstreamed migration in their work?**

SECTION F: SUSTAINABILITY

16. **Describe any activities that were conducted to strengthen the investment/involvement of external stakeholders and partners of the project.**

17. **What were the capacity building and/or skills transfer initiatives that happened in this project at a regional level?**

18. **What was the vision of this project for sustainability?**

19. **How will the health needs of migrant mine workers, ex-mine workers, their families and communities be addressed at a regional level now that this project has closed?**

20. Do you have any other comments and questions.

THANK YOU FOR YOUR TIME!

End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16)

Key Informant Interview Guide

In country partner organisations (Government & other partners)

Introduction

Good morning/afternoon! My name is: _____ from Sarraounia Public Health Trust. We have been commissioned by IOM and VSO to conduct an End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16).

Background

The **International Organisation for Migration** (IOM) in partnership with **Voluntary Service Overseas** (VSO) has commissioned the Sarraounia Public Health Trust to undertake an End Line Evaluation of the **Partnership on Health and Mobility in the Mining Sector project** (2013 -2016) focusing on Southern African countries. This project is implemented under the auspices of Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The study will provide recommendations about how to further strengthen the work of the project. The study involves interviewing the project staff, local stakeholders and partners, and the beneficiaries of services. The study poses no risk to the individuals, and individual names and positions will not be used in the reporting.

Instructions/Notes to interviewer:

- Adapt terms used in this tool for the project. Use the name of the project throughout the interview. **Simplify language as and when appropriate.**
- Assure respondents that all information is confidential and people will not be quoted by name. Make sure that each respondent signs the informed consent.
- Ask permission to record the interview. Only record if permission has been granted.
- The questions are open-ended and require probing. Make sure you are well-acquainted with the questions.
- Where respondents have already answered a question previously do not ask the question again but note that the question was answered.
- The questionnaire is long. Work quickly and effectively through the responses.
- Accurately transcribe interesting/important **QUOTATIONS (word-for-word)** or note where they occurred so you can transcribe from the recording.
- Ask for copies of any relevant documentation that may be referred to in the interview

Section 0: Information about the Interview & the Key Informant

0.1 Date of interview: _____

0.2 Time began:_____Time ended:_____

0.3 Name of Interviewer:_____

0.4 Name of Key Informant:_____

0.5 Organisation:_____

0.6 Title/Designation/Position:_____

0.7 Length of time in that position: _____

SECTION A: GENERAL

18. Tell me about your organisation and what you do?

19. Please describe your role or your relationship with the project in the last three years

Probe: for any changes to this role in the last 12 months

SECTION B: RELEVANCE

20. What has happened in this country in the last three years to support the health of migrant mine workers, ex-mine workers, their families and communities?

21. What was the role of the project in bringing about this change?

22. Describe the response of your constituency to the project?

Probe: For stories of active support or withdrawal of support, are there differences of opinion amongst your constituency?

23. As the project draws to a close, to what extent has the project met the expectations of your constituency?

SECTION C: EFFECTIVENESS

24. What do you regard as the major successes of the project?

Probe: research, policy, advocacy work, implementation at the local level, regional level; national level

25. What do you regard as the major failures of the project?

Probe: research, policy and advocacy work, implementation at the local level, regional level; national level

26. **What evidence have you seen or heard about the effectiveness of the project?**

Probe: Regional level and national level

27. **Describe the opportunities that the project did not act on?**

Probe: For the reasons behind this

SECTION D: EFFICIENCY (INCLUDING COST EFFICIENCY)

28. **Describe how you (as an external stakeholder) contributed to the governance, planning and/or implementation of the project.**

Probe: For examples of specific activities or events

29. **Describe how you as an external stakeholder contributed in cash and kind to the project? Describe these contributions.**

Probe: for in kind contributions admin support, venues, representatives at meetings etc

30. **Do you have any comment you would like to make about the resources that were made available to implement the project?**

31. **Do you think there was a way that the project could have reached more beneficiaries? How could this have happened?**

32. **In your opinion was the way the project was delivered cost efficient? What could have been done to make improvements?**

SECTION E: IMPACT

33. **How are the lives of migrant mine workers, ex-mine workers, their families and communities changed because of the project?**

Probe: Is there a positive story you can share

34. **How has the work of your organisation been changed because of this project? In what ways have you mainstreamed migration in your work?**

35. **What remains to be done for the health of migrant mine workers, ex-mine workers, their families and communities?**

Probe: For at the national level and at the local level

SECTION F: SUSTAINABILITY

16. How will the work to support the health of migrant mine workers, ex-mineworkers, their families and communities be carried forward now the project has closed?

Probe: For the national level and the local level

17. How do you see yourself as a national stakeholder taking forward the vision of the project in the future?

Probe: For planned activities 2017 to do this

19. Do you have any other comments and questions.

THANK YOU FOR YOUR TIME!

End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16)

Key Informant Interview Guide

Regional stakeholders

Introduction

Good morning/afternoon! My name is: _____ from Sarraounia Public Health Trust. We have been commissioned by IOM and VSO to conduct an End Line Evaluation of Partnership of Health and Mobility in the Mining Sector project (2013-16).

Background

The **International Organisation for Migration** (IOM) in partnership with **Voluntary Service Overseas** (VSO) has commissioned the Sarraounia Public Health Trust to undertake an End Line Evaluation of the **Partnership on Health and Mobility in the Mining Sector project** (2013 -2016) focusing on Southern African countries. This project is implemented under the auspices of Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The study will provide recommendations about how to further strengthen the work of the project. The study involves interviewing the project staff, local stakeholders and partners, and the beneficiaries of services. The study poses no risk to the individuals, and individual names and positions will not be used in the reporting.

Instructions/Notes to interviewer:

- Adapt terms used in this tool for the project. Use the name of the project throughout the interview. **Simplify language as and when appropriate.**
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- Ask permission to record the interview. Only record if permission has been granted.
- The questions are open-ended and require probing. Make sure you are well-acquainted with the questions.
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- The questionnaire is long. Work quickly and effectively through the responses.
- Accurately transcribe interesting/important **QUOTATIONS (word-for-word)** or note where they occurred so you can transcribe from the recording.
- Ask for copies of any relevant documentation that may be referred to in the interview

Section 0: Information about the Interview & the Key Informant

0.1 Date of interview: _____

0.2 Time began:_____Time ended:_____

0.3 Name of Interviewer:_____

0.4 Name of Key Informant:_____

0.5 Organisation:_____

0.6 Title/Designation/Position:_____

0.7 Length of time in that position: _____

SECTION A: GENERAL

1. **Tell me about your organisation and what you do?**

2. **Please describe your role or your relationship with the IOM project in the last three years.**

Probe: for any changes to this role in the last 12 months

SECTION B: RELEVANCE

3. **What has happened at the regional level in the last three years to support the health of migrant mine workers, ex-mine workers, their families and communities?**

4. **What was the role of the project in bringing about this change?**

5. **Describe the response of your constituency to the project?**

Probe: For stories of active support or withdrawal of support, are there differences of opinion amongst your constituency?

6. **As the project draws to a close, to what extent has the project met the expectations of your constituency? What were your expectations at the start?**

SECTION C: EFFECTIVENESS

7. **What do you regard as the major successes of the project?**

Probe: research, policy and advocacy work; regional level; national level

8. **What do you regard as the major failures of the project?**

Probe: research, policy and advocacy work; regional level; national level

9. **What contextual factors influenced the project?**

10. **What evidence have you seen or heard about the effectiveness of the project?**

Probe: Regional level and national level

11. **Describe the opportunities that the project did not act on?**
Probe: For the reasons behind this

SECTION D: EFFICIENCY (INCLUDING COST EFFICIENCY)

12. **Describe how you (as a regional stakeholder) contributed to the governance, planning and/or implementation of the project.**
Probe: For examples of specific activities or events

13. **Describe how you (as a regional stakeholder) contributed in cash and kind to the project? Describe these contributions.**
Probe: for in kind contributions admin support, venues, representatives at meetings etc

14. **Do you have any comment you would like to make about the resources that were made available to implement the project?**

15. **Do you think there was a way that the project could have reached more beneficiaries? Describe this.**

16. **In your opinion is the way the project was delivered cost efficient? What could have been done to make improvements?**

SECTION E: IMPACT

17. **How are the lives of migrant mine workers, ex-mine workers, their families and communities changed because of the project?**
Probe: Is there a positive story you can share

18. **What changes have occurred in your organisation as result of your involvement in the project? To what extent have issues to do with migration been mainstreamed?**

19. **What remains to be done for the health of migrant mine workers, ex-mine workers, their families and communities?**
Probe: For at the Regional level and at the national level

SECTION F: SUSTAINABILITY

20. **How will the regional level work to support the health of migrant mine workers, ex-mineworkers, their families and communities be carried forward now the project has closed?**

21. **How do you see yourself as a regional stakeholder taking forward the vision of the project in the future?**

Probe: For planned activities 2017 to do this

22. **Do you have any other comments/ questions.**

THANK YOU FOR YOUR TIME!