IOM Partnership on Health and Mobility in East and Southern Africa (PHAMESA II) Mid-Term Review -ANNEXES

Contents

ANNEXES

Annex 1. Field visits report and stakeholders interviewed by country –Kenya, Zambia, and Lesotho

1.1 Kenya Country visit report & stakeholders list

The mid-term evaluation of the program *"Partnership on Health and Mobility in East and Southern Africa"* – PHAMESA II focused on Kenya as one of the three countries to be visited for data collection. The field work was done from May 9 to the 13 in the city of Nairobi and involved IOM staff from the regional office for East Africa, government officials, implementing partner organization representatives, beneficiaries and key stakeholders. The two people in charge of the visit where the consultant Lyda Gomez and María Fernanda Salazar Rodríguez. This report summarizes the findings that came out of the analysis of the information collected, as well as some recommendations for the IOM team in Kenya.

Kenya Field Visit Plan vs actual field work:[1]

- **Key informants (semi-structured interviews) (p: participants):** 12 p. (1 p. Coordination team; 2 p. International agencies/organizations; 2 p. District Border Officials; 2 p. Implementing partners (in Lusaka and District Border); 1 p. Academic/University; 2 p. Relevant ministries 2p. Migrant association) – *in total 9 interviews were done*
- **Peer reviewers trained:** 3 (Bilingual – English plus other language) – *3 peer reviewers were trained*

[1] For information regarding the reasons for deviation from the original field work plan consult the Limitation section of this report

- **Peers interviewed by Peer Reviewers:** 9 (They may speak any of these languages Swahili, French, Somali, Nyanja, Bemba or English but must be able to community with peer reviewer). – *9 peers interviewed by peer reviewers*
- **Focus groups (fg) – run in English:** 1 fg. Service providers; 1 fg. Change agents; 1 fg. Beneficiaries Male over 25; 1 fg. Beneficiaries Female over 25; 1 fg. Young people under 25, aim 50% men/50% women. – *All planned focus groups were done*

Main findings observed in the field by Outcome

OUTCOME 1 – MONITORING MIGRANTS' HEALTH	
Achievements	• The inclusion of the migrant category in two surveys (national health survey and AIDS survey) thanks to the advocacy work done by the IOM is a great achievement of the project and a reflection of the advocacy work done by the IOM in Kenya. • The implementation of a pilot project incorporating migration variables in health management information systems, for health facilities.
Challenges	• The greatest challenge of this outcome and of the whole initiative in Kenya in general is the fact that the issue of migrant health does not seem to be a priority for the government. When it does consider it, it does so focused on controlling particular diseases or epidemics. • There is no recognition of how migration dynamics affect the population. For instance, the majority of the actors do not even recognize the difference between refugees and migrants. Neither of them is seen as permanent resident, they are considered to be temporarily in the country while they return to their country of origin or in transit somewhere else. They are thus not considered to be a priority population.
Recommendations	The inclusion of the migrant category in the different surveys has been a significant achievement and will generate valuable data. Work needs to focus on securing real, tangible government commitment that leads to this data being used to guide policy.

OUTCOME 2 – POLICIES AND LEGAL FRAMEWORKS	
Achievements	• The advocacy work carried out by the OIM has been very significant and has exercised pressure on the political establishment which has led to inclusion of the migrant population on policies and strategies. Of great importance is for example the fact that the Kenya Aids Strategic Framework now recognizes "fishing communities, truck drivers, street children, migrant population especially those in humanitarian crisis and mobile workers" as vulnerable populations. • With regards to output 2.1, government entities directly working on services and specific projects demonstrate recognition of the importance of the physical and mental wellbeing of migrant groups. However, this recognition does not extend to higher levels, indicating that stakeholders and policy makers who can really influence change in legislation, policies and strategies around issues of migrant health do not understand or even recognize the impact that these groups have on Kenyan society. • IOM provided technical support in the revision of the Busia County Health Strategy, which now includes migrants among its target populations.
Challenges	With regards to access to healthcare of the migrant population, the new Kenyan Constitution (2010) guarantees healthcare for all persons, including migrants and refugees. However, in practice this translates as primary care only and there is great confusion at all levels regarding difference in fees that might apply to them. The national government dictates guidelines that are then adapted and implemented by sub counties but there is uncertainty if the difference in fees is a government policy or if it is a result of other factors (corruption, discrimination, etc.) and it is implemented in an ad hoc manner.
Recommendations	Clearer understanding of what happens on the ground (in terms of migrant access to service and in what condition) is essential to being able to further the advocacy work, focusing not only on the policies and legal frameworks but going beyond to the real implementation of said policies to ensure that the rights of migrants are not only included there but also really

	respected when they look to access services.

OUTCOME 3 – MIGRANT SENSITIVE SERVICES	
Achievements	• The experience of the Eastleigh clinic and the good results obtained there is considered by the OIM as an example in terms of migrant friendly services that could be imitated elsewhere. • IOM provided technical support in the revision of the Busia County Health Strategy, which now includes migrants among its target populations. • The services provided at the Eastleigh Clinic have been able to offer both migrant as well as local population of the area quality, friendly services, and has been able to address some of the shortcomings of the government facilities, such as medicine stock outs, and free services in equal conditions to all. • The services offered at the Eastleigh Clinic go beyond the focus of the program (HIV, Malaria and TB) and offer comprehensive healthcare to the community thus improving the health and quality of life of the patients beyond the treatment of the 3 diseases.
Challenges	• Regarding the training of the Change Agents, they themselves expressed that they were in need of more training. It was also expressed by the OIM staff that as they had been trained by the IPs, which have changed several times in recent years, there is uncertainty regarding the level of training and preparation of them. • In terms of migrant sensitive services, the population expressed that the hours of operation of the clinic sometimes make it difficult for them to access services. The clinic closes at 4, and after that the population is left without any healthcare services as the government clinic also closes at that time. • The referral systems possess a real challenge for the monitoring and reporting of the services. Within Eastleigh there are different types of referrals, i.e. from Change Agents to the IOM Clinic, from Change Agents to the government facilities/other partner facilities, from the IOM Clinic to the government facility/other partner facilities. The internal referrals from the Change Agents to the Eastleigh clinic can be monitored without significant difficulties; however, all external referrals cannot be tracked. Some Change Agents reported that they follow up on them informally (asking the patients or their family members). • The health workers from other facilities are not sufficiently sensitized regarding migrant sensitive services. They also lack clarity of the rights of migrants in terms of accessing health services.
Recommendations	• Though participation of migrants as Change Agents is sometimes seen as challenging given the high turnover rate present among them because of the very nature of migrants, they need to be further engaged because they are crucial in addressing cultural, language and religious differences, which are often barriers for seeking health care services, and especially SRH services. • Further training and clarification is necessary regarding the definition of indicators to improve data collection and ensure it is standard throughout the region. This is particularly important as it relates to referrals, given that the Eastleigh clinic has several types of referrals (internal, external, etc.) • The referral system needs to strengthen in collaboration with the government facilities so that more accurate reporting and evaluating is possible. • Some form of recognition of the CA, such as a t-shit, cap, or ID, will aid in them being recognized within the community as well as help keep them motivated.

OUTCOME 4 – MULTI-SECTORAL PARTNERSHIPS AND NETWORKS	
Achievements	At the sub-county level, officials who are in direct contact with the population understand the real impact of migration on the communities and the importance of the issue and thus show a deep commitment to continue working on the issue.
Challenges	• The main difficulty is the fact that currently for the Kenyan government, the issue of migration and health is not considered to be a priority at the national level. • With regards to the relation between IOM and the Implementing Partners, it needs to be strengthened so they may remain more in touch with what is being done on the ground.

	This is for example important as it relates to the Change Agents and the training that they receive, which IOM staff has expressed that is source of uncertainty and concern for them. • Other UN agencies are valuable partners, with important presence in the country and resources, partnerships with them should be strengthened. However, they feel that their role is to support what the government considers to be their priority which poses a challenge in terms of getting them to prioritize the issue of migrant health, considering that the government doesn't. Further advocacy is needed in this regard.
Recommendations	It was also observed that it was unclear for some partners, especially within the government, what their collaboration with IOM entailed and how the coordination was structured. It would be useful to elaborate a joint roadmap of action for said collaboration.

Other findings

Finding regarding the relevance of the program in Kenya	• The change from PHAMESA I to PHAMESA II has had great impact in the project in Kenya (especially as it relates to Outcome 3) because it has directly affected the population with access to services. The move to the concept of "spaces of vulnerability" has led to the entire community of Eastleigh being eligible for services at the clinic, which was previously exclusively for migrants and refugees. Though this change has aided in integrating the migrant population in with the wider Eastleigh community and to decrease resentment towards them, the impact of this move in said population is unclear and IOM staff interviewed is undecided as to whether this change in focus should be a permanent one for the organization. There is concern that the migrant population now makes up a minority of those accessing services. • Several weaknesses in terms of data collection and reporting have been identified in Kenya. In addition to the issue of referrals discussed under outcome 3, data reported is also not disaggregated by sex and some of the indicators being reported on seem to sometimes be misunderstood based on the data being reported. An additional layer of this difficulty is that the data is not feeding a live evaluation process that analyses it and uses it to improve the intervention.
Findings regarding the sustainability of the program in Kenya	• The commitment of the IOM with sustainability is evident in the partnerships that it has established and the stakeholders it has involved in the initiative. However, the greatest challenge to sustainability remains the fact that the there is no real government buy in of the initiative. The issue of migrant health is not currently a priority for the national government. Furthermore, the current climate in the country regarding refugees seems hostile considering that the national government recently announced it would close down its refugee camps and in fact has already dismantled the Ministry of Refugee Affairs. • In addition, the upcoming elections (2017) pose for the IOM and the program the risk that the alliances that have been forged over the past years might need to be re-established if there is a change in government staff, especially at the higher levels. This is a particular risk for partnerships that may have been established with individuals rather than with institutions.

Conclusion

PHAMESA II in Kenya has made great advances on the issues of migrant health in the past 2 years. The inclusion of the migrant category in two national health surveys is regarded as a great achievement and it is a clear result of strong advocacy efforts made by the IOM. However, so far this has not translated into real, tangible evidence of commitment from the government. The greatest challenge to the work in Kenya is undoubtedly real government buy in. The issue of migrant health continues not to be a priority for the current government, which poses serious threats for the sustainability of the actions. The current situation, both in terms of internal political tensions, as well as regarding the issue of refugees, makes for a worrisome combination. In addition, the upcoming national elections (2017) threaten the alliances that have been made with government agencies.

With regards to the services provided, the experience of the Eastleigh Clinic is evaluated positively, as a safe space that offers quality free services to the community, free of stigma and discrimination. It has succeeded in positioning itself as a safe space where both Change Agents and Beneficiaries feel welcome. The change to expand services to the community at large instead of being restricted to migrants has fostered the inclusion of the migrants within the

community and has helped dissipate tensions. However, it has led to a great percentage of those served not being migrants.

People interviewed

Person	Organization
Mr. James Angawa	Disease surveillance coordinator
Mary Kanou	Refuge point
Helgar Musyok	Kamukunji Sub-county – focal point for health management
Dr. Masini	TB Coordinator – Ministry of Health
Dr. Ng'ang'a	Gender Policies
Mr. Edwin Kimutai	National AIDS Control Council
Mr. Nelson Andanje	Busia County
Dr. Kitetu	Ministry of Health
Mr. Osoro	Kenya National Bureau of Statistics

1.2 Zambia Country visit report & stakeholders list

The mid-term evaluation of the program *"Partnership on Health and Mobility in East and Southern Africa"* – PHAMESA II focused on Kenya as one of the three countries to be visited for data collection. The field work was done from May 9 to the 13 in the city of Lusaka and involved IOM staff, government officials, implementing partner organization representatives, beneficiaries and key stakeholders. The person in charge of the visit to Zambia was the consultant Luis Alcalá. This report summarizes the findings that came out of the analysis of the information collected, as well as some recommendations for the IOM team in Kenya.

Zambia Field Visit Plan vs actual field work:[2]

- **Key informants (semi-structured interviews) (p: participants):** 12 p. (1 p. Coordination team; 2 p. International agencies/organizations; 2 p. District Border Officials; 2 p. Implementing partners (in Lusaka and District Border); 1 p. Academic/University; 2 p. Relevant ministries 2p. Migrant association) – *in total 8 interviews were done*
- **Peer reviewers trained:** 3 (Bilingual – English plus other language) – *3 peer reviewers were trained*
- **Peers interviewed by Peer Reviewers:** 9 (They may speak any of these languages Swahili, French, Somali, Nyanja, Bemba or English but must be able to community with peer reviewer). – *9 peers interviewed by peer reviewers*
- **Focus groups (fg) – run in English:** 1 fg. Service providers; 1 fg. Change agents; 1 fg. Beneficiaries Male over 25; 1 fg. Beneficiaries Female over 25; 1 fg. Young people under 25, aim 50% men/50% women. – *1 focus group of change agents (many of who were former beneficiaries) done with 13 participants*

Main findings observed in the field by Outcome

OUTCOME 1 – MONITORING MIGRANTS' HEALTH	
Achievements	• Strategic alliances have been established for the inclusion of migrant variables in several national data collection instruments (Central Statistics office, National Aids Council and the Ministry of Health). Negotiations are still underway. • IOM is working with the national police to include indicators on migration in the GbV victims' database. • At least two research studies (mental health of truck drivers and risky behaviour with regards to HIV) that have been used in the advocacy processes mentioned.
Challenges	• So far, no migrant variables or indicators have been included in the national data collection instruments. • The migrant population does not feel safe approaching the public institutions for fear of deportation, which leads to the majority of them falling under the radar of the institutions with little information available regarding this group.
Recommendations	• Given that the UN System in Zambia operates a "delivering as one" approach, the IOM could lead a taskforce of several UN agencies to advocate for the inclusion of the migrant population in the data collection mechanisms in the health system and other areas (UNDP, UNAIDS, UN-WOMEN, UNFPA, OIM, UNHCR). • Continue with the communication and behaviour changing campaigns, as they can influence decision makers in this regard.

OUTCOME 2 – POLICIES AND LEGAL FRAMEWORKS	
Achievements	• Migrant population has been included as a priority population in the National Strategic Framework on HIV/AIDS. • At least 100 decision makers have participated in capacity building on issues of migration and health and this has allowed the issue of migration to be included in public policies and strategies in the health sector and beyond at the national and local level. • In collaboration with UNDP, through the Transport Sector Technical Working Group on HIV of which the IOM is a member together with the National AIDS Council, the program succeeded on migration and HIV being included in the issues on which funds from capital projects can be invested according to their social impact. • The Investment Plan on HIV, currently supported by the IOM in 3 districts, has specific

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	actions aimed at migrant and communities affected by migration.
Challenges	• Despite the advances made, the legal framework of the health system rarely mentions migrants which often hinders their access to services as there is no clarity whether they have the right to receive services or not. • The lack of clear policies, has created a permanent tension between those who seek to assist and support this population and the officials who are focused on making them return to their countries of origin. This causes confusion and uncertainty and leads migrants living under the government radar without access to any type of public service.
Recommendations	The program could establish spaces of dialogue that involve decision makers, academia and the media, where the framework of protection of migrant population is shared and clarified and guarantees for their protection be established.

OUTCOME 3 – MIGRANT SENSITIVE SERVICES	
Achievements	• The program has trained more than 150 change agents who have been key in facilitating the access of migrants to services. They have earned the trust of the migrant population, which has led to them being the first point of reference for the population on matters of health. • Thanks to the joint GbV program, in which IOM participates, PHAMESA has been able to join the health services with legal counselling to survivors of GbV. At least 1.115 survivors have been referred for support and protection. • Change Agents have contributed to social cohesion as they work hand in hand with migrants, which has strengthened solidarity and collaboration among them and facilitated the integration of migrants in the communities. • An alliance with the transport sector allowed the program to reach truck drivers and their families, police officers, commercial sex workers, border officers, service providers and other key actors along the transport corridors and border controls.
Challenges	• Despite the advances, the program has done little on issues of tuberculosis and barriers of Access to healthcare still exist, especially for migrants. • The number of women trained as Change Agents is significantly lower than that of men. • Aside from the satisfaction questionnaires for users, there are no other mechanisms for evaluating services. • One of the most important factors that hinders the access of migrants to health services is the lack of information regarding the rights they are entitled to. There exists among this population the idea that they will be deported if they seek healthcare.
Recommendations	• The program must implement a communication strategy that is aimed at the entire community and not just the migrant population that informs and educates the general public on the rights of migrants, especially concerning access to healthcare. The alliances stablished with the media can be a starting point. The same strategy can include messages directed at the health care providers, so they recognize their duty to this population. Change Agents can be great allies in such a campaign. • Given the importance of the role of the Change Agents in the program, it is fundamental to evaluate periodically and monitor closely their performance, as well as the tools and methodologies used in education activities. Clear criteria must be established on who can train Change Agents, what must be covered in the training and what criteria will be used to evaluate if they have acquired the knowledge and abilities to carry out their role. • The program must establish strategies to increase the number of female Change Agents, especially if one considers that female migrants (women and girls) are in a situation of higher vulnerability than their male counterparts.

OUTCOME 4 – MULTI-SECTORAL PARTNERSHIPS AND NETWORKS	
Achievements	• The program in Zambia has been successful in establishing alliances with strategic partners both at the national and local level. • Being Zambia a country where the UN system operates under “Delivery as One”, several agencies have become involved in the activities of the program through joint programs

	such as the capital projects or the GbV program. Below please find some examples of the alliances established to date: - Alliance with the provincial coordinators of the National AIDS Council that has contributed to the definition and implementation of at least three Investment Plans on HIV in border districts - The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level – AMICAALL led the Annual General Conference of local authorities to include the health of migrants as a priority area in the 2015 declaration (the Livingstone Declaration). - The Alliance with the Ministry of Health, the Central Statistics Office and the National Aids Council has allowed the health vulnerabilities of migrants to be at the centre of the public institutions' agenda. - The joint program on GbV has facilitated the access of migrant women and local women of communities affected by migration to health, counselling and legal services. - The Alliance with the newspaper Times of Zambia has allowed the general population to have access to information regarding migration, which has promoted empathy, social cohesion and integration processes.
Challenges	- The alliances at the local level can be affected by the inability of the program to have a stronger presence of the IOM staff in the field. - The change to a new government after the elections to be held in August of this year poses the challenge of being able to give continuity to the good relationship with the government partners, especially the Ministry of Health and Community Development.
Recommendations	The Alliance with the university to promote studies around migrant health must be focused in carrying out research studies that respond to the challenges identified in each area. For example, a study that provides evidence on the advantages for Zambia of including the migrant population in the health monitoring instruments; or a study that clarifies the cost it represents for the nation not to offer a broad approach to migrant health, etc.

Other Findings

Finding regarding the relevance of the program in Kenya	• The focus on spaces of vulnerability has allowed the program to better focus its interventions. As this focus does not individualize the migrants, it benefits the entire community and migrants are seen as members of that community. • The program is identifying new spaces of vulnerability; for example: the fishing sector and the sugarcane plantations. In both cases the presence of migrants is significant. • New priority areas in relation to the health of the target population of the project have emerged, such as early marriage and pregnancy and the abuse of drug and alcohol among minors.
Findings regarding the sustainability of the program in Kenya	• The capacity building and service improvement activities have been implemented in existing health units and organizations, strengthening existing structures instead of creating new ones. • The inclusion in the Environment Management Act of a social impact evaluation that takes into account the health of the migrant population allows for the channelling of funds that can help sustain the local benefits of the program. • Although advocacy has been done for the inclusion of the issue of migrant health in the national policies, more advances have been made on this matter at the local level. In fact, the program has promoted the consolidation of a force at the local level that advocates for the inclusion of this issue in the public agenda. • The program has mobilized $871.000 (mainly from UN funds) • The program has established an alliance with the newspaper Times of Zambia, which has contributed to generate more knowledge and empathy in the general population regarding the issue of migration. This contributes to a better acceptance of the program and its activities at the national and local levels.
Findings regarding	• The reduced human resources and the important number of alliances and actions implemented by the program in different geographical areas make monitoring and

management and processes	follow-up a difficult task.

Conclusion

PHAMESA II in Zambia has made important advances towards the expected results of the program. In general, the more important results can be seen in the inclusion of the migrant population in several policies and strategies both at the national as well as the local level. The involvement of the thousands of community members and migrants in activities around education, health care, and support and protection in cases of GbV; and the consolidation of strategic alliances that have broadened the transformation potential of the program and have contributed to strengthen the sustainability of the initiative.

The most important challenges of the program in Zambia are due to the difficulty of not having a legal framework in the general health care system (not only regarding HIV) that explicitly mentions the migrant population. This brings about complex situations in the day to day access to services by individual migrants.

Despite the challenges of the program found in Zambia, both at the institutional as well as at the social sphere, there are several successful stories of change that Zambia can share with the rest of countries part of PHAMESA, particularly with regards to the creation of strategic alliances and the support of local investment plans.

Stakeholders interviewed

Person	Organization
Ian Milimo	UNDP (Capital projects)
Shupe Makashini	UNDP (GBV)
Medhin Tshehaiu	UNAIDS
Abibatou Wane	OIM
Noma Ncube	OIM
Getrude Ngenda	University of Zambia
Stephen Kapambwe	The Times of Zambia newspaper
Victor Kachabe	Ministry of Community Development
Dr. Kapata	Ministry of Health
Peter Ndemena	National HIV/STI/TB Council
Prudence Mwansa	Action Africa Help
Munsaka Mubela	Mobility Alive Zambia
Judith Chande	Mulangile Women Organization
Crispin Sapele Christina Mutale	CHAMP
Rosemary Masaku	Provincial AIDS Coordinating Adviser (Southern Province)
William Kauche	Provincial AIDS Coordinating Adviser (Western Province)

1.3 Lesotho Country visit report & stakeholders list

The mid-term evaluation of the program *"Partnership on Health and Mobility in East and Southern Africa"* – PHAMESA II focused on Lesotho as one of the three countries to be visited for data collection. The field work was done from May 16 to 20 in the province of Leribe and city of Maseru and involved IOM staff from the regional office for Southern Africa and staff member currently in Lesotho, government officials, implementing partner organization representatives, beneficiaries and key stakeholders. The two people in charge of the visit were the consultant Lyda Gomez and María Fernanda Salazar Rodríguez. This report summarizes the findings that came out of the analysis of the information collected, as well as some recommendations for the IOM team in Lesotho.

Lesotho Field Visit Plan vs actual field work:[3]

- **Key informants (semi-structured interviews) (p: participants):** 12 p. (1 p. Coordination team; 2 p. International agencies/organizations; 2 p. District Border Officials; 2 p. Implementing partners (in Lusaka and District Border); 1 p. Academic/University; 2 p. Relevant ministries 2p. Migrant association) – *in total 14 interviews were done*
- **Peer reviewers trained:** 3 (Bilingual – English plus other language) – *3 peer reviewers were trained*
- **Peers interviewed by Peer Reviewers:** 9 (They may speak any of these languages Swahili, French, Somali, Nyanja, Bemba or English but must be able to community with peer reviewer). – *9 peers interviewed by peer reviewers*
- **Focus groups (fg) – run in English:** 1 fg. Service providers; 1 fg. Change agents; 1 fg. Beneficiaries Male over 25; 1 fg. Beneficiaries Female over 25; 1 fg. Young people under 25, aim 50% men/50% women. – *All planned focus groups were done*

Main findings observed in the field by Outcome

OUTCOME 1 – MONITORING MIGRANTS' HEALTH	
Achievements	Advocacy work by IOM was decisive in the inclusion of migration variables in the 2016 national census.
Challenges	As a migrant producing country, Lesotho cannot act alone in terms of migrant health and it needs the collaboration of the migrant receiving countries, in particular South Africa. Information sharing and system integration pose a serious challenge but one that needs to be addressed in order to further strengthen the work of the IOM in Lesotho
Recommendations	The IOM, as an internationally recognized organization is in a privileged position to support the government of Lesotho and to further strengthen its partnership with the different government agencies. In this regard, it could act as liaison between the governments of Lesotho and South Africa in order to promote information exchange that can aid in following up on migrants' health, contributing to treatment adherence and promoting prevention campaigns in communities affected by migration on both sides of the border.

OUTCOME 2 – POLICIES AND LEGAL FRAMEWORKS	
Achievements	• The IOM is actively supporting the planning for the execution of the integrated HIV/Tuberculosis biological and behavioural study among migrant mine worker communities funded by the SADC HIV Special Fund. • The Migration and Health Partnership Forum creates a great opportunity to bring together governmental and non-governmental actors to work on the agenda of migration and health.
Challenges	• Despite the commitment of the government of Lesotho with the issue of migrant health, the current migration panorama is quickly changing with different populations, such as young women, now migrating as well. This change in migration dynamics must be taken into consideration when designing policies and legal frameworks concerning the matter and must be considered by the IOM and its partners when doing advocacy work on the matter. . • The coordination of the program in Lesotho from South Africa poses serious challenges in

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	terms of the work with different government agencies. Having a dedicated person in the country strengthens said relationships and facilitates the work around advocacy.
Recommendations	Having a permanent IOM representative in Maseru would strengthen the relationship between the organization and the government and aid in strengthening the advocacy work.

OUTCOME 3 – MIGRANT SENSITIVE SERVICES	
Achievements	• The number of Change Agents has been increased and the referral system has been strengthened • The new implementing partner has been able to motivate the CA through different strategies such as training, compensation contracts (350R every three months for 3 hours of work, 3 days per week), and provision of t-shirts. • Alliances with local authorities and local organizations from the Leribe province has been established and consolidated which has led to joint actions being implemented and stronger work being done in the community.
Challenges	• The Change Agents continue to be primarily women which poses a challenge for reaching the miners and ex miners who are all men. Likewise, the health personnel at the health facilities is almost exclusively female, which also deters men from seeking services. • Some health facilities refuse to stamp the referral forms. The reason is not completely clear, IOM staff said they are already overworked and do not want to do additional administrative work. While some CA stated that they do not want to stamp the forms because they think NGOs make money at the expense of the patients because they receive money for each referral. • The Implementing Partner is in need of more support, especially as it relates to financial reporting. In addition, they are not receiving consistent feedback on their reports. • The implementation was delayed because funds had not arrived. • Basic needs such as food security are not met for a good percentage of the population, which is an important reason for treatment defaulting. • Topography of the country makes reaching health services extremely difficult, which causes patients to primarily seek medical care when they are already very sick. Also, traveling to the medical facilities is often expensive for many people and they are unable to afford it on a regular basis to get medication or for regular follow-ups.
Recommendations	• Further sensitization with healthcare providers regarding the work IOM and the IP does would be important to ensure that they are on board with the work and they understand the importance of the referrals. • Expand the work to income generating activities for beneficiaries as well as Change Agents. It is particularly important to be able to support CA in getting out of the poverty cycle and to promote their empowerment beyond the work they do with the IOM • It is crucial to increase the number of male change agents and consolidate a network of them who can reach miners and ex miners. An interesting alternative to reduce duplication of efforts and promote coordination with partner organizations would be the possibility of collaborating with existing networks of male change agents of such as those of the ex-miners' association, MDA or the government should be considered. • Strengthen the work of the CA covering their air time and transportation (it should also be considered that sometimes they have to provide money for transportation to community members who are very sick to be able to access services. An alternative to be explored would be for this to be managed through the use of new technologies for example through Mpesa credit, like CHAI is doing in some of their initiatives. • Considering that the greatest challenge in accessing services is the topography of the country, it would be essential to advocate for initiatives of mobile health clinics or other strategies that can bring the services to the community. It would be important, for example, for the Change Agents to be able to provide more services, in particular contraceptives. This is especially important considering that some of the government clinics are in fact managed by the catholic church and do not distribute condoms or contraceptives.

OUTCOME 4 – MULTI-SECTORAL PARTNERSHIPS AND NETWORKS

Achievements	The creation of the Health and Migration Partnership Forum has created an opportunity for different stakeholders invested in the issue of migration and health and related matters to come together and exchange experiences, lessons learned, challenges, etc. This will allow the different stakeholders to join forces and work together, causing greater impact in the communities they work with. In addition, the mapping of services being done will be extremely useful in terms of coordination and reducing duplication of efforts.
Challenges	• Though the Health and Migration Partnership Forum is a great opportunity both for the IOM as well as for the rest of the partners, the IOM still needs to capitalize on the momentum it has created with this initiative and further consolidate the partnerships with the different stakeholders and advocate for more active information exchange in a context where organizations see each other as competitors for limited funding and are thus reluctant to share information with each other. • The IOM needs to ensure that they meet the expectations they create. Partners expressed that they often feel as if the IOM comes to them only when they need information and then fail to share with them the reports produced or the results of the initiatives. Also, when reports and recommendations are produced, there is confusion within government agencies as to who is responsible for its implementation.
Recommendations	• Work actively on securing funds to give continuity to the presence of a permanent person in Maseru as this would aid in maintaining more regular communication with the different stakeholders and it would make the partnerships stronger. • The Forum has created great expectations among its members, and the IOM is in a unique position to lead real change and make a real difference around issues of migrant health and to position itself as the leading organization in the matter. To do so it must maintain the forum active and promote the collaboration of the members. This includes leading by example and participating in initiatives proposed by other partners.

Other findings

Finding regarding the relevance of the program in Lesotho	• The migration panorama in Lesotho is changing rapidly and the IOM initiatives in the country should respond to that. The groups that are migrating are changing, which changes the migration dynamics and its consequences both on the migrants as well as on the communities affected by migration. The strategies and actions of IOM initiatives should actively respond to that.
Findings regarding the sustainability of the program in Lesotho	• The consolidation of partnerships can be a good strategy not only for political incidence but also for securing funds. It is particularly recommended to explore partnerships with organizations that can complement the work currently being done by the IOM, such as CHAI, which is currently leading innovative projects that promote the use of new technologies to improve the health of the population.
Findings regarding management and processes	• The Implementing Partners need more support from the IOM. When the evaluation was conducted the new implementing partner (already in place for 5 months) had not yet received training on financial reporting and the technical staff expressed they needed more consistent feedback to the evaluation reports submitted to the IOM. • Administrative issues that delay the release of funds hinder the implementation of the project, delaying actions and threatening the success of the project.

Conclusion

Lesotho has a long standing tradition of its population (mainly men though that is changing in recent years) migrating, primarily to South Africa for work and the issue of migrant health is a real priority for the government. The country experiences primarily circular migration – the migrant travels outside of the country for work and eventually returns home either seasonally or permanently. As a migrating country the issue of migrant health is a real priority for the government. There is real commitment in terms of policies and budget allocation to the issue. However, as a poor country with one of the highest prevalence of HIV and TB in the world, resources fall short.

IOM is in a unique position in Lesotho to further the agenda on migrant health. As a well-respected organization with a long standing tradition in the region working on the issue, it can truly be a driving force for real improvement in the health of migrants and migrant-affected communities.

One of the most significant aspects of the work done in Lesotho is what pertains to the creation of the Migration and Health Partnership Forum. It has helped to bring together the different organizations and government agencies that work on the matter and has created a space where they can exchange their know-how, their experiences, build alliances, and reduce duplication of efforts. The Forum has opened a great opportunity that the IOM needs to further capitalize on to strengthen its position as an expert organization on the matter.

Concerning the services provided, and particularly in Leribe province where the Implementing Partner carries out the sensitization and prevention actions, the project offers a good opportunity for migrant affected communities to further their knowledge and awareness of health issues and to receive support from the Change Agents. In terms of the work done by the Change Agents it is regarded as very valuable by the community and needs to be further strengthened and expanded.

Person Interviewed	Organization
Dr. Maama	Ministry of Health
Dr. Marealle	Ministry of Health
Mrs. Moliehi Rmonate	Ministry of Labour
Mr. Lebitsa	Ministy of Labour
Ms. Puleng Letsie	UNAIDS
Mrs. Anaita Singh	Clinton Health Access Initiative (CHAI)
Mr. Isaacs ShaFiQ	Miner's development Association (MDA)
Mr. Rantso Manti	Ex- Miners Association
Mrs Mohlomi	Ex-Miners Association
Mr. Lerato Nkhetse	Migrant Workers Association
Mr. Ramosoeu	Call for Africa Development
Mr. Ndumiso Tshuma	CARE
Director and Project Coordinator	Phelisanang Bophelong

Annex 2: Data Collection Tools

Desk Review

Documents/files reviewed

IOM Website

Files received from IOM

- 2009 SADC Policy Framework for Population Mobility and Communicable Diseases
- 2011 PHAMESA Annual Report
- 2012 PHAMESA Strategic Meeting Report
- 2015 final monitoring visit –care SA
- 2015 Lesotho Monitoring Visit Report
- 2015 Swaziland Monitoring Visit Report
- 2016 Kenya Country Workplan
- 2016 RSA Workplan
- 2016 Swaziland ME Support Visit Report
- 2016 Zambia Workplan
- Baseline Assessment 2009 PHAMSA
- Baseline Assessment and Strategy of PHAMESA II Programme: South Africa
- Baseline Outcome 1, 2, 4 Samuel Hall.
- Call for Applications Baseline assessment and development of strategic plans for PHAMESA East Africa countries (Kenya, Tanzania, Uganda)
- Change agents curriculum
- Change Agents Curriculum (Beginning – Intermediate)
- Declaration of Tuberculosis in the Mining Sector 2012
- DOCUMENT (2015-2016)2014 PHAMESA Annual Meeting Report
- Dutch Baseline Mozambique Report 2015
- Dutch Baseline South Africa 2015
- Emails exchanged with countries during data cleaning processes
- Final MRF Report PHAMSA II
- Final PHAMESA Evaluation Report Mauritius and the Indian Ocean Countries Work Plan Budget
- Final Regional Mining Reponse IOM VSO Proposal
- Final SADC HRH Strategic Plan 2007- 2019
- Health Care Professionals Training Material
- Health of Migrants WHA61.17
- Improving access to healthcare services for migrants, mobile populations, and affected communities: Capacity building for healthcare providers
- IOM PHAMESA End of Project report 2010-2013
- Kenya 2 year proposal
- Lesotho 2 year Programme Proposal
- Lessons and Reflections from 84 Sida Decentralized Evaluations 2013 – a Synthesis Review
- Migration and Health in South Africa
- Migration Initiatives 2014, 2015 & 2016
- PHAMESA Baseline Botswana
- PHAMESA Baseline Mozambique
- PHAMESA Baseline Regional
- PHAMESA Country Projects
- PHAMESA East Africa Baseline Survey Report (Kenya – Uganda – Tanzania) & Annexes
- PHAMESA Factsheet
- PHAMESA II 2015-2016 IOM
- PHAMESA II 2016 Narrative report RSA

- PHAMESA II consolidated annual work plans 2016
- PHAMESA II 2015 - 2017 Master Programme Database
- PHAMESA II Annual Reports 2014 and 2015
- PHAMESA II country Projects
- PHAMESA II Final Indicator Protocol
- PHAMESA II Indicators Final
- PHAMESA II Media Strategy
- PHAMESA II Narrative report 2016 KE
- PHAMESA II Narrative Reporting template
- PHAMESA II Progress to Date –data report
- PHAMESA II Zambia annual report Mar 2015
- PHAMESA RBM
- PHAMSA II End of Project Report
- Proposal to the donor November 2013 PHAMESA II
- Regional HIV&AIDS Team Contribution Overview
- Regional Strategy for Southern Africa 2014-2016
- Regional Synthesis
- Report of the 1st PHAMESA Senior Management Committee Meeting
- RIPFUMELO Final Evaluation Report
- Ripfumelo II Project Description
- SA National Strategic Plan on HIV, STIs & TB
- SA Vision 2030
- SADC National & Sector HIV/AIDS Policies in Member States
- SADC Ports Regional Synthesis Report Abstract
- South Africa and Zambia 2 years proposal
- Sustainable Goals Fact Sheet
- TB in the mines declaration
- Theory of change document

Other files found online

- PHAMESA YouTube video
- PHAMESA II YouTube video Kenya
- Newsletters June and Sept 2015
- PHAMESA I end of Project Evaluation Report
- Migration context in Africa and flows –various publications.
- PHAMESA Newsletters

Peer Review

2.1.1 Example of training activity

1. **Peer interviewer workshop**

INTRODUCTION

Why do you think you have been invited to talk to us?

Why did you come here today?

Explain what the peer review is and how you can help us: an introduction

Have you ever interviewed other people? Tell us about that experience

THE BASICS OF ETHICS

Ask participants the following questions to get the ball rolling. Put their answers on two separate flipchart papers if available – one labelled 'DO' and the other labelled 'DON'T'.

2. What do you think you SHOULD do during an interview?

3. What do you think you should NOT do during an interview?

Add to the list any important issues that may be missing. Included on the list should be the following:

DO	DON'T
Ask people if they want to participant before interviewing them; allow them to leave if they want to	Use interviewees names when telling their stories to the external review team or anyone
Obtain interviewees full, informed consent	Pay interviewees any money
Create a comfortable environment	Force someone to participate against their will
Clarify your objectives as well as the time commitment needed from interviewee	Laugh or joke about anything the interviewee tells you
Ensure that no harm comes to the participant	Judge anyone
Keep everything that interviewees say confidential	Interrupt interviewees
Remain neutral; maintain a professional tone and manner	
Dress informally and avoid over-the-top formalities	
Be a good listener!	
Conduct the interview in a place where the interviewee feels comfortable and that ensures his/her privacy	

WHO IS A PEER?

Ask peer interviewers who they think their peers are in general. Then, explain that for the purposes of this project, a peer is someone else who has benefitted from the project.

HELLO, HOW DO YOU DO?

How would you begin an interview? Would you just jump in? Make sure that you do the following when you approach someone:

1. Introduce yourself

2. Say which organization you're with (show badge if applicable)

3. Tell them about what you're doing – capturing stories of change, how lives have been changed as result of X project

4. Ask them whether they'd like to participate

5. Remind them that everything will be confidential and anonymous; no names will be used – only male/female and age

6. Get their final permission (again!)

7. Ask them where they'd like to have the interview – a space with privacy!

8. Do they have any questions before you start?

- ROLE PLAY: You may want to act out the above so that the peer interviewers can witness a good introduction. Ask one of the peer interviewers to role play with you.

14:15 PREPARING INTERVIEW QUESTIONS

If you wanted to find out how the **X** project has make a difference in your peers' lives, what questions would you ask?

Ask them to work together and give us some ideas. Complement their ideas e.g.:

- How did you get involved in the project? Why?
- What different has the project made to you, and how?
- If you have observed any positive or negative changes from your participation in this project, what has been the most important to you? Why?
- What difference has the project made to other people like you? Why?
- What is the most important aspect of the project to you?
- What have you found most challenging?
- What recommendations would you give to IOM for future projects like this?

WHAT IF THEY GIVE SHORT ANSWERS?

Explain to peer interviewers that sometimes interviewees can feel shy and not know how to answer questions. It's our job, as interviewers, to help them by asking questions that will help trigger their memory and feel comfortable in answering.

- ROLE PLAY: The facilitator is the interviewer, and he/she interviews either the other facilitator or a volunteer. The first question that the facilitator asks is 'How did you get involved in project?' The interviewee responds, 'A friend told me about it.' The facilitator stops at this point to ask the peer interviewers what they would ask next to get the information they need. The facilitator then provides examples of how to probe:
    - What did your friend tell you about?
    - How did your friend know about it?
    - When your friend told you, how did you react?
    - What happened after your friend told you?
    - What was your friend's experience of the project? Did he/she like it? If so, why?

What is the difference between probing and leading questions? Which one of the following is a probing question?

- How did you find out about the project?
- You found out about the project through a friend, didn't you?

Why do we want to avoid leading questions? Would it still be the interviewee's story? Reiterate the importance of probing, rather than 'leading'. The whole point of the PEER review is to listen to our peers' stories of change!

REMEMBERING THE STORIES

Explain we will be there as note takers

MAKE FINAL ARRANGEMENTS:

How to report back?

IDs to identify themselves as peer reviewers

Logistics

Etc.

Example of Peer Review questionnaire

Note: we will use the word project, programme, initiative or the name of the project when referring to PHAMESA II, based on how the beneficiaries identify this work at local level.

- Name (do you prefer a particular way for me to call you?)
- Age
- Tell me about you:
    - Have you always lived in this community? If not, where are you from? How long ago did you come? What was the main reason that brought you here? Is your family here with you? What do you do for a living?
    - Have you always lived in this community? If yes, is your family here with you? What do you do for a living?
- Tell me about your involvement in this project?
    - Have you participated in any education or information activities? Where the topics covered important to you? Why? Are there things you learned in those activities that you are using/practicing now?
    - Have you received any health services by IOM/Implementing partner? What services? Why would you say those services were important to you?
    - What would you say is the most important positive or negative change this project has made so far in your life?
- What different has the project made to you so far?
- What difference has the project made to other people like you? Why?
- What recommendations would you give to the implementers to improve the lives of people in this community?

Semi-structured interviews key stakeholders

A. INTRODUCTION: objectives of the mid-term review; interviewers, etc.
B. Interviewee information: Name, Role, Time of Involvement in Current Role
C. General information about the migration context/needs in the country
1. What do you perceive are the main needs/concerns in terms of migration and health in your environment (country/county/community depending on interviewee role)?
2. From what you know in your involvement with PHAMESA II, how this initiative is contributing to address those needs/concerns? What are the gaps? How PHAMESA II could fill those gaps?

D. current/past collaboration with IOM-PHAMESA II (identify to what outcomes/outputs this collaboration contributes to) :
1. Tell me about your involvement with the PHAMESA II initiative?
2. What do you consider are the main achievements of your collaboration with the PHAMESA II initiative?

3. What do you consider are the main challenges in your collaboration with the PHAMESA II initiative?
4. From what you know, what would you say is the main achievement of PHAMESA in your (country/county/community depending on interviewee role)?
5. Tell me more about the partnership/collaboration: what factors have contributed to a healthy collaboration? What factors may have created barriers for a healthy, effective and efficient collaboration?
6. What would it be your main recommendation for the PHAMESA II program for the next two years?

Semi-structured interviews regional/country staff PHAMESA II

A. INTRODUCTION: objectives of the mid-term review; interviewers, etc.
B. Interviewee information: Name, Role, Time of Involvement in Current Role
C. General information about the migration context/needs
3. What do you perceive are the main needs/concerns in terms of migration and health in your environment (region/country/county/community depending on interviewee role)?
4. How do you think PHAMESA II is contributing to address those needs/concerns? What are the gaps? How PHAMESA II could fill those gaps?
5. What would you highlight as the main difference (positive "evolution") from PHAMESA to PHAMESA II? (use examples from the recommendations of the PHAMESA I evaluation)
6. Let´s discuss about the theory of change developed to inform decision making processes in PHAMESA II – What have been the advantages of using a theory of change? How implementation has contributed to test the hypotheses that underpin your theory of change? Do you foresee any changes in your theory of change as a result of what you know today after two years of implementation?
7. Let´s discuss about the concept of "spaces of vulnerability": what have been the advantages of this framework? How has it impacted the way the work is implemented?
8. Let´s discuss about the RBM approach: what have been the advantages of this framework? How has it impacted the way the work is implemented?
9. Let´s discuss about partnerships. We understand partnerships are key to the successful implementation of PHAMESA II. What are the advantages and challenges of working in partnership? What have been the most positive outcomes of this work in partnership? What do you think partners gain from their collaboration with IOM?
10. Let's discuss about the use of the SDCB framework. How does it help the implementation of interventions linked to outcome 3?
11. What do you consider are the main achievements of PHAMESA II over the last two years? What do you attribute these achievements to?
12. What do you consider have been the main challenges for PHAMESA II over the last two years? How such challenges have been addressed? Which ones remain?
13. How efficient and effective have the programme's management, monitoring, evaluation and learning (MEL), quality control and financial systems been? What capacity gaps existed and have these been overcome?
14. Additional questions based on the specific role of the interviewee.

Focus groups beneficiaries

Note: in situ questions will be formulated in a more "friendly" / easy to understand/ informal way.

STEP 1: Introduction, rules, verbal consent

STEP 2: Profile

1. Let's do a quick round of introductions. Can each of you tell the group your name, what do you do for a living and how long have you been living in x community?

STEP 3: Questions

2. Let's talk a bit about migration here….Could you share information about how migration has impacted this community over the last few years?
3. Let's talk about the health needs in your community? What do you perceive as the main health needs of people in this community? Why do you think people have those needs?
4. We understand that you have participated in education activities with IOM. Do you think the information provided in the context of these activities contribute to address the health needs you just mention? How?
5. What are the main barriers to access health services in this community? Have you seen any changes/improvement in health services in this area over the last two years? Provide examples
6. What other things you would like to see in these education/information activities in the future? What are the things/contents that would make the biggest difference for people in the community?

Focus groups health workers

This guide provides general guidance –it needs to be adapted to cover issues that have more focus in some countries (e.g. GBV in Zambia)

STEP 1: Introduction, rules, verbal consent

STEP 2: Profile

1. Let's do a quick round of introductions. Can each of you tell the group your name, your job and for how long have you been doing this job?

STEP 3: Questions

2. Let's talk a bit about migration….Could you share information about how migration has impacted this community over the last few years? How has it impacted the health services?
3. What do you consider the main barriers for migrants to access health services here?
4. How are your health facilities responding to the needs of the migrant communities? Do you think they are doing enough? Why yes? Why not?
5. How are the health services adapting to incorporate/consider migration issues in service delivery?
6. What would be the characteristics of a service that is prepared to address the needs of migrant communities?
7. What would be the characteristics of a health worker who is prepared to address the needs of migrant communities? Provide examples
8. We understand you have participated in the PHAMESA II initiative. What would you say are the most positive things that the PHAMESA II has contributed to the health services in this area? What other support is required to continue improving the services provided to migrant communities?

Focus groups change agents

STEP 1: Introduction, rules, verbal consent

STEP 2: Profile

1. Let's do a quick round of introductions. Can each of you tell the group your name? How long have you been living in x community? How and when you became a Change Agent?

STEP 3: Questions

1. Let's talk a bit about migration….Could you share information about how migration has impacted this community over the last few years?
2. What do you see as the main health needs of the populations you serve?
3. What do you consider the main barriers for migrants to access health care here?
4. What do you feel is the main contribution of Change Agents to the community? How Change Agents contribute to minimize barriers to access health care for migrant and other vulnerable communities?
5. What Change Agents could do better in order to address the needs of migrants and other vulnerable groups?
6. Do you feel supported (having necessary tools, training, for example) to implement your work? How this could be better?

Online Survey

Mid-term review process PHAMESA II

Welcome!

As you may know, IOM is currently implementing a mid-term review (MTR) process for the PHAMESA II programme. The MTR aims to ascertain whether the program is on track in terms of progress towards the main goal and to draw lessons and propose recommendations to inform improvement decisions.

The MTR involves the implementation of different evaluation methods by an external consultancy team. From April to end of May, the consultancy team will implement a desk review, key informants´ interviews, field visits to Kenya, Zambia and Lesotho (interviews, focus groups and peer review methodology) and an online survey.

This online survey helps us to ensure everyone has their voice heard for this MTR. The survey targets IOM´s staff involved in the implementation of PHAMESA II at all levels -country level, regional level and headquarters. The questions aim to gather your views about PHAMESA II´s approach, processes/systems, achievements and areas of improvement.

Please complete this anonymous short survey (approx. 15 minutes required from your time) before Thursday 26th of May 2016. If you have any questions, please send an email to: Marcela Rueda G. lmruedagomez@gmail.com

Best regards,

Mid-term review consultancy team

About you

* 1. Type of involvement in PHAMESA II (select the option that best describe your involvement with the programme)

* 2. Number of months/years you have supported the implementation of PHAMESA

PHAMESA II Design

* 3. Were you involved in the design process of PHAMESA II? (e.g. development of the proposal for the donor, development of theory of change, discussion process leading to the final proposal submitted to the donor)

* 4. For the following statements choose "Totally agree", "partially agree", "partially disagree", "totally disagree"

	Totally agree	Partially agree	Partially disagree	Totally disagree
PHAMESA II design process took into consideration the recommendations from the end-line evaluation of PHAMESA I (e.g. the recommendations were discussed during design meetings; an action plan was made to address key recommendations)	○	○	○	○
PHAMESA II design process involved all relevant internal key stakeholders (headquarters/regional/country level staff with expertise/direct responsibilities in the field of migration and health)	○	○	○	○
PHAMESA II design process involved relevant external key stakeholders (e.g. partners, other agencies, key experts in the fields of migration, HIV, sexual and reproductive health, etc.)	○	○	○	○
PHAMESA II design process took into consideration existing evidence (including evidence produced under previous phases of PHAMESA/PHAMSA) on migration and health to develop its results framework.	○	○	○	○
PHAMESA II design process was an opportunity to discuss IOM´s specific niche in the field of health an migration (e.g. by doing a SWOT analysis, by discussing what other stakeholders are doing, by discussing what is the value added of IOM).	○	○	○	○
The development of the results based framework was informed by a participatory theory of change process	○	○	○	○

* 5. For the following statements please choose "Totally agree", "partially agree", "partially disagree", "totally disagree" or "N/A" (choose "N/A" if you feel you do not have information about these components of the programme due to the nature of your role)

	Totally agree	Partially agree	Partially disagree	Totally disagree	N/A
The results based framework has given us the opportunity to prioritize our interventions	○	○	○	○	○
The results based framework has allowed us to define meaningful and measurable indicators	○	○	○	○	○
PHAMESA II´s interventions are informed by existing best practices known to contribute to the achievement of outcomes/outputs of the results based framework	○	○	○	○	○
Outcome 1, 2, 3 and 4 are implemented in an integrated manner (e.g. outcome 1 evidence informs prioritization of advocacy efforts under outcome 2 or adaptations for services/information provided to beneficiaries under outcome 3).	○	○	○	○	○
By focusing in spaces of vulnerability, the PHAMESA II programme has been able to prioritize its interventions	○	○	○	○	○
By focusing in spaces of vulnerability, the PHAMESA II programme has been able to improve its monitoring and evaluation activities.	○	○	○	○	○
By focusing in spaces of vulnerability, the PHAMESA II programme has been able to generate evidence of what works/what does not work for different migrant populations.	○	○	○	○	○
Internally, there is an agreed definition of spaces of vulnerability	○	○	○	○	○
The spaces of vulnerability concept/approach requires further discussion to understand its advantages and limitations	○	○	○	○	○
There is a common understanding on the characteristics/requirements of migrant sensitive health systems, among PHAMESA II staff and implementing partners	○	○	○	○	○
PHAMESA´s II partners, governments and donors understand our unique role in health and migration	○	○	○	○	○

* 6. For the following statements choose "Totally agree", "partially agree", "partially disagree", "totally disagree" or "N/A" (choose "N/A" if you feel you do not have information about the process/system due to the nature of your role)

	Totally agree	Partially agree	Partially disagree	Totally disagree	N/A
PHAMESA II's management structure allows timely decision making for the programme at all levels (e.g financial decisions, annual planning, etc.)	○	○	○	○	○
PHAMESA II's management structure supports decentralised decision making when necessary	○	○	○	○	○
Staff involved in PHAMESA II has a clear understanding of how their job/function contributes to the achievement of the results based framework	○	○	○	○	○
The existing monitoring tools provide enough information to support decision making (e.g to decide outcomes/outputs where an accelerated plan is required, to identify strengths/areas of improvement of an implementing partner)	○	○	○	○	○
PHAMESA II's programme has put in place mechanisms/tools to facilitate effective internal communication.	○	○	○	○	○
PHAMESA II's programme has put in place effective mechanisms/tools to facilitate sharing and learning among regions, country offices and implementing partners	○	○	○	○	○
PHAMESA II's programme has put in place effective mechanisms for data verification and improvement of data quality (e.g. data verification at community level/with implementing partners)	○	○	○	○	○

	Totally agree	Partially agree	Partially disagree	Totally disagree	N/A
PHAMESA II´s programme has put in place mechanisms/tools to assess that services provided under outcome 3 are migrant sensitive (e.g. quality assurance tools); and these mechanisms/tools are utilized across countries.	○	○	○	○	○
The internal financial processes support the smooth implementation of the programme	○	○	○	○	○
The internal human resources processes (e.g. hiring, staff workplan development, etc.) support the smooth implementation of the programme	○	○	○	○	○
PHAMESA II´s reporting tools are clear and user friendly	○	○	○	○	○

PHAMESA II programme achievements and areas of improvement

* 7. What do you see as the main achievements of PHAMESA II over the last two years? (max 60 words)

* 8. What do you see as weaknesses/areas of improvement in the implementation of PHAMESA II over the last two years? (max 60 words)

* 9. Are you aware of any unintended positive outcomes resulting from PHAMESA II? (If yes, please describe the outcome and its significance/value for the programme max 100 words)

10. Describe any potential risks that in your view could affect the implementation of PHAMESA II in the next 18 months (max 60 words)

11. Additional comments (please share additional views/comments to enrich the recommendations of the mid-term review process. max 60 words)

Annex 3. Evaluation Team Bios

Marcela Rueda - Team leader

Marcela brings with her a wealth of expertise and knowledge in the area of international development, gender based violence, sexual and reproductive health services and communication. She holds a Bachelor's degree in Government and International Relations, a Master's degree in Gender, Public Policy and Society and various certificates linked to the area of communication–Risk Communication Strategies Certificate, Creative Writing diploma, Social Science Translation Letter of Certification and Digital Journalism. Over the past 18 years Marcela has served as an advocate, board member and technical expert in various international and local organizations and networks including the International Planned Parenthood Federation (2003-2013), the Youth Advisory Group created by the Director of United Nations Population Fund (2004-2006), the Latin American and Caribbean Youth Network for Sexual and Reproductive Rights (1999-2004) and Profamilia-Colombia (1998-2004). Currently, she manages her own consulting and translation company. Marcela has led initiatives aimed at implementing integrated health services and gender based violence programs globally; to increase youth -particularly young women- participation; to increase access to safe and legal abortion in Latin American and African countries and to develop cervical cancer prevention and treatment initiatives in African countries. She has actively participated in strategic planning processes and initiatives to strengthen NGOs capacity to develop strong proposals and to evaluate projects and programs.

Luis Alcala (field visits)

Luis is an enthusiastic lawyer majoring in politics, with Master´s degrees in Cultural Management and Local Development, Peace and International Cooperation. He brings his expertise in the areas of sexual and reproductive health, gender and violence prevention. For the past seven years, Luis has been involved in the United Nations Population Fund in Honduras, participating in initiatives aimed at improving national and local policy-making capacities on sexual and reproductive rights, comprehensive sexuality education, and young people health services. He also has a wide working experience in community-based interventions to prevent teen pregnancy, sexually transmitted infections and gender based violence.

María Fernanda Salazar (field visits)

María Fernanda has extensive experience working in developing initiatives in Europe, Africa and the Americas with an expertise in gender equality and prevention of gender based violence. She has collaborated with large international organizations such as the International Planned Parenthood Federation in New York as well as with smaller organizations such as Fundación Mujeres in Madrid and grassroots organizations throughout all three continents. She holds a BA in International Relations and Latin American Studies with a minor in Sociocultural Anthropology from New York University and has completed all coursework of a Master's degree in Gender Equality and Violence, with a double specialty in Research and Equality Agent from Universidad Complutense de Madrid. María Fernanda has over 7 years of experience in project development, implementation, evaluation and management in developing countries on issues of human rights, women empowerment, economic development, political participation, prevention of gender based violence, SRHR and global health. She also possesses extensive experience working with youth in developing countries in Africa and Latin America. She is a researcher with demonstrated experience conducting empirical research and the development of tools, documents of recommendation, roadmaps of action, etc.

Lyda Gómez (field visits, migration expert)

Lyda is a migration expert with years of experience working with different types of migrants groups. She holds a Law degree from the Universidad Industrial de Santander in Colombia, with an endorsement

from the Alicante University in Spain. She also holds a Master's degree in Quality Management with a focus on service provision and a Post-graduate Specialization on "Migration, Integration and International Law" and on "Integration, Counseling, and Service Provision to Migrant Groups" all from the University of Valencia in Spain. a Master's degree. She has years of experience working with migrant groups both within non-governmental organizations providing Legal and social support to individuals and collectives from Africa, Asia and Latin America on issues the rights of migrants especially as they pertain to healthcare, employment and education. She has also collaborated on international consultants advising on legal/contractual matters linked to the implementation of international projects. Currently Lyda leads her own law firm focused on migration law in Spain.

Catherine Kahabuka (Tools and reports revision/feedback)

Dr. Kahabuka holds a bachelor degree in Medicine from Muhimbili University, Tanzania (2005) and a PhD in Health Systems from Bergen University, Norway (2012). She has over six years' experience in Health Systems Research, particularly in areas of Maternal, Newborn and Child Health, and recently adolescent's health. Since Jan 2013, Dr. Kahabuka has been working as a consultant for health systems research in Tanzania where she has been providing both technical and implementation support to research projects and health programs under the government and non-governmental organization, including at the national level. Between 2013-2014, Dr. Kahabuka has successful accomplished and/or has ongoing assignments with organizations such as Family Health International (FHI360), Futures Group, International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR), Jhpiego, Johns Hopkins Bloomberg School of Public Health, WaterAid & UK's department for international development (DFID). Dr. Kahabuka currently serves as the CEO and Lead Consultant for CSK Research Solutions, which is a private company dedicated to providing high quality research solutions to inform effective, efficient and sustainable health programs. Kahabuka has strong skills and extensive experience in utilizing both the quantitative and qualitative, as well as mixed research methods. She is conversant with various statistical software such as SPSS, Epidata and N-vivo. She has a total of six publications (first author of four) in peer reviewed international journals, including the Lancet.