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

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Contents

Abbreviations and acronyms

AMICAALL - Alliance of Mayors Initiative for Community Action on AIDS at the Local Level

CA – Change Agent(s)

EAC - East African Community

ESA – East and Southern Africa

GBV – Gender-based Violence

HIV - Human Immunodeficiency Virus

ILO – International Labor Organization

IOM – International Organization for Migration

IP – Implementing Partner

JUPSA – Joint UN Programme of Support on HIV/AIDS

M&E – Monitoring and Evaluation

MTR – Mid-term Review

NGO – Non-governmental Organization

PEPFAR - U.S. President's Emergency Plan for AIDS Relief

PHAMESA – Partnership on Health and Mobility in East and Southern Africa

PHAMSA - Partnership on HIV/AIDS and Mobility in Southern Africa

RBM – Results-based Management

SADC – Southern Africa Development Community

SALGA – Southern Africa Local Government Association

Sida - Swedish International Development Cooperation Agency

SRHR – Sexual and Reproductive Health and Rights

STI - Sexually Transmitted Infection(s)

TB – Tuberculosis

UNAIDS - Joint United Nations Programme on HIV and AIDS

UNDP – United Nations Development Programme

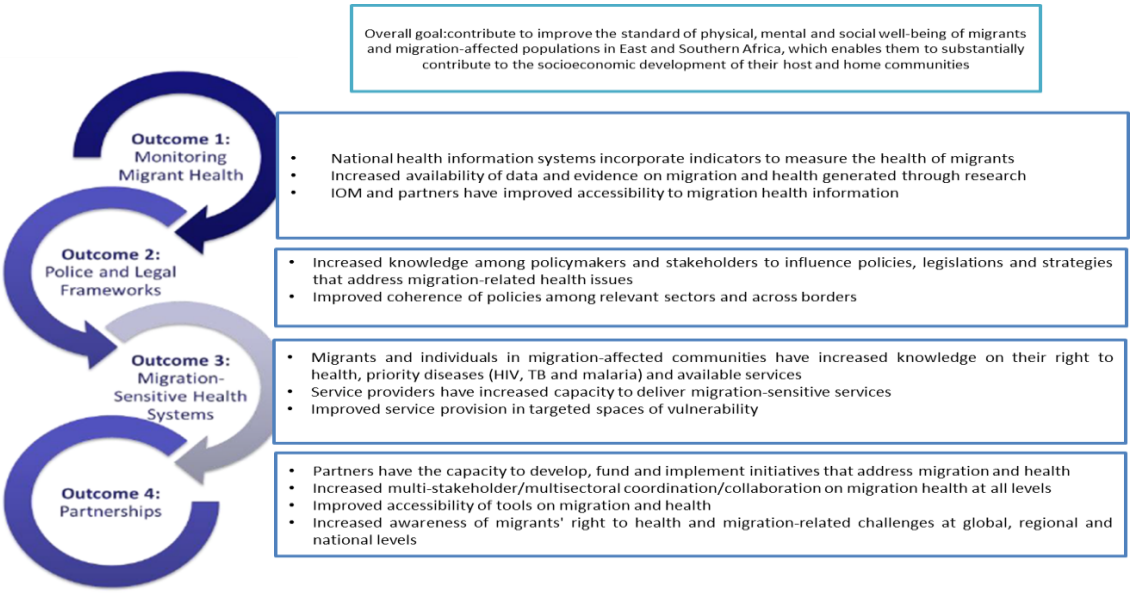
USAID – United States Agency for International Development

WHA - World Health Assembly

Executive Summary

The Partnership on Health and Mobility in East and Southern Africa (PHAMESA) programme has been active since 2010. Prior to PHAMESA, a similar programme, The Partnership on HIV/AIDS and Mobile Populations in Southern Africa (PHAMSA) had been implemented in Southern Africa only, and was focused on HIV/AIDS and mobility. PHAMESA is an expansion of PHAMSA both in terms of geographical coverage with the inclusion of East Africa, and also thematically with a broader focus on health in general. The expanded programme is currently in its second phase (January 2014-December 2017). The PHAMESA II programme follows a result-based management (RBM) approach, emphasizing a shift away from inputs and activities to focus on the achievement of immediate, intermediate, and long term results guided by a dynamic theory of change:

Diagram I. PHAMESA II programme results-based management framework



In order to achieve these results, IOM has implemented a comprehensive package of interventions that addresses not only direct health needs, but also social determinants of health at the individual, institutional, and structural/normative levels. PHAMESA also utilizes a spaces of vulnerability (SOV) approach, targeting geographical areas where migrants and communities interact, which can lead to increased health vulnerability. In addition, PHAMESA takes a regional approach to health programming in order to address region-wide factors that impact the health of migrants and migration-affected communities at any point of the migration processes.

In April 2016, IOM contracted a mid-term review (MTR) to ascertain whether the program is on track in terms of progress towards the main goal. The MTR is also meant to assess the programme performance against the five OECD/DAC standard mid-term review criteria, including sustainability, relevance, efficiency, and effectiveness, as well as impact.

The scope of the MTR was defined in terms of the duration of the programme, seed funding provided by Sida, geographical coverage, target groups, and the results framework defined by the programme. Evaluation questions were prepared to assess each OECD/DAC criteria. The evaluation methods used during the mid-term review include a desk review, key informant interviews, focus groups (with beneficiaries, health providers, and change agents) and a peer review methodology –an adapted version of the participatory ethnographic evaluation and research method in which members of the beneficiary group conduct conversational reviews with other people involved in the program to hear their stories and perspectives.

Findings

Relevance

The PHAMESA II programme supports the operationalization of global and regional priorities on migration and health. The programme is aligned with World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants (2008), and is also consistent with IOM's institutional priorities on the issue, providing opportunities to build institutional partnerships and collaborations and to transfer lessons learned to other projects run by the organization. The programme has supported the development and implementation of numerous initiatives on migration by the Regional Economic Communities, contributing to the recognition of migrants as a key population. Through the implementation of interventions consistent with its results-based framework and based on needs assessment at the country and SOV level, PHAMESA II responds to some of the most significant issues affecting the health of migrant communities in Eastern and Southern Africa. These issues include communicable diseases, struggling public healthcare systems, lack of recognition and prioritization of migrants in public policies, and dominant perceptions that migrants are bearers of diseases. Issues such as maternal mortality and morbidity, unplanned pregnancy, sexual and reproductive health and rights in general, and non-communicable diseases are also critical health needs among migrant communities and are addressed through punctual interventions, including by incorporating training on these issues when working with health providers and Change Agents. Areas that require further attention in terms of relevance are consistency with donors' priorities. A shift in donor focus from stand-alone HIV programmes or HIV/TB focused programmes to broader agendas (e.g. SRHR in the case of Sida[i]), means that PHAMESA II needs to reassess its entry points for programming and partnerships.

Effectiveness and impact

For the 2014-2015 period, the PHAMESA II programme showed progress for the majority of output level indicators (the only exception being output 1.3.1 "One operational migration health knowledge-sharing platform", however key informants have confirmed efforts to complete this task are currently being implemented in 2016). Interventions to support the achievement of outcomes and output level indicators have been implemented in partnership with a diverse group of partners, including the Regional Economic Communities, public authorities, international agencies, universities, migrants' associations, and NGOs, among others. The achievement of Outcome 3 (migrant-sensitive services) has been guided by a Service Delivery and Capacity Building (SDCB) Framework for the implementation of efforts to generate demand, enable the supply of services, and create an enabling environment with the support of implementing partners and Change Agents. Areas that require further attention in terms of effectiveness include a better dissemination of the information available on migration and health among partners, increased efforts to monitor and ensure implementation of all legislative/regulatory gains, improved incentive systems for Change Agents working at the SOV level, and the availability of standardized tools to measure/improve the level of migrant sensitivity in health services.

In terms of impact, the MTR methodology does not include strong enough evaluation methods to assess the achievement of impact indicators (e.g. population based surveys, data from health surveillance systems, scale). The evaluation team captured beneficiaries' perceptions about the impact of the programme (at individual or community level), including identifying preliminary, positive changes in terms of positive perception about their health and well-being, changes in lifestyle to improve their health, and self-efficacy in making behavior change decisions.

Efficiency

Different factors were assessed within this criterion:

- The efficiency of the seed funding model to address migration health problems in the bi-regional programme: Over the last two years, the PHAMESA II programme has secured multi-million dollar funding to tackle health risks associated with migration through collaborations at the regional level, has supported partner organizations in securing international funding, and has implemented shared-cost initiatives with several partners at the country level. The amount of funds leveraged by IOM and partners to strengthen migration health programmes/initiatives in Eastern and Southern Africa through December 2015 totals US $3,286,956 (out of the US $12,000,000 target committed for the PHAMESA II Programme), well below the expected outcome.
- The contribution of spaces of vulnerability to a more efficient use of resources: The SOV approach has contributed not only to the relevance and effectiveness of the PHAMESA II programme (see 'Relevance and Effectiveness' section), but has also contributed to a more efficient use of resources. The SOV approach contributes to a better

prioritization and identification of partners and primary beneficiaries to generate evidence of what works/what does not work for different migrant/host populations.

- The efficiency of PHAMESA II management arrangements: Following recommendations from the PHAMESA I endline evaluation, and in order to better respond to the commitments under the RBM, IOM adapted the PHAMESA II programme management structure. While these changes have contributed to the successful implementation of the programme, further adaptations could strengthen the efficiency of certain decision-making processes.
- The efficiency of other functions and processes: PHAMESA II has many strengths in the monitoring and evaluation area. However, further action is required to strengthen data quality, particularly in the areas of consistency, completeness, and validity. In terms of learning systems in place, the evaluation team did not identify sufficient opportunities to promote exchange of lessons learned across countries and implementing partners.

Sustainability

PHAMESA II has put in place measures to ensure continuation of efforts in the long-term. These efforts are consistent with recommendations from authoritative sources on influencers/enablers of sustainable programmes, and include measures to ensure political support, ensure sustained funding, build ownership at different levels, and strengthen capacities and structures.

Recommendations

Based on the findings presented above, a set of recommendations has been articulated by the MTR team. These recommendations aim to improve the programme's business processes, as well as to position IOM to achieve its desired outcomes. Recommendations are included on the main report and linked to specific findings on relevance, effectiveness, efficiency and sustainability.

Mid-term Review Scope & Methodology

Mid-term review background[ii]

The Partnership on Health and Mobility in East and Southern Africa (PHAMESA) programme has been active since 2010. Prior to PHAMESA, a similar programme, The Partnership on HIV/AIDS and Mobile Populations in Southern Africa (PHAMSA) had been implemented in Southern Africa only, and was focused on HIV/AIDS and mobility. PHAMESA is an expansion of PHAMSA both in terms of geographical coverage with the inclusion of East Africa, and also thematically with a broader focus on health in general. The expanded programme is currently in its second phase (January 2014-December 2017). The PHAMESA II programme follows a result-based management (RBM) approach, emphasizing a shift away from inputs and activities to focus on the achievement of immediate, intermediate, and long term results guided by a dynamic theory of change. Additionally, the Swedish government (the main donor) requires periodic, external mid-term reviews to ascertain whether the programme is on track in terms of progress towards the main goal, as well as to identify lessons learned and present recommendations to inform decisions regarding programme improvement.

The main purpose of this mid-term review (MTR) is to evaluate the programme's performance against the desired results as articulated in the associated result framework. The MTR will also assess the programme's performance against the five OECD/DAC standard mid-term review criteria, including sustainability, relevance, efficiency and effectiveness, as well as impact. The resulting recommendations will be used to improve the programme's business processes, as well as position the programme to achieve the desired results in the most sustainable, effective, and efficient manner.

Mid-term review specific objectives[iii]

1. Assess the PHAMESA II programme progress towards the realization of its intermediate and long-term results to date;

2. Assess whether the PHAMESA II programme is on track against the five OECD/DAC mid-term review criteria (relevance, effectiveness, efficiency, sustainability, impact);

3. Analyze PHAMESA programme processes (planning and budgeting, implementation, monitoring and evaluation (M&E), resource mobilization, and knowledge management), identify strengths and weaknesses, and make recommendations for improving programme implementation;

4. Assess the quality and effectiveness of PHAMESA II technical and implementation partnerships on regional, national, and local levels;

5. Ascertain the extent to which the PHAMESA I (2010-2013) end-term recommendations have been implemented during PHAMESA II;

6. Highlight the most significant achievements that the programme has had so far and identify programme components or aspects that lead to the observed results;

7. Identify key success stories, emerging best practices, and lessons learned during the first two years of PHAMESA II and develop recommendations to inform and improve programme direction.

Mid-term review scope[iv]

The scope of the MTR considers the duration of the programme, seed funding provided by the Swedish International Development Cooperation Agency (Sida), geographical coverage, target groups, and the results framework defined by the programme.

Programme Period: 01 January 2014 – 31 December 2017
Geographical Coverage: East and Southern Africa –Focus countries and spaces of vulnerability within these countries: Kenya, Tanzania, Uganda, Angola, South Africa, Lesotho, Mozambique, Zambia, Swaziland, Mauritius, Namibia, Botswana
Programme Beneficiaries: Migrants, in particular, migrant workers, family members, asylum seekers, refugees, displaced persons, communities affected by migration, government officials, healthcare workers

Programme Goal and Results Framework:
Overarching goal: Improve the standard of physical, mental, and social wellbeing of migrants and migration-affected populations in East and Southern Africa, enabling them to substantially contribute towards the social and economic development of their communities.
Programme Outcomes:
1. Improved monitoring of migrants' health to inform policy and practices;
2. Policies, legislations, and strategies comply with international, regional, and national obligations with respect to the right to health of migrants;
3. Migrants and migration-affected communities have access to and use migration-sensitive health services in targeted spaces of vulnerability in countries of origin, transit, and destination; and
4. Strengthened multi-country/sectoral partnerships and networks for effective and sustainable response to migration and health challenges in East and Southern Africa.
Programme Partners: Regional Economic Communities (COMESA, EAC, IGAD, and SADC), national AIDS councils and commissions, Ministries of Health, Ministries of sectors dealing with migration (Agriculture, Home Affairs, Labour, Maritime, Mining, Public Works, Transport, etc.), private sector companies, unions, UN Partners (ILO, UNAIDS, UNHCR, UNICEF, WHO, WFP), international and local civil society organizations (CSOs), and community-based organizations (CBOs)
Seed Funding Available: Sida Contribution: $ 13,250,001

Mid-term review design

Criteria and questions

The mid-term review applied the five OECD/DAC criteria for evaluating development assistance: effectiveness, relevance, impact, efficiency, and sustainability.[v] Specific questions were developed and refined to further define each criteria (listed under "Findings" for each criteria).

Guiding principles

The mid-term review evaluation team employed the following set of guiding principles: leading with purpose, involving beneficiaries and stakeholders from all levels of intervention, maximizing rigor without compromising relevance, and inclusiveness and sensitivity to the diverse needs and backgrounds of beneficiaries.[vi]

Approach, methods, and sampling strategy

Based on the guiding principles and keeping in mind the need to gather information to assess all criteria and questions, the mid-term review contemplated complementary evaluation approaches: participatory evaluation, beneficiary and stakeholders assessment, case study, and stories of change –how things were envisioned, how things were done, successful/less successful efforts along the way and adaptation to challenges and changes within the context.[vii]

The implementation of the evaluation approaches took into account all levels of intervention in PHAMESA II –including spaces of vulnerability (SOVs) and local/national and regional levels. Regarding spaces of vulnerability and local/national levels, three countries were selected for field visits –Kenya, Lesotho, and Zambia (see Annex 2 for Country visit plans, Visit reports, and Stakeholders interviewed). These countries were selected in consultation with the PHAMESA II team, using the following criteria:

- Geographical representation: At least one country from the Eastern region and one from the Southern region;
- Significant PHAMESA II intervention: Countries where the initiative targets diverse spaces of vulnerability and where the country is working towards various components of the theory of change;
- A combination of countries of origin, transit, and destination;
- Previous evaluations: In order to avoid fatigue in local teams, we sought to prioritize countries that have not been/will not be involved in a similar evaluation;
- Possibility of meeting a combination of regional + country level staff;
- Availability and willingness to coordinate the visit in the short timeframe allocated for the review;
- Ease of obtaining government authorization/support for implementing the mid-term review.

Data collection methods

The mid-term review data collection methods are explained below (See Annex 3 to access the data collection tools).

Desk review: The team reviewed relevant programme annual reports, work plans, proposals, strategy documents, theory of change documents, PHAMESA I evaluations, newsletters, etc., pertaining both to the regional initiative as well as to the specific projects implemented in the countries selected for field visits. To access a complete list of documentation reviewed, see Annex 4.

Key informants: Semi-structured interviews lasting approx. 45 minutes with relevant staff at headquarters on a regional/country level, a representative of Sida, and key partners/implementers. The interviews prioritized different evaluation questions depending on the stakeholder's profile and level of involvement in the implementation of the PHAMESA II programme. When possible, the interviews were conducted in person, and by phone/Skype if it was impossible to meet in person.

Sampling as per inception report[viii]

- Semi-structured interviews with PHAMESA programme staff– maximum 10 people from headquarters on a regional level and maximum 3 country programme coordinators
    - Criteria used to select interviewees:
        - Overall programme manager, M&E staff, outcome leads, finance role, media/communications role, 3 country programme coordinators, one key MHD member at HQ (Geneva level)
- Semi-structured interviews with partners/implementers:
    - Criteria used to select interviewees:
        - Regional level: 3 participants (representatives from multi-country/sectoral partnerships and networks that have actively participated in the implementation of Outcome 4)
        - Country level: 12 per country (max. 15 if the local teams felt the need to increase the number), ensuring a mix between international agencies/organizations, public sector, national and local level authorities -including statistics/surveillance agencies when relevant-, migrant associations, implementing partners, academic/university representatives
- Semi-structured interviews Sida representative:
    - Criteria used to select interviewees:
        - Donor representative involved in the monitoring of PHAMESA II

Participation

Table I. Participation of stakeholders in semi-structured interviews

Country	Inception report: PHAMESA staff	Actual participation: PHAMESA staff	Inception report: Key stakeholder/partner participation	Actual participation: Key stakeholders/partners	Inception report: Donor representative	Actual participation: Donor representative
Kenya	1	2	12	9		
Zambia	1	3	12	8 interviews (14 participants, as some interviews had more than 1 participant)		
Lesotho	1	2	12	14		
Regional	6	8	3	2		
Headquarters	1	0				
Donor					1	1***
Total	10	15*	39	33**		

Reasons for variances

* In order to get additional perspectives and more in-depth information on the programme implementation on different levels, we interviewed 4 additional staff members at the country level and 2 additional staff members at the regional level. Invites were sent to staff members at headquarters, however no staff members confirmed and the interview did not take place. In light of this, HQ staff was invited to participate in the online survey. Although it was not included in the inception report, invites were also extended to arrange semi-structured interviews with additional country level staff (beyond the three selected countries). Due to conflicting schedules, these additional interviews were not conducted, but staff members were nevertheless invited to participate in the online survey.

** In Kenya the team faced the limitation that some stakeholders were unavailable during the field visits. In order to address this limitation, the consultants were as flexible as possible (within the schedule approved by IOM to submit the reports), offering the option of meeting face to face or of conducting the interviews via telephone or Skype in an attempt to adapt to the availability of the interviewees. Regarding Regional Partners, there is negative variance of 1 person. This is due to the availability of interviewees during the dates suggested for the interviews.

***This interview was conducted after submission of the draft report, meaning the donor representative was aware of the MTR findings at the time of the interview.

Informal interviews and conversations were also held with local personnel encountered by the consultants during their field visits. Said interviews offered different points of view and were a valuable source of information and an opportunity to corroborate data obtained through the formal methodology. For example, during the field visit in Lesotho, the team was able to visit one of the government clinics where PHAMESA beneficiaries are referred and took advantage of the opportunity to engage in informative conversations with the clinic staff. This was an excellent opportunity to corroborate some of the issues that had emerged during the focus groups and interviews with beneficiaries, as well as the information found in the reports.

Online survey (Survey Monkey): This short survey was an opportunity to engage with the IOM staff involved in PHAMESA II. The survey prioritized closed questions to facilitate completion, analysis, and standardization of the information. However, a few open questions were also included to gather the participants' perspectives and recommendations, contributing to the triangulation of the data obtained through other evaluation methods (e.g. recommendations obtained through the semi-structured interviews). The survey was targeted to PHAMESA staff at headquarters, regional, and country levels. As indicated on the inception report, the survey was not used to assess impact or sustainability criteria.

Sampling as per inception report

- Inclusion criteria – any role in the design/implementation/monitoring of the PHAMESA II programme at a regional or country level
- Exclusion criteria –participation in semi-structured interviews

Participation

Of the 27 invited staff members, a total of 12 participated in the survey: 41.7% had country level responsibilities with direct participation in PHAMESA II; 25% had regional/headquarters level responsibilities with direct participation in the project; 16.7% had a supporting role in the project at country level; and 16.7% had a supporting role at regional/headquarters levels. [ix]

Peer review: The mid-term review included an adapted version of the PEER method (participatory ethnographic evaluation and research), in which members of the beneficiary group conducted conversational interviews with other people involved in the programme to hear their stories and perspectives. The PEER approach generates a more authentic 'insider view' of the subject, helping to overcome barriers of culture, language, and general mistrust. The approach is suitable for use with non-literate groups and people with no previous research experience. For successful implementation of the PEER review methodology, a short training workshop was conducted with the selected reviewers, covering topics including: introduction

to the PEER review methodology, who is considered a peer, ethical considerations, probing, refining the interview questionnaire, and logistics.

Sampling as per inception report

- Profile for selection of PEER reviewers (interviewers):
  - 3 per space of vulnerability visited
  - Primary beneficiary in a space of vulnerability; ideally bilingual (English + other language relevant to the local migrant community); willingness to participate; ability to dedicate at least 5 hours
  - At least one adult male, one adult female, one young person under 25 years old
- Profile for selection of peers to be interviewed:
  - 3 per interviewer (Total of 10; 1 person can be interviewed by the consultancy team)
  - Willingness to participate; ability to dedicate at least 45 minutes
  - At least three men, three women, three young people

Participation

Table II. Participation of beneficiaries in PEER review process

COUNTRY	PEER REVIEWERS	TOTAL NUMBER OF INTERVIEWEES	TOTAL NUMBER OF WOMEN INVOLVED (PEER REVIEWERS+ INTERVIEWEES)	TOTAL NUMBER OF MEN INVOLVED (PEER REVIEWERS+ INTERVIEWEES)	TOTAL NUMBER OF YOUNG PEOPLE INVOLVED (PEER REVIEWERS+ INTERVIEWEES)
Kenya	3	6	3	6	3
Zambia	3	9	7	5	3
Lesotho	3	12	8	4	4
Total	9	27	18	15	10

Focus groups: When visiting the area of implementation of the project (space of vulnerability) in Kenya, Zambia, and Lesotho, the evaluation team conducted focus groups with Change Agents, health workers, and beneficiaries.

Sampling as per inception report

- Profile for the selection of focus group participants (exclusion criteria: beneficiaries who participate in the peer review exercise are excluded from the focus group):

  ✓ Change agents:

  - 1 focus groups; 6 participants max.
  - Willingness to participate; ability to dedicate at least 45 minutes; minimum three months of participation in PHAMESA II; balance in terms of sex/gender representation; willingness to be recorded (voice)

  ✓ Health workers:

  - 1 focus group; 6 participants max.
  - Willingness to participate; ability to dedicate at least 45 minutes; participation in minimum 1 training activity in the context of PHAMESA II; willingness to be recorded (voice)

  ✓ Primary beneficiaries:

  - Maximum of 5 focus groups per space of vulnerability; 6 participants max per group
  - At least 1 group of men, 1 group of women, 1 group of young people

- Willingness to participate; ability to dedicate at least 45 minutes; participation in PHAMESA II activities; willingness to be recorded (voice or note taking)

Table III. Participation in focus groups

COUNTRY	HEALTH WORKERS	CHANGE AGENTS	BENEFICIARIES		
			MALE	FEMALE	YOUTH
Kenya	1	1	1	1	1
Zambia		1			
Lesotho	1	1	1	1	1

Reasons for variances

All focus groups were held in Kenya and Lesotho. In Zambia, it was not possible to conduct the focus group with health care providers as the local IOM team had difficulties with the logistical arrangements. The health workers work in different parts of the city, and it is problematic for them to leave their posts given that they work without much support. Despite insistence from the consultant on the ground, the local team was unable to execute this focus group. Considering the already tight agenda, the IOM country team decided to prioritize interviews with stakeholders. The consultant in the field was able to hold interviews with staff from partner organizations Mulanguile and CHAMP, service providers that have been trained by IOM as part of the project (Directly related to Indicator 3.2.2: Number of individuals in key stakeholder organizations capacitated on migration and health).

It was also impossible to hold the focus groups with beneficiaries in Zambia. Given the tension present in the country towards migrants at the time of the field visit, the IOM local team felt it was not prudent to convene this group.[x] In an attempt to compensate for this, the team interviewed some of the beneficiaries during the peer review activity. Additionally, several of the participants from the focus group for Change Agents had previously been beneficiaries of the project. These interviewees were also able to provide the consultants with the beneficiary perspective.

Data quality

Triangulation

Throughout the mid-term review, the consultants put mechanisms in place to ensure that all members of the team concurred in terms of understanding/interpretation of data collection tools, time allocated to different data collection methods, etc. The following measures were taken to ensure data quality and adequate triangulation of the data:

- All members of the team participated in a training on the utilization of data collection tools prior to the country visits.
- To facilitate consistency, one member of the team implemented all regional interviews.
- To facilitate analysis of the information by different members of the team, all interviews, focus groups, and peer review activities were recorded.
- During the data analysis report, the evaluation team assessed the consistency of data generated by different collection methods (e.g. data collected on management and processes through semi-structured interviews vs. data collected on the same issue through the online survey). It is important to note that, as stated in the inception report[xi], not all data collection methods are meant to inform findings for all OECD criteria/questions.
- During the data analysis report, the evaluation team assessed the consistency of data gathered using the same method (e.g. comparing answers from multiple key informants).

Limitations

The IOM has years of experience focused on the issue of migrant health in East and Southern Africa. Beginning in 2004 with the Partnership on HIV and Mobility in Southern Africa (PHAMSA), the programme then grew to include countries in Eastern Africa and expanded its focus to Malaria and TB through the Programme on Health and Mobility in East and Southern Africa (PHAMESA I). The programme currently being evaluated is a direct continuation of PHAMESA I. Though each project has been different, and big identifiable changes in strategy and approach were implemented with each initiative, the impact of

IOM's work in the region can be attributed precisely to this ongoing presence and continuous work. It is difficult to isolate the impact of the PHAMESA II actions using the methodology of this evaluation.

For the desk review methodology, a significant limitation was presented by the fact that PHAMESA II is a programme that is constantly changing. While this speaks positively about the programme's capacity to adapt, it is important to highlight that the changes are not always well documented and identifiable from a review of the programme's documents, making it difficult to determine if the information contained within the documents corresponds to the current status of the project. To address this challenge, doubts were clarified with regional staff during the semi-structured interviews.

It is also important to highlight the language issue. A majority of the migrant population in the countries visited speaks local languages, which the consultants unfortunately do not speak. Though the team made every effort to address these issues through the use of interpreters at all times, it must be acknowledge that translation is never 100% perfect. As a result, we recognize that there might be some issues that were overlooked due to language constraints. In addition, the presence of an interpreter alters the dynamics of interviews and focus groups, and conditions spontaneous participation despite the best efforts of the team, the interpreters, and the participants to be patient and adapt to the situation. It should be noted that interpretation was not included in Lesotho and Zambia in the consultancy proposal approved by the IOM. This would have limited the team to interviewing only English-speaking participants. However, as budget was available, the team made an extra effort to secure interpreters based on the reasoning that the added value of being able to speak with a wider range of beneficiaries far outweighed the potential limitations of communicating through an interpreter.

In the case of Zambia, the team was met with the limitation that some activities were unable to be conducted. The focus group with healthcare providers could not be held it is problematic for them to leave their posts given that inside the health facilities they work without much support. It was also not possible to hold the beneficiaries' focus groups. The local IOM team felt it was not prudent to convene this group given the current political tensions in the country and the recent riots against migrants (See above, page 6 -"Focus groups, reasons for variances"- to access more information on how the team approached this situation).

Finally, given the partnerships component of the project, a significant part of the evaluation work depended upon being able to speak with the partners in order to analyze the work being done, and depended greatly on the availability and willingness of these partners to speak to the team. The team faced the limitation that some stakeholders were unavailable during the field visits. In order to address this limitation, the consultants were as flexible as possible, offering the option of meeting face to face or of conducting the interviews via telephone or Skype in an attempt to adapt to the availability of the interviewees. In Kenya, some of the partners were unavailable and meeting times had not been arranged when the team arrived in country. In Zambia and Lesotho, the IOM team organized the agenda in detail, and the majority of the interviews were conducted either in the field or by phone following the visit.

Validity of findings and recommendations

The findings included in this report are the result of an analysis and comparison of all data collection methods –desk reviews, online survey, semi-structured interviews, focus groups, and peer review activities. Specific examples and references to particular data collection methods are included throughout the report to substantiate the findings. Although the semi-structured interviews helped inform the findings, specific quotes have been omitted in order to avoid placing too much weight on a single testimony. Certain findings led the evaluation team to develop recommendations. In some cases, one recommendation addresses more than one finding (findings and recommendations are clearly linked in the 'Recommendations' section of this report).

Validation by IOM and Sida

Relevant IOM and Sida staff had the opportunity to hear and comment on the findings and recommendations through an online meeting conducted via Skype. A formal set of consolidated, anonymous comments were provided to the team based on the first draft of the evaluation. The donor also provided a separate document with general and section-specific comments. Each comment was addressed individually.

Independence

The evaluation team was independent from any functions within IOM, Sida, partner organizations, and participating governmental entities, and therefore able to conduct the mid-term review with objectivity and neutrality. The evaluation

team –including interpreters hired locally- followed a code of conduct, including the signing of individual confidentiality agreements, an understanding of the guiding principles, and a child protection policy.

Data confidentiality

As agreed in the inception report, the evaluation team implemented the following measures to minimize concerns related to data anonymity and confidentiality:

- Prior to starting any interview/focus group, participants were informed about the objectives and expectations of their participation. It was explicitly explained that their participation was voluntary, and that they had the right to stop participating at any time, without needing to justify their decision to the consultancy team.
- Prior to starting any interview/focus group, the evaluation team explained their intent to record the sessions and asked for verbal consent from participants. If participants did not consent, the evaluation team member in charge took notes.
- All raw data resulting from the interviews/focus groups are confidential and accessible only to the evaluation team. Personally identifiable data (e.g. voice records) will be kept no longer than is necessary, and will be deleted within three months following the completion of the mid-term review.

The PHAMESA II Programme

Policy context on migration, health, and needs

"In the last decade, protection of the human rights of migrants, including the right to health, has been increasingly recognized and has risen up the international agenda"[xii], as evidenced by the inclusion of "migration for the first time in the global development framework (Sustainable Development Goals), recognizing well-managed migration's integral role in and immense contribution to sustainable development"[xiii] and by other "landmark global initiatives such as the Resolution 61.17 on the Health of Migrants, 61st World Health Assembly, 2008; the Declaration of Commitment on HIV/AIDS, United Nations General Assembly Special Session on HIV/AIDS (UNGASS), 2001; the International convention on the protection of the rights of all migrant workers and members of their families adopted by GA resolution 45/158 of 1990; and Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the United Nations convention against trans-national organized crime, GA 2000."[xiv]

On a regional and sub-regional level –Eastern and Southern Africa- migration and health have also been integrated into multiple initiatives, including the "EAC Regional Strategy on Integrated Health and HIV Programming along Transport Corridors 2015 – 2020; the EAC's HIV and AIDS/STI and TB Multisectoral Strategic Plan and Implementation Framework 2015 – 2020; the SADC HIV, SRH, TB and Malaria Integration Strategy (2016 –2020); and the migration and health strategy for the South West Indian Ocean Countries (to be launched in 2016)."[xv] "Accordingly, governments are showing an increased appreciation for the need to formulate health programmes and policies that address health inequities and remove access barriers to health facilities, goods and services."[xvi]

"Despite these efforts, however, migrants continue to be overlooked in many countries, where access to health care often remains limited and conditional for them."[xvii] Existing interventions often fail to consider the impact of the conditions surrounding the migration process, which exposes migrants and those they interact with to various risks, making them vulnerable to ill health. These risks include increased vulnerability to communicable diseases (tuberculosis, malaria, measles, sexually transmitted infections including HIV, etc.), mental health issues, occupational health and safety conditions, and negative sexual and reproductive health outcomes.[xviii]

The PHAMESA II Programme at a glance[xix]

PHAMESA is a bi-regional, long-term programme that supports governments and other migration and development stakeholders in addressing the health risks and vulnerabilities associated with the ever-increasing movement of vulnerable populations within and between regions in East and Southern Africa (ESA). In January 2014, the programme entered its second phase (PHAMESA II), with seed funding from the Swedish International Development Cooperation Agency and the Dutch Minister for Foreign Trade and Development Cooperation. PHAMESA II builds on the lessons learned and recommendations made in the end-term project evaluation from the first phase (2010-2013). The World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants (2008) identified four key intervention areas to improve migrants'

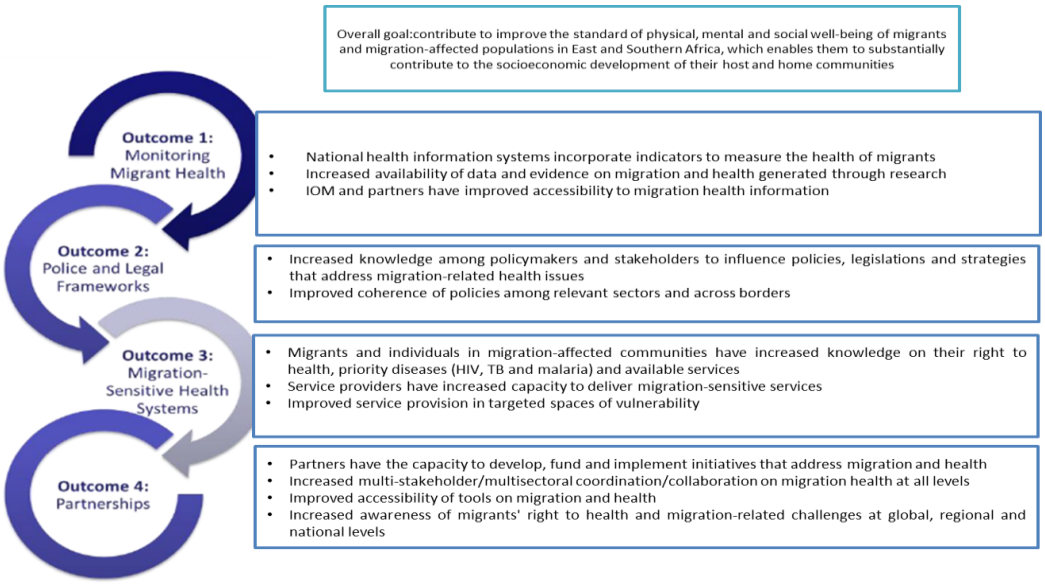
health. PHAMESA II thus supports the operationalization of the resolution. The programme responds to the following four pillars of the WHA Resolution: 1) Improved monitoring of migrants' health; 2) Migrant-sensitive policies and legislations; 3) Migrant-sensitive health systems; and 4) Multi-country/sectorial collaboration and coordination.

Under the PHAMESA programme, IOM implements a comprehensive package of interventions that addresses not only direct health needs, but also social determinants of health at the individual, institutional, and structural/normative levels. PHAMESA also utilizes a spaces of vulnerability (SOV) approach. SOVs are areas where human mobility creates an environment conducive to increased health risks in a community. They can include places where migrants and mobile populations live, work, pass through or originate from. The SOV approach recognizes that health vulnerability stems not only from an individual's health profile and behavior but also from social and economic factors.

Finally, PHAMESA utilizes a regional approach to health programming. This is based on the oscillating nature of population mobility and associated health risks in the two regions, and evidence that diseases know no borders. This approach enables PHAMESA to address region-wide factors that impact the health of migrants and migration-affected communities at any point in the migration process. The PHAMESA programme receives seed funding with the expectation to fundraise additional resources. By doing so, the programme generates an umbrella framework, with other projects guided by PHAMESA.

The programme is designed to influence change across four interlinked and interdependent results areas that contribute to the overall impact of the programme (See Diagram I).

Diagram I. PHAMESA II programme results-based management framework



PHAMESA II institutional and management arrangements

Institutionally, PHAMESA II is housed within the IOM's Migration Health Division (MHD) At a global level, this Division conducts activities in the following three areas: H1: Migration Health Assessments and Travel Assistance; H2: Health Promotion and Assistance for Migrants; H3: Migration Health Assistance for Crisis-Affected Populations. PHAMESA II is implemented primarily under H2, although it sometimes overlaps with the other two areas depending on the specific country and context.[xx]

The PHAMESA II management structure has evolved from previous phases of the programme as part of a shift towards results-based management (RBM). As explained in the 2014 Annual Report, the regional teams in Eastern and Southern Africa were restructured to ensure optimization of skills and experience, to foster RBM practices, and to reinforce programme quality. In the new arrangement, each PHAMESA II strategic result area (outcome) has a lead staff and team with clearly defined roles that are responsible for ensuring quality programme delivery and accountability. The result area leads report to an overall programme manager. One of the result area leads is also the coordinator of the East Africa programme. To ensure the independence of the M&E function, the M&E team is made up of one officer from each of the two regions. They report to the programme manager and work collaboratively with the outcome leads on matters of planning, programme delivery, and accountability. In addition, a desk officer function has been created to support communication with country programmes. This function consists of regional staff members in the Southern Africa Region that filter communication and maintain more regular contact with specific country programmes.[xxi]

Findings

Relevance

Following the OECD/DAC definition, the evaluation team assessed the extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities, and partner and donor policies.[xxii] Questions set forth in the inception report included: to what extent are the interventions consistent with beneficiaries/spaces of vulnerability/country/regional needs and priorities?; How has the targeting of spaces of vulnerability supported the relevance of PHAMESA II programme interventions?; To what extent are the current interventions relevant to achieve the outcomes/outputs expected from the PHAMESA II programme? The evaluation methods prioritized to answer these questions include desk review, semi-structured interviews and the online survey.

Consistency with global and regional priorities

- PHAMESA II supports the operationalization of the World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants (2008). The programme, as observed in the results-based framework, responds to the following four pillars of the WHA Resolution: 1) Improved monitoring of migrants' health; 2) Migrant-sensitive policies and legislations; 3) Migrant-sensitive health systems; and 4) Multi-country/sectorial collaboration and coordination. From the perspective of PHAMESA staff, PHAMESA II has opened doors for strategic collaboration with regional governmental bodies and national governments (e.g. the incorporation of migration and health indicators in National Health Information Systems).[xxiii]
- In terms of global priorities, the PHAMESA II programme is also responsive to institutional priorities on migration and health, as IOM's approach is aligned with the four pillars of the World Health Assembly (WHA) resolution.[xxiv] This means that PHAMESA II does not operate in a vacuum, and can integrate with other institutional efforts to address the needs of migrants. This consistency with institutional priorities also allows PHAMESA II to build institutional partnerships, collaborations (e.g. coordinating mechanisms), tools, frameworks, etc., and to transfer lessons learned to other projects run by the organization.
- PHAMESA II supports both the development and implementation of initiatives on migration and health by the Regional Economic Communities. A selection of examples that illustrate this support are included in Table IV.[xxv] By strengthening collaboration with these regional bodies, PHAMESA II has contributed to the recognition of migrants as a key population in priority regions, and has paved the road for future collaboration.[xxvi]

Table IV. PHAMESA II examples of support for regional priorities on migration and health

Regional level/country	Partner	Examples of work
Southern Africa	SADC	- Co-financing study on the SADC financing mechanisms for mobile populations to assess the benefit of investing in health financing for migrant populations - SACD ports study, disseminated to four key countries –Mozambique, Namibia, South Africa, and Tanzania- to inform decision making - Collaboration on the development of the draft HIV, SRH, TB, and Malaria Integration Strategy (2016 –2020) - Collaboration on the development and implementation of several migration-inclusive initiatives, including: 1) the SADC E8 Global Fund Malaria Initiative; 2) the SADC Global Fund Response to TB in the Mining Sector of Southern Africa

Regional level/country	Partner	Examples of work
Eastern Africa	EAC	- Health Service Mapping to inform the EAC strategy on access to health services along the transport corridor - As a result of PHAMESA advocacy and involvement, the EAC Regional Strategy on Integrated Health and HIV Programming along Transport Corridors 2015 – 2020 and accompanying minimum package of health services and fisher folk framework, and the EAC HIV and AIDS/STI and TB Multisectoral Strategic Plan and Implementation Framework 2015 – 2020 are responsive to migrant health
Indian Ocean	IOC	- As part of PHAMESA II efforts, IOM has been involved in policy dialogues and initiatives of the Indian Ocean Commission's (IOC) regional migration and health strategy for the South West Indian Ocean countries focusing on SRHR, HIV/AIDS, and other STIs. The strategy will serve as a tool for effective long-term development of initiatives addressing migrant health. To date, the strategy has been developed and validated in Comoros, Madagascar, and the Seychelles. It is expected to be officially launched in 2016.

Consistency with donor and stakeholder priorities

- The recent inclusion of migration in the global development framework (SDGs), with specific references to PHAMESA II outcomes under goals 10 and 17 (10:7- planned and well-managed migration policies; and 17:18- data disaggregation (including by migratory status)) shows that the programme is aligned with global priorities and, as donors have started adapting their strategies to support the achievement of the 2030 agenda, to donor priorities.[xxvii]
- However, particularly in the African context, donor focus has shifted towards broader agendas like SRHR (in the case of Sida), and away from stand-alone HIV programmes or HIV/TB focused programmes.[xxviii] This shift in priorities means that PHAMESA II needs to define its added value on these issues, as well as reassess its entry points for programming and partners in order to find complementary expertise that facilitates work on a broader agenda.
- Although the PHAMESA II proposal was developed through a participatory process involving country, regional and headquarters level staff, it did not include a formal process to involve other stakeholders (migrants themselves, government partners, private sector, WHO, UN partners in countries and NGOs).[xxix] These other stakeholders can provide relevant insights regarding their respective agendas/plans, and how PHAMESA can complement/avoid duplicating efforts. Although a formal process was not implemented, the PHAMESA team is confident that other stakeholders´ aspirations and needs are/were included through the documentation review process that informed the programme design process, and through the experience of the country staff that have interacted and worked with these groups over time.[xxx]
- In terms of addressing other stakeholders´ priorities/aspirations, partners interviewed expressed the opinion that IOM could do a better job in mapping and disseminating information on what different partners are currently doing, the added value of each organization working on migration and health, and the existing gaps.[xxxi] Doing so might improve coordination and accelerate the progress that can be made.

Consistency with regional, country, and beneficiary needs

- Eastern and Southern Africa have certain context specificities that justify the need to work on migration and health: high levels of international and internal migration in the two regions: a high prevalence of communicable diseases, such as HIV, tuberculosis, cholera, malaria, and measles; struggling public healthcare systems; lack of recognition and prioritization of migrants in public policies; and dominant perceptions that migrants are bearers of diseases. [xxxii,xxxiii] PHAMESA II contributes to addressing these needs by implementing interventions that are based on needs assessments at country and SOV level, and are consistent with the project's results-based framework (see the Institutional Processes section to learn about internal processes to ensure consistency during work planning).[xxxiv] In terms of the issue of needs assessment and how it is used to better address regional, country, and beneficiary needs, the evaluation team found that the results of the baseline assessment implemented in 2014-2015 have informed adaptations of the programme and interventions at different levels.[xxxv]
- While the needs described in the paragraph above are considered the most critical, there are additional concerns in the health field that are relevant both to migrants and host communities, and that are not the main focus of the PHAMESA II programme. The inclusion of these issues, including maternal mortality and morbidity, unplanned pregnancy, sexual and reproductive health and rights in general, and non-communicable diseases, is essential to achieve the overall goal of contributing the improvement of the standard of physical, mental, and social well-being of migrants and migration-affected populations.[xxxvi] Although at first this may be perceived as a limitation, it was confirmed through the various

data collection methods that PHAMESA II has made efforts to incorporate training on these issues into the activities with health providers (See Module 5- Improving access to healthcare services for migrants, mobile populations, and affected communities: Capacity building for healthcare providers[xxxvii]), and that service provision interventions include a more comprehensive package of care which goes beyond communicable diseases (e.g. Eastleigh clinic in Kenya –See Box 1 on this page; services provided under the GRZ-UN Joint Programme on Gender-Based Violence in Zambia –See Box 2 on this page).

***Box 1. The Eastleigh Community Wellness Centre (Kenya)**, Established in 2008 in Eastleigh, East Nairobi, Kenya, this health center serves both local Kenyans and migrants, including a small number of refugees, with voluntary counselling and testing (VCT), tuberculosis, maternal and child health services, primary health care, and other services. The area primarily receives Somali, Ethiopian, and Oromo migrants. http://kenya.iom.int/our-work/programmes/urban-migrant-health-programme*

- In terms of how the PHAMESA II programme responds to the particular needs of beneficiaries, the SOV approach has enabled PHAMESA to prioritize geographic areas where there are real and significant migration health needs within a country or region, allowing the programme to operate where it is needed most.[xxxviii] However, the evaluation team did not have access to sufficient information within each SOV to confirm that the intervention packages are always tailored to address the particular needs of diverse groups of migrants and host community members –e.g. men-friendly/youth-friendly interventions:
    - The Change Agents Curriculum and the document "Improving access to healthcare services for migrants, mobile populations, and affected communities: capacity building for healthcare providers", which guide training interventions under PHAMESA II, do not include a particular emphasis on layers of vulnerability for different types of migrants, or on the provision of friendly services for particularly vulnerable groups. This does not exclude the possibility that these issues may be included when the actual training occurs. As the field visits were not organized with the specific intention to observe the implementation of the training activities, the evaluation team did not have the opportunity to observe these trainings in-situ.
    - Health providers, Change Agents, and beneficiaries in Lesotho expressed the need for services and educational activities tailored for young people and men. Offering tailored/person-centered interventions may lead to improved health outcomes in the populations served by the PHAMESA II programme[xxxix], as suggested by various sources which that provide authoritative information on the importance of understanding the particular needs, layers of vulnerabilities, and barriers to access of specific individuals (e.g. youth).[xl]

Box 2. The GRZ-UN Joint Programme on GBV (Zambia)

*This programme aims to reduce GBV in Zambia through the establishment of an integrated and multi-sectoral mechanism to implement the Anti-GBV Act. Results are achieved through the following four (4) interrelated outcomes. (i) GBV survivors will have increased access to timely and appropriate health services; (ii) GBV survivors will have increased access to an efficient justice delivery system; (iii) GBV survivors will have increased access to protection and support services; (iv) The Ministry of Gender will have coordinated an effective, evidence-based and multi-sectoral response to GBV in Zambia. The programme is implemented by various State and Non-State Agencies and coordinated by the Ministry of Gender, with technical and financial support from six (6) UN Agencies (ILO, **IOM**, UNDP, UNFPA, UNICEF, and WHO) and Bilateral Cooperating Partners (Sweden and Ireland). In 2015, GBV survivors received services including psychosocial support, shelter, and medical and legal services through this programme,. Survivors also received economic empowerment support from the programme, including training and mentorship on business skills. (Main source: http://mptf.undp.org/factsheet/fund/JZM00).*

Relevance of programme design/intervention logic

- As mentioned above, the programme design was informed by the four pillars of the World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants (2008). These four pillars form the building blocks for the achievement of PHAMESA´s overall goal, and have informed the definition of outputs, interventions, and indicators.[xli] The intervention logic of PHAMESA II, which follows the theory of change approach, allows for clear identification of IOM´s areas of contribution. However, the intervention logic is missing connections between the different

outcomes/outputs/interventions. This means that a clear picture of integration among the four outcomes does not exist (e.g. how interventions under Outcome 2 lead to desired change under Outcome 3). From a programmatic point of view, this lack of connections in the intervention logic may lead to missed opportunities to capitalize on achievements across the different outcomes, for example how achievements under Outcome 1 (e.g. increased availability of data and evidence on migration and health generated through research) can directly contribute to improved results under Outcome 3 (e.g. increased capacity of service providers to deliver migration-sensitive services).

Effectiveness

Following the OECD/DAC definition, the evaluation team assessed the extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance; and the extent to which an intervention has attained, or is expected to attain, its major relevant objectives.[xlii] Questions set forth in the inception report include: What overall progress has PHAMESA II made towards the realization of its expected outcomes and outputs?; What are the PHAMESA II components and delivery approaches that have been most effective to reach different groups of primary beneficiaries and which have been least effective?; How has targeting spaces of vulnerability supported the effectiveness of PHAMESA II programme interventions?; What needs to be done to improve performance to achieve the expected results? The evaluation methods prioritized to answer these questions include desk review, semi-structured interviews and focus groups with beneficiaries, change agents and service providers.

For the period 2014-2015, the PHAMESA II programme showed progress for the majority of output level indicators (the only exception being Output 1.3.1 "One operational migration health knowledge-sharing platform". Key informants have confirmed efforts to complete this task are currently being implemented in 2016). Below, we provide information on performance under each outcome and an analysis of how the package of interventions of PHAMESA II has contributed to the attain the outputs and outcomes.

Outcome 1 – Monitoring migrants' health

- As observed in Diagram II (below), the PHAMESA II programme has successfully advocated to include questions on migration and health as part of key national, routine data collection instruments in three countries – South Africa, Kenya, and Namibia (as of December 2015). During 2016, IOM country offices in countries such as Kenya, Lesotho, Namibia, South Africa, Zambia, and Tanzania[xliii] have continued this effort, implementing activities that directly contribute to the achievement of this output[xliv] –desk review of national tools, meetings and formal collaboration with relevant public authorities, provision of technical assistance to government partners. Additionally, the country mission of Mauritius has provided technical assistance to the Indian Ocean Commission to raise awareness, conducting capacity building activities in IOC member States on the importance of up-to-date and reliable migration data for decision-making and planning on migration and health.[xlv] While performance of this indicator shows an achievement of 27% against the target (3 out of 11 countries), the country level work plans show there is a high level of prioritization of these efforts.
- As observed in Diagram II (below), the number of research studies conducted with a focus on migration and health has surpassed the target expectations, with a compliance of 133% (12 studies out of 9). Strong partnerships at regional and national levels have contributed impressively to this success. For example, on a regional level, IOM collaborated with SADC and EAC to implement studies on migration and health. These studies are already being used to inform the development of health strategies and programmes in each region. On the country level, IOM is collaborating with various partners to conduct and disseminate studies focused on different SOVs –e.g. A study on HIV vulnerability in the mining and other extractive industries in Uganda- that have informed interventions for the Karamoja Sub-Region under the Joint UN Programme of Support on AIDS (JUPSA). During the field visit in Zambia, the evaluation team found examples of more recent partnerships that will contribute in the long term to additional achievements, including a partnership with the University of Zambia.
- As previously mentioned, the availability of information on migration and health is already informing the development of strategies and programmes on a regional and country level. However, key informants from partner organizations noted that IOM could implement additional efforts to disseminate the evidence and results from the studies and the national data collection systems. This need will be partially met by the knowledge-sharing platform expected to be launched in 2016.

Diagram II. PHAMESA II programme performance Outcome 1

	PHAMESA II 2015 - 2017 MASTER PROGRAMME DATA BASE Indicator Description	Grand Total 2014-2017	PROGRAMME TARGET (2014-2017)	PERCENT ACHIEVEMENT (2014-UPTO DECEMBER 2015)
	OUTCOME 1 - MONITORING MIGRANTS' HEALTH			
	OUTPUT 1.1 - National Health Information Systems incorporate indicators to measure the health of migrants			
1.1.1	Number of key national routine data collection instruments that incorporate questions on migration and health (Sida indicator)	3	11	27%
	OUTPUT 1.2. - Increased availability of data and evidence on migration and health generated through research	0		
1.2.1	Number of research studies conducted focused on migrants' health and migration-related health issues	12	9	133%
	OUTPUT 1.3. -IOM and partners have improved accessibility to migration and health information			
1.3.1	One operational migration health knowledge sharing platform	0	1	0%
OUTCOME INDICATOR	Number of countries that have incorporated migration in their health monitoring systems	0	11	0%

Outcome 2- Policies and legal frameworks

- As observed in Diagram III (below), and as already highlighted in the section '**Consistency with global and regional priorities'**, the PHAMESA II programme has contributed to the inclusion and prioritization of migrants in policies, strategies, and programmes at a regional, country, and SOV level, with a target compliance of 75% (9 policies out of 12). Interventions contributing to this achievement include regular advocacy, provision of technical support to government partners, and active participation in task forces and technical groups. Taking the institutional capacities into consideration, this is a remarkable achievement. Yet considering the number of levels and countries involved, the broad range of instruments –legislations, policies, and strategies- covered by this indicator, and the fact that this programme builds on previous phases, the evaluation team considers the target for this indicator to be low.
- Implementation levels of the newly developed/amended policies, strategies, and programmes vary from country to country, and at SOV level. IOM has already identified interventions to overcome this challenge- e.g. partnering with "paralegal organizations and strengthening community-based paralegal initiatives in migrant-populated areas in at least three countries (Kenya, South Africa, and Zambia). These programmes will train and support migrant and non-migrant community paralegals to promote accountability regarding implementation of policies and laws and ensure access to services at the community level. Paralegals support provision of legal aid services and referrals, generally for vulnerable and marginalized population groups, and, in many contexts, go beyond legal aid to advocate with communities for public services (including health) and other community concerns."[xlvi]

Diagram III. PHAMESA II programme performance Outcome 2

	PHAMESA II 2015 - 2017 MASTER PROGRAMME DATA BASE Indicator Description	Grand Total 2014-2017	PROGRAMME TARGET (2014-2017)	PERCENT ACHIEVEMENT (2014-UPTO DECEMBER 2015)
	OUTCOME 2 - POLICIES AND LEGAL FRAMEWORKS			
	OUTPUT 2.1 - Increased knowledge among policy makers and			
2.1.1	Proportion of policy makers and stakeholders with increased knowledge on migration health related issues and the importance of migration and health in health policies	**279**	70%	
	OUTPUT 2.2 - Improved coherence of policies among relevant			
2.2.1	Number of non-health sectors that have incorporated migration and health in their policies, legislations and strategies	**2**	3	67%
OUTCOME INDICATOR	Number of regional and national policies, legislations, and strategies amended or developed to become migration inclusive	**9**	12	75%
OUTCOME INDICATOR	Extent to which policies, legislation and strategies that are migrant-inclusive are operationalised	**0**	At least three of the 11 countries have operationalized policies, legislations and strategies that are migrant-inclusive.	
OUTCOME INDICATOR	Extent to which accountability mechanisms are in place and utilized	**0**	At least three countries establish or utilize existing accountability mechanisms.	

Outcome 3 – Migrant-sensitive services

- As observed in Diagram IV (below), the following indicators have no targets: 3.3.2a/3.3.2b/3.3.2c/3.3.3b/3.3.4/3.3.4a. For indicators where a target has been set, the majority has their compliance levels above 50%. Two areas with low levels of compliance include i) the number of individuals of reproductive age reached with sexual and reproductive health education; and ii) the number of individuals in key stakeholder organizations trained in migration and health (12% and 7% respectively). For the first indicator, it is possible that the number of individuals reached to increase their knowledge on their right to health, priority diseases, and available services also includes some individuals reached with sexual and reproductive health education.[xlvii] For the second indicator, the low number is due in part to the re-definition of this indicator during the 2015 revision of the PHAMESA results matrix.[xlviii]

Diagram IV. PHAMESA II programme performance Outcome 3

	PHAMESA II 2015 - 2017 MASTER PROGRAMME DATA BASE Indicator Description	Grand Total 2014-2017	PROGRAMME TARGET (2014-2017)	PERCENT ACHIEVEMENT (2014-UPTO DECEMBER 2015)
	OUTCOME 3 - MIGRANT-SENSITIVE SERVICES			
	OUTPUT 3.1. - Migrants and individuals in migration affected communities have increased knowledge on their right to health, on priority diseases and available services			
3.1.1.	Number of individuals reached through community education to increase their knowledge on their right to health, priority diseases and available services (*disaggregated by gender, age and nationality*)	501395	750,000	67%
3.1.2	Number of reproductive age individuals reached with education on sexual and reproductive health -sida (disaggregated by gender, age and nationality)	47538	400,000	12%
3.1.3	Number of community led initiatives to address social determinants of health in migration affected communities	93	14	664%
	OUTPUT 3.2. -Service providers have increased capacity to deliver migration-sensitive services	0		
3.2.1	Number of CA trained who demonstrate capacity and skills to facilitate community dialogue and education on social determinants of health	1779	70%	
3.2.2.	Number of individuals in key stakeholder organizations capacitated on migration and health (*disaggregated by civil society/government*)	213	3,000	7%
3.2.3	Number of health workforce members capacitated on migration and health (*disaggregate by community-based/facility based)*	1400	1400	100%
	OUTPUT 3.3 -Improved service provision in targeted spaces of vulnerability			
3.3.1	Number of coordination mechanisms established/strengthened to improve service delivery in migration-affected communities	6	7	86%
3.3.2	Proportion of beneficiaries referred for health and other relevant services (disaggregate by gender, age, nationality and type of services)	103920		
3.3.2 a	Proportion of beneficiaries referred for health and other relevant services who received services at referral destination (disaggregate by gender, age, nationality and type of services)	3592	80%	
3.3.2 b	Number of Individuals referred for HIV testing	7348		
3.3.2 c	Number of individuals referred for HIV testing who received their HIV results at the referral destination	83517		
3.3.3	***Number of people screened for TB***	27402	3,500	783%
3.3.3 a	***Number of individuals with TB symptoms referred for diagnosis and treatment in migration affected communities (subset of total TB screened)***	646		
3.3.3 b	***Number of referred individuals with TB symptoms who received diagnosis and treatment at referral destination (subset of total TB symptomatic referred)***	1660		
3.3.4	Number of SGBV survivors identified and referred by service providers for support and protection	2335		
3.3.4 a	Number of SGBV victims identified and referred by service providers for support and protection who received services at the referral destination (sub-set of the total SGBV cases identified and referred)	453		
	OUTCOME 3 INDICATORS			
OUTCOME 3 INDICATORS	% of sexually active girls and women using contraceptive methods at their last sexual intercourse in target spaces of vulnerability		5% increase from baseline value for each of the seven country sites by the end of 2017.	
	% of beneficiaries in target spaces of vulnerability reporting use and satisfaction with migration-sensitive services that improve health		10% increase in report of use and satisfaction with the services from baseline values for each of the sites/countries surveyed during baseline.	
	% of women and men aged 15-49 in target spaces of vulnerability who report having received an HIV test in the last 12months and who know their HIV status.		5% increase from baseline value for each of the country sites indicated by the end of 2017.	
	% of service providers in target spaces of vulnerability that are providing migration-sensitive services that improve health.		70% of SPs are providing migration-sensitive services in the target spaces of vulnerability at the end of 2017	
	% of sexually active men and women in target spaces of vulnerability who used condom condom with a non-marital or non-regular partner at the last sex.		For countries with a score below 60% to increase by 10% by the end of 2017. 5% increase from baseline value for those with scores over 60%.	

- The package of interventions under Outcome 3 follows the IOM´s Service Delivery and Capacity Building (SDCB) framework. This approach, based on public health and community development and communication theories, seeks to strengthen the local community health system by creating demand, enhancing supply, and creating an enabling local environment. Migrant-sensitive health services are understood as those health services that are non-discriminatory, culturally and linguistically appropriate, physically accessible and available during hours when migrants can access them, affordable, staffed with healthcare workers sensitive to how migration can impact health vulnerability, and that support/facilitate referrals processes.[xlix] The implementation of migrant-sensitive health services, in the context of this initiative, is supported by a diverse healthcare work force, including Change Agents –groups of health activists drawn from the target population.

Diagram V. IOM´s Service Delivery and Capacity Building (SDCB) framework

- Two activities are prioritized under the PHAMESA II programme in terms of demand creation: i) peer led health communication; and ii) social behavior change communication through Change Agents.
  - ✓ As shown in Diagram IV (above), 1,779 Change Agents have been trained. Disaggregated data shows that 1,007 are female and 387 are male (there is no information available about the gender of the other 392 Change Agents). Among them, only 40 are categorized as migrants, which is explained by the high mobility of this population.[l]
  - ✓ Implementing partners use both IOM tools and their own training materials to train Change Agents. The quality of implementing partners' materials and their alignment with the IOM framework is not systematically assessed.[li] Specifically in Zambia, it was noted that Change Agents are trained using the cascade training methodology in some settings. However, there is no system in place to identify whether the training has the same scope and quality standards in all situations.
  - ✓ As recommended by the SDCB framework, change agents identify safe spaces for the people from target groups to systematically engage in face-to-face discussions on identified issues. The communication activities occur as part of mass campaigns, events, theatre activities, and door-to-door visits. Beneficiaries involved in the MTR (both through focus groups and peer review methodology) highlighted the value of the door-to-door visits, as they provide the opportunity for open communication, follow-up of health treatments, and the identification of household members' additional needs.
  - ✓ Change Agents are volunteers; however, they receive some inputs for their participation in the programme. These inputs are not standardized –in some cases they include transportation costs, airtime for the mobile phones, t-shirts, or a stipend. Change Agents involved in the MTR (through focus groups in Kenya, Lesotho, and Zambia) voiced the need to make further investments in both financial and non-financial inputs. Examples of the inputs requested include: a) certifications available for trainings completed and additional refresher courses; b) additional "merchandise" (t-shirts, bags, etc.) to facilitate identification of Change Agents by community members; c) additional financial resources to cover transportation and airtime cost required to implement follow-up services (e.g. accompanying patients to health facilities to ensure treatment adherence).
- In terms of enhancing the supply to achieve migration-sensitive health services, the SDCB framework recommends interventions tailored to communities of destination, communities of origin, and communities of transit. As observed in Diagram IV (above), efforts have been implemented to this end, with 1,400 health workforce members trained on migration and health and six coordination mechanisms established/strengthened to improve service delivery in

migration-affected communities. Currently, there is no standardized tool to measure if health services targeted by the interventions (e.g. public health facilities whose service providers participate in PHAMESA II trainings) are "migrant-sensitive" or have incorporated changes as a result of the work implemented by PHAMESA II. However, both the programme files (e.g. Annual Reports) and the MTR visits (focus groups- health providers, change agents and beneficiaries) documented numerous examples that illustrate how services are addressing the needs of migration-affected communities (see Box 3), as well as areas that require further attention. The latter include:

- ✓ Services that support/facilitate referrals processes: Referral completion rates have remained low due to a variety of reasons, including under-reporting– many clients referred do not report back after receiving the services, structural barriers such as long distances to facilities, fear of deportation- especially among undocumented migrants, poor service provider attitude, and general low health seeking behavior.[lii]
- ✓ Sensitive health workers:
  - Poor mental health and stigma issues were often mentioned by primary beneficiaries and partners in all three countries, when discussing the specific needs of migrants. Change agents and health providers did not identify having had any opportunities to be trained on how to address these issues.
  - Health providers who have participated in the training sessions supported by PHAMESA II showed different levels of awareness about the needs of migrants and migration-affected communities. The need to receive additional sensitization and training to understand how they can provide a more migrant-sensitive service was highlighted.

i. Physically accessible and available during hours when migrants can access them: change agents and beneficiaries identified that geographical conditions as well as opening times of health facilities available within the SOVs create significant challenges to access health services. While some measures have been put in place in specific contexts –e.g. opening hours in the Eastleigh Center (Kenya) have been increased gradually, with services currently available up to 4 pm- primary beneficiaries identify the need to have late evening healthcare available, as many local residents are not able to receive services because of their work or personal responsibilities.

- In terms of creating an enabling environment, PHAMESA II has put in place context-specific efforts to address the contextual barriers to health, address gender in the context of migration, and lobby for change at the local level (interventions recommended on the SDCB framework). In Zambia, for example, micro-loans for income generation initiatives have been provided to GBV survivors through the United Nations Joint Programme on GBV.[liii] In Mozambique, Lesotho, and Swaziland, VSO and IOM have supported the implementation of the POPA project through funding from the Dutch government. This program primarily targets the widows of former miners and other vulnerable women, improving their livelihoods by providing them with small business skills and funds to establish and run income-generating activities.[liv]

Outcome 4 – Partnerships

- As observed in Diagram VI (below), performance of Outcome 4 has surpassed expectations, with most indicators reporting a compliance of over 100% against the target. Examples of work included in this outcome include provision of support to multiple initiatives on migration and health, integration of migration and health into the curricula of universities and training institutions, and participation in international, regional, and local conferences and forums. While achievements under Outcome 4 are remarkable, taking into consideration the institutional capacities, the fact that this programme builds on previous phases, and the number of levels and countries involved, the evaluation team considers the targets for output indicators to be low.
- IOM key informants at the regional and country level acknowledge the role partners have played in increasing the visibility of the PHAMESA II programme, accelerating progress, bringing additional expertise to the table, scaling-up the interventions promoted under PHAMESA II, and leveraging financial resources. At times, the partnership work has been challenging. While IOM has managed to overcome many of these challenges, it is important to acknowledge that in some contexts, these difficulties have created barriers for successful or timely implementation (e.g. conflicting schedules with partners for the implementation of interventions where collaborative work is required; lack of prioritization of migration and health in the government agenda leading to difficulties in formalizing partnerships with common objectives).
- Key informants from partner organizations acknowledged the important role IOM plays in the field of migration and health, however, many of them highlighted areas of improvement within the collaboration that could help accelerate results:

- Lack of clarity about IOM's role and the role of other key stakeholders: Some country level partners expressed the need for a better understanding of IOM's role in health and migration and how their role complements the activities of other stakeholders. This is particularly important for public officials, who sometimes receive demands from multiple actors and struggle in prioritizing their interventions.
- IOM's follow-up following coordinated initiatives: While partners celebrated IOM's coordinating role in some settings (e.g. provision of funding for the Forum on Migration and Health in Lesotho, which brings together organizations from all sectors), stakeholders insisted on the need for IOM to follow-up on agreements made by partners in the context of these forums/collaborative initiatives to make sure all stakeholders develop and implement action plans and share knowledge and expertise on a regular basis.

Diagram VI. PHAMESA II programme performance Outcome 4

	PHAMESA II 2015 - 2017 MASTER PROGRAMME DATA BASE			
	Indicator Description	Grand Total 2014-2017	PROGRAMME TARGET (2014-2017)	PERCENT ACHIEVEMENT (2014-UPTO DECEMBER 2015)
	OUTCOME 4 - MULTI-SECTORAL PARTNERSHIPS AND NETWORKS			
OUTPUT 4.1 - Partners have the capacity to develop, fund and implement initiatives that address migration and health				
4.1.1	Number of initiatives that received technical support from IOM	22	15	147%
4.1.2	Number of research and academic institutions integrating migration and health into their academic curricula and research	3	3	100%
OUTPUT 4.2 - Increased multistakeholder/multisectoral				
4.2.1	Number of multi-country and/or multi sectoral partnerships and networks established/strengthened for effective coordinated response to migration and health (disaggregate by regional, national and sub-national)	32	10	320%
4.2.2	Number of partnerships with relevant stakeholder organizations formalized and/or strengthened	22	5	440%
OUTPUT 4.3 - Improved accessibility of tools on migration and health				
4.3.1	Number of tools, guidelines and technical briefs on migration and health disseminated	10	8	125%
OUTPUT 4.4 - Increased awareness of migration and health challenges at global, regional and national levels				
4.4.1	Number of relevant forums, dialogues, campaigns and conferences that include migration and health.	12	7	171%
OUTCOME INDICATORS	Amount of funds leveraged by IOM and partners to strengthen migration health programmes/initiatives in ESA (sida indicator)	3286956	$ 12,000,000	27%
	Number of initiatives undertaken by partners to respond to migration and health challenges	14	15	93%
	Extent to which multi-country and/or multi-sectoral partnerships and networks integrate migration and health		30	0%

Impact

Following the OECD/DAC definition, the evaluation team assessed the positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended. [lv] Questions set forth in the inception report included: what are some of the evidences of results at impact level among individual beneficiaries?: The evaluation methods prioritized to answer these questions include desk review, peer review methodology and focus groups with beneficiaries. However, the evaluation team acknowledges that methodology of the MTR does not include strong enough evaluation methods to assess the achievement of impact indicators –e.g. population based surveys, data from health surveillance systems, scales. The evaluation team was able to capture the voices of beneficiaries regarding their own perceptions about the effects of the programme (at the individual or community level). Through the focus groups and the peer review methodologies, the team was able to gather testimony on three impact indicators included on the PHAMESA II Programme Indicator Protocol:

- Impact Indicator 2: Percentage of individuals surveyed that had a **positive perception about their health and wellbeing:** This indicator measures self-perceived health. According to WHO, self-perceived health outcomes for individuals include positive mental, physical, and social functioning, as well as having a general sense of wellbeing.
- Impact Indicator 3: Percentage of individuals surveyed in spaces of vulnerability that have **changed their lifestyle to improve their health:** This indicator measures self-reported behavior changes. People change their behavior voluntarily when they become concerned about the need for change; convinced that the change is in their best interests or will benefit them more than it costs them; when they organize a plan of action that they are committed to implementing; and when they take the actions that are necessary to make the change and sustain the change.
- Impact Indicator 4: Percentage of individuals **reporting self-efficacy in making behavior change decisions:** Self-efficacy refers to one's perception of his/her ability or level of empowerment to make decisions about his/her own health. Such skills may include: diagnosing task demands, constructing and evaluating alternative courses of action, setting proximal goals to guide one's efforts, creating self-incentives to sustain engagement in taxing activities, managing stress, and deliberating intrusive thoughts. Self-efficacy is influenced by behaviors, environment, and personal/cognitive factors.

The evaluation team did not make any attempt to capture information about the number of people who were ill in the past x period (Impact Indicator 1) - e.g. by including it on the focus group and/or peer review questionnaires. The evaluation team is aware that a stronger methodology needs to be implemented to ensure the validity of these findings. The information presented below captures only the voices of beneficiaries in the three countries visited, and does not attempt to present general conclusions about the impact of the PHAMESA II programme.

- In terms of positive perception about their health and wellbeing, individuals who had accessed health services as part of the PHAMESA II programme, or who knew someone who had accessed services, had a relatively positive view about their current health status –either because they were no longer defaulting on treatments, because they had received care last time they were ill, or because they were more confident in their knowledge of how to protect themselves. However, they were able to identify persistent situations that still affected the health and wellbeing of their communities. Issues such as teenage pregnancy, gender-based violence, discrimination, stigma, HIV/TB, malaria, lack of access to medicine, food insecurity, violence, and rape were mentioned as barriers to improving the health and wellbeing of individuals in their communities.
- In terms of lifestyle changes, beneficiaries did not share examples of their own personal lifestyle changes, but instead described changes in other members of their communities. In Zambia, for example, beneficiaries had the perception that participants in the gender-based violence activities were better able to communicate with their families and partners. Beneficiaries who knew someone with HIV or TB who was/is supported by a Change Agent had the perception that these people were more aware and capable of making decisions about their nutritional needs, although food insecurity issues sometimes prevented them from following these recommendations.
- Finally, in terms of self-efficacy, the most common example offered by beneficiaries that had been in contact with a Change Agent or a health service was the beneficiaries' perceived capacity to make decisions about their treatment (not defaulting on treatment), and about requesting a diagnosis from the health services. Beneficiaries involved in business training/business empowerment activities (Zambia) felt that these trainings had given them the opportunity to move on with their lives and make decisions about their/their family's future.

Efficiency

Following the OECD/DAC definition, the evaluation team assessed how economically resources/inputs (funds, expertise, time, etc.) are converted to results in the PHAMESA II programme.[lvi] Questions set forth in the inception report include: how efficient is the PHAMESA II funding model (seed funding)?; Is this model effective and efficient in addressing migration health problems in the bi-regional programme?; How has the targeting of spaces of vulnerability contributed to the efficient use of resources in PHAMESA II programme interventions?; How efficient and effective have the programme's management, monitoring, evaluation, and learning , quality control, and financial systems been?; What capacity gaps existed and have these been overcome?; How does the new structure optimize the programme potential to foster learning,

accountability, and result achievements? The evaluation methods prioritized to answer these questions include desk review, semi-structured interviews and the online survey.

Efficiency of the seed funding model for the PHAMESA II programme

Before analyzing the efficiency of the seed funding model, it is important to clarify how the PHAMESA II programme is funded and how resources are allocated. As with PHAMESA I, "…PHAMESA II is a projectized regional programme, which means that it is 100% dependent on external funds."[lvii] This dependency on external funds, however, is not exclusive to this programme. "…IOM country missions or country offices are entirely dependent on external funds, including for all staff costs, from Chief of Mission downwards. IOM's regional offices are funded through IOM's internal core funding and can also manage regional programmes dependent on external funds (as of July 2013)."

The PHAMESA II programme receives seed funding from Sida (a total allocation of US $13,250,001 over 4 years). In addition to this seed funding, IOM is expected to fundraise supplementary resources at the regional and country level to support interventions to achieve the outputs and outcomes set via the PHAMESA II results-based framework. Through December 2015, the programme had received a total seed contribution of US $8,591,972, of which 57% was allocated (as per budget) to cover staff and office costs for regional and country missions. The interim financial report for the period January 2014 to 31 December 2015 shows a budget consumption of 58%. Resource allocation to implement RBM-aligned regional and country level interventions occurs in the context of work planning. The Consolidated Operational Work Plan for PHAMESA II (April 2016 version) clearly identifies outcomes, outputs, activities proposed, budget allocations, and source funding.

The following findings illustrate the efficiency of the seed funding model:

- PHAMESA II team has had the opportunity to support the development and implementation of several migration-inclusive initiatives at the regional level, securing multi-million dollar funding to tackle health risks associated with migration.[lviii]

- PHAMESA II has supported partner organizations to secure funding from international organizations. For example, the ex-miners association in Lesotho and Swaziland was able to secure funding from the World Bank thanks to IOM support. [lix] Through this funding, the high incidence of TB among mineworkers and ex-miners –one of the main SOVs targeted by PHAMESA II- will be tackled.

- PHAMESA II has implemented shared-cost initiatives with the Joint UN Programme of Support on AIDS (JUPSA) in Uganda, the UN Joint Programme on GBV in Zambia, IOM internal funding from Health Assessments in Kenya, the Embassy of the Kingdom of the Netherlands (EKN) Regional Mining Project in Lesotho, and USAID/PEPFAR in South Africa, among others. These shared-cost initiatives have provided an opportunity to amplify the project's reach within the different SOVs prioritized by PHAMESA II, implementing interventions in the three key areas of work that IOM prioritizes to strengthen local community health systems and support the access and use of migration-sensitive services: demand creation, supply enhancement, and enabling environments.[lx]

- Through December 2015, IOM and partners leveraged a total of US $3,286,956 to strengthen migration health programmes/initiatives in Eastern and Southern Africa (of the US $12,000,000 target committed to the PHAMESA II programme). To accelerate progress, IOM developed a resource mobilization strategy and provided training to staff members to facilitate a shared understanding of the resource mobilization needs and priorities. IOM has actively submitted proposals to different donors, however the demand for limited resources is high, considering that there are currently more actors involved in issues of migration and health.[lxi]

- In a few cases, the efficiency of the seed funding model is affected by external challenges. For instance, "…delays in disbursement of complementary JUPSA funding in Uganda led to significant delay in implementation of some activities in the 2015 work plan."[lxii] While this was not identified as a common occurrence, it helps illustrate a potential challenge to achieving the established outcomes when funds come from different sources.

Spaces of vulnerability contribution to the efficient use of resources in PHAMESA II programme interventions

- The SOVs approach has contributed not only to the relevance and effectiveness of the PHAMESA II programme (see section Relevance and Effectiveness), but has also contributed to a more efficient use of resources. The SOV approach

contributes to improved prioritization and identification of partners and primary beneficiaries and the generation of evidence of what works/what does not work for different migrant/host populations.[lxiii]

Efficiency of management

Before analyzing the efficiency of the management structure, it is important to provide an overview of current management arrangements. Following recommendations from the PHAMESA I endline evaluation, "…the regional teams in Eastern and Southern Africa were restructured to ensure optimization of skills and experience, help foster RBM practice, and reinforce programme quality. In the new arrangement, each PHAMESA II strategic result area (outcome) has a lead staff and team that have clearly defined roles for that result area and are responsible to ensure quality programme delivery and accountability. The result area leads report to an overall programme manager. One of the result area leads is also the coordinator of the programme for East Africa. To ensure the independence of the M&E function, the M&E team comprising one officer from each of the two regions reporting to the programme manager and working collaboratively with the outcome leads in matters of planning, programme delivery and accountability. In addition, to support communication with country programmes, a desk officer function has been created –regional staff members in the Southern Africa Region who filter the communication/maintain more regular contact with specific country programmes. To strengthen programme governance and oversight, a Senior Management Committee (SMC) comprising of senior PHAMESA staff members from each of the regional teams, representation from Migration Health Division in IOM Headquarters, the two regional Directors and two Country Chiefs of Mission on a rotational basis was formed in April 2014. The primary role of the SMC is to provide overall strategic guidance and decision making on broad programme matters."[lxiv]

It is important to highlight that under this new structure, not all staff members with a regional role in the implementation of PHAMESA II sit in the Regional Office. In the organigram, some regional staff members sit in the country office (e.g. the South Africa Office), which, in practice, means that they report to the Chief of Mission of the specific country where they are based.

The review of the current management structure led to the following findings on efficiency:[lxv]

- Having outcome leads has contributed to the generation of ownership of the RBM, as staff members have a more defined role and increased accountability for their respective area of work. Having outcome leads also helps capitalize on the staff members' expertise and strengths, which in turn supports better programming.
- The current management structure can, at times, slow down the decision making process- for example, during the work planning process, outcome leads, desk officers, and M&E staff are responsible for providing input. This means that there is a long consultative process where a country's work plan goes through many hands before ultimate approval.
- The fact that some members of the regional team sit in the country offices may be problematic at times, as individual work plans and evaluations are done at country level and do not always contemplate the needs and priorities of the PHAMESA II programme.

The M&E and quality control functions

- IOM key informants and survey participants at regional and country levels made positive remarks about how the M&E function has evolved since PHAMESA I. Participants felt that the M&E concepts are better understood during this phase, and that staff members at all levels are more aware of the importance of the monitoring function. This is a result of the regular support provided by the M&E team, including training for country offices and implementing partners, more user-friendly reporting templates, and feedback during the data cleaning process.
- However, as most country missions do not have M&E officers, the National Migration Health Coordinator is expected to also perform the M&E role. Constraints in staff time mean that regular monitoring, supportive supervision, follow-up, and provision of feedback to implementing partners (Outcome 3) and other initiatives are not executed on an ongoing basis. Key informants from partner organizations voiced the need for more regular dialogue with IOM's country missions to jointly identify areas of success, gaps, and potential for further collaboration.[lxvi]
- Regarding quality control (assessment of completeness, uniqueness, timeliness, validity, accuracy and consistency of data –Diagram VII), the IOM team has put different processes in place: [lxvii]
    - Training is provided to implementing partners and IOM country offices
    - Data verification takes place during field visits

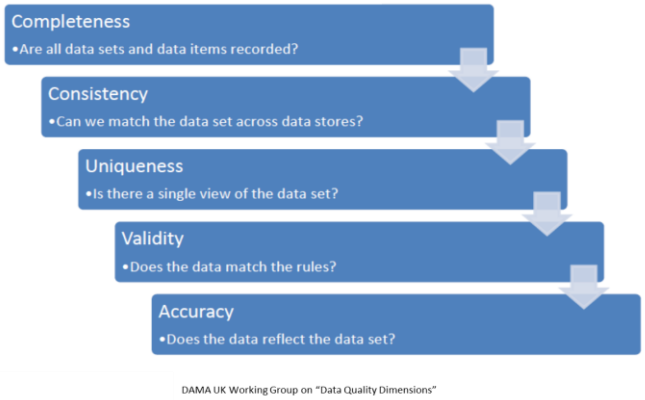
- The M&E team have standardized all reporting forms for implementing partners, facilitating data verification and data cleaning processes
- Agreements made with implementing partners clearly state the regulations regarding data protection and confidentiality
- IOM Country Offices are contacted during the data cleaning process for data sets that require revision or to address concerns
- An indicator protocol that defines all indicators is in place. However, the fact that this document has not been updated to incorporate recent changes means it is limited in its use as a reference document. The evaluation team confirmed that a revised version will be available in 2016.

- Despite these efforts, the evaluation team identified some aspects that require attention in terms of the completeness, consistency, and validity of data:
  - Completeness:
    - The requirements of the indicators are not always met, preventing a thorough data analysis of how different groups benefit from certain interventions (e.g. young people). Indicators 3.1.1 and 3.1.2 require disaggregation by age, however this information is not reflected in the PHAMESA II 2015 - 2017 Master Programme Database. IOM key informants indicated that this is due to the practicality of asking a participant's age in the context of large-scale public activities. Indicators on the provision of services (3.2; 3.3; 3.4) require disaggregation by gender, age, and migration status, however reporting of the disaggregated data varies from country to country. IOM key informants indicated this is due to local capacities, and due to the fact that in some settings it is highly sensitive to request the migration status of the beneficiary.

  - Consistency:
    - In a few cases, there is a lack of consistency between the PHAMESA II 2015 - 2017 Master Programme Database and the Country Data Report. For Indicator 2.3.1 (Number of non-health sectors that have incorporated migration and health in their policies, legislations, and strategies), Zambia's country report states three non-health sectors for the 3rd quarter of 2015, while the aggregated regional report indicates only 1 non-health sector for this country. In addition, there is some contradicting information within the PHAMESA II 2015 - 2017 Master Programme Database worksheets (e.g. For Indicator 1.2.1, the "Target vs. Achievement" worksheet indicates 17 research studies conducted, while the "Master Copy" worksheet states that 12 studies have been implemented.) The evaluation team acknowledges that lack of consistency is not a common occurrence, and may be due simply to the fact that the data cleaning process was occurring at the same time as the mid-term review.

  - Validity:
    - Validity means that the data measures what is intended to measure. For the Indicator 3.3.2c (Number of individuals referred for HIV testing who received their HIV results at the referral destination), the number is significantly higher than the number of people who were referred (captured under Indicator 3.3.2b). The reason for this discordance is that the M&E team also uses Indicator 3.3.2c to capture the people who seek HIV services, as there is no specific indicator to measure this intervention. The evaluation team acknowledges the value of finding a solution to report information on a key service being provided at the SOV level, however, the validity of the indicator in its current form needs to be assessed.

Diagram VII. Data Quality Dimensions



DAMA UK Working Group on "Data Quality Dimensions"

Learning processes in PHAMESA II

- The PHAMESA II programme builds on lessons learned from previous phases. As noted in the proposal submitted to Sida in 2013, PHAMESA incorporated the evaluation recommendations of PHAMSA II (e.g. the need to strengthen the research component, engagement and coordination among regional civil society partners, strengthening of governance and M&E, etc.) In turn, PHAMESA II has incorporated recommendations from the PHAMESA endline evaluation (e.g. using a results framework which is the basis for a set of measurable and meaningful indicators as well as baselines and targets and using clear criteria to select and prioritize countries or spaces of vulnerability).

However, the team noted some areas for improvement:

  - Burden of "keeping up" with change/learning: The project has embraced learning and change. While this is generally a positive thing, pragmatically, change translates into the need to regularly update documents and provide refresher training (e.g. on indicators), which may be a stretch for the human resources available.
  - Some efforts have been made to promote learning between countries and across implementing partners, such as sharing the annual report with all countries so they can learn from what others are doing and be informed about the overall performance, exchange visits for decision makers organized under Outcome 3, and the upcoming launch of the knowledge sharing platform. However, implementing partners and other partners (e.g. governments) expressed the need for IOM to make additional investments in this area.

Efficiency of other institutional systems

- Budget approvals: During 2015, the PHAMESA II programme "reviewed its results framework based on lessons from the past year and the baseline study. This also led to a restructuring of its budget whose approval took long."[lxviii] While this delayed the implementation of activities in all PHAMESA countries, the high level of compliance with most programme indicators shows that the team has been able to adapt their work plans to overcome these delays.
- Work planning: The process of planning the work at regional and country levels involves different steps and tools. Country/regional offices identify interventions that lead to the achievement of each output and set targets/budgets accordingly. In addition, the work plans receive input from all outcome leads, the M&E team, and the country level team, ensuring adequate alignment with the overall goal. However, as previously mentioned, the consultative process means that developing work plans can take up to six months, converting this process into an overwhelming task.
- Human resources: The implementation of the programme has been affected by staff turnover and by the IOM's rotation system.[lxix] In 2015, for instance, Namibia, Uganda, and Tanzania did not have country coordinators, and the PHAMESA regional partnership specialist was transferred. In 2016, the Programme Coordinator and the Outcome 3 lead are due to leave the project as part of the rotation system. While the organization is resilient to these changes, as it is a routine practice, these changes during a critical point of the programme could delay the implementation of activities during 2017.

Sustainability

Following the OECD/DAC definition, the evaluation team assessed the probability of continuation of benefits from a development intervention after the assistance has been completed; and the resilience to risk of the net benefit flows over time. [lxx] Questions set forth in the inception report include: what evidence is there that the programme has put in place necessary measures that will boost sustainability of programme outcomes?; to what extent has migration and health been integrated in regional, national, and local level policy or programming? The evaluation methods prioritized to answer these questions include desk review and semi-structured interviews. The triangulation of data from the two data collection methods indicates that PHAMESA II has put in place measures to ensure long-term continuation of efforts. These efforts are consistent with recommendations from authoritative sources on influencers/enablers of sustainable programmes and include measures which can be grouped within the following categories: ensuring political support, ensuring sustained funding, building ownership at different levels, and strengthening capacities and structures. [lxxi]

Ensuring political support

- Under Outcome 2 (See 'Effectiveness' section), PHAMESA II has made significant investments to ensure policy makers at regional, national, and SOV levels prioritize the inclusion of migrants and other hard to reach populations. This prioritization is reflected in legal and regulatory frameworks. Although the implementation of legal gains is still a

challenge in some settings, PHAMESA II implements sustained advocacy through one-on-one collaboration with public authorities and participation in taskforces, forums, and other spaces for dialogue.

- Sustained political support, essential for the continuation of benefits in the long term, is affected by changes in the political environment, including decentralization processes (i.e. Zambia and Kenya), election processes (i.e. Tanzania in 2015 and Uganda in 2016) and changes in public sector decision-making staff. While these changes constitute a threat for sustainability, the fact that PHAMESA II minimizes potential adverse consequences through its established country offices and the human resources focused on monitoring changes in the political environment and implementing ongoing advocacy efforts.

Ensuring sustained funding

- "The availability of resources to ensure the health and safety of those on the move and communities they interact with is paramount."[lxxii] PHAMESA II implements ongoing efforts to raise additional resources to support the implementation of interventions linked to the achievement of the results-based framework (See section on Efficiency).
- In addition, PHAMESA II has supported efforts to integrate migration and health in budget and investment plans on regional, country, and SOV levels (e.g. by securing multi-million dollar funding for the implementation of newly developed initiatives from SADC, EAC, ECSA, and other regional bodies; integrating migration and health in investment plans of provincial coordinators of the National AIDS Council in Zambia[lxxiii]; supporting the preparation and execution of the National Prevention Conference, focused on the need to consolidate a comprehensive national strategy to guide actions and the allocation of resources for HIV prevention in Mozambique.) See Case Study I. A good practice to ensure sustained funding for migration and health: The case of Zambia.
- However, beyond the examples from Zambia and Mozambique outlined in this paragraph, the evaluation team did not have access to sufficient data to confirm that the monitoring of budget allocations and financial transparency and accountability is a priority intervention for the PHAMESA II programme. One of the critiques of investments in advocacy work is precisely the sustainability of its achievements –many organizations achieve the desired political change, but implementation is limited due to lack of resources. To increase the probability of continued long-term benefits, monitoring of budget allocations and accountability should be included from the initial stage of the advocacy planning process.[lxxiv]

Building ownership at different levels

- The PHAMESA II programme works in collaboration with partners both from different sectors –public, private, non-profit, country missions of international agencies, and at different levels –regional, national, and SOV. Partners play a role in designing, implementing, and evaluating interventions connected to the different outcomes of the results-based framework, and "…through this they have gain a better understanding of the issues that need to be tackled" in each specific context. [lxxv] Numerous examples have shown how partners have taken ownership of health and migration issues (examples provided below are just a small selection of experiences and are provided for illustration purposes), by:
    - Institutionalizing these issues into their own programmes (e.g. developing formal education programmes on migration and health that will continue following the end of PHAMESA II).[lxxvi]
    - Integrating migration into their current activities (e.g. Times of Zambia newspaper dedicates a page every week to cover migration and health issues, which has made information more accessible to a wider population. As evidence shows, the media plays a critical role in the public's attitude and its relationship to social change.)[lxxvii]
    - Integrating migration into their existing/future strategies (e.g. Through the migration and health forum supported by IOM in Lesotho, some stakeholders –such as CHAI and the Miners' Development Association- had the opportunity to meet, learn about each other´s work, and start new alliances focused on migrant populations).

Strengthening capacities and structures

- Transfer of skills and knowledge is considered a key component to ensuring sustainability beyond the programme life cycle.[lxxviii] The PHAMESA II programme has implemented a broad range of interventions to address this. For instance, the programme has worked with implementing partners on the ground to build the capacity of the Change Agent networks[lxxix] and service providers[lxxx] (PHAMESA II RBF - Outcome 3) and partnered with organizations in Kenya to train community paralegals as Change Agents in spaces of vulnerability[lxxxi] (PHAMESA II RBF –Outcome 2). For Outcome 3,

the sustainability of the work **beyond the programme life cycle** might be threatened by issues such as turnover of staff and Change Agents, the capacity of Change Agent networks to continue their work without refresher training and resources to cover basic expenses (e.g. transportation), and a lack of resources to institutionalize training programmes in SOV organizations and public facilities.

Case Study I. A good practice to ensure sustained funding for migration and health: The case of Zambia.

Work is an important driver for migrants moving to, and within, Zambia. Major public and private infrastructure projects, known as capital projects, are contributing to an unprecedented movement of migrants across national borders. These projects are sometimes located in remote and unpopulated areas that rapidly attract workers, truck drivers, and all kinds of service providers to satisfy the basic needs of the people involved in the projects. Although capital projects can improve socio-economic growth, evidence shows that they can also fuel health-related issues, including the HIV epidemic, as many of these migrants spend weeks or even months away from their homes and away from their regular sexual partners.

The Zambian Environmental Management Act stipulated that all capital projects must conduct environmental impact assessments prior to the start of the project, and 5%-8% of the total budget must be allocated to mitigate the determined environmental risk. Although environmental risk was clearly addressed, the policy did not mention social impact as another area that needed to be assessed.

IOM, along with the UNDP, the ILO, and several national stakeholders such as the National HIV/AIDS Council and the National Drivers Association, worked together to provide policy makers with substantial evidence in favor of the inclusion of social impact assessments within the requirements of the Act. The Environmental Management Act was amended in 2015, and a social impact mitigation clause was added. The technical assistance that IOM provided to the task force led to the inclusion of migration, HIV, and gender and human rights as key considerations within the social impact assessment. This amendment enables migrants and migration-affected populations to benefit from capital projects in a different way. As a result of the amendment, projects like "Link Zambia 8,000 Roads Development Project", the "Pave Zambia 2000", or the rural electrification projects are providing funds for HIV and AIDS. The funds are used to provide services to the workers or to finance the overall AIDS response in the communities where the projects take place (health education and promotion, demand creation of all high-impact programmes, and response coordination and management).

Recommendations

Based on the findings presented above, a set of recommendations has been articulated by the MTR team. These recommendations aim to improve the programme's business processes, as well as to position IOM to achieve its desired outcomes and to successfully secure funds for future implementation.

OECD/DAC CRITERIA	FINDING	RECOMMENDATION
Relevance Subsection- Consistency with donor priorities	Shift in donors' focus (page 11)	i. When planning the next phase of PHAMESA II, identify complementary expertise to work on a broader agenda (e.g. sexual and reproductive health and rights organizations or initiatives). ii. Develop a complementary theory of change to identify the main preconditions which lead to the long term goal of "improved sexual and reproductive health and rights of migrants and migrant-affected populations". In this context, open an institutional space to discuss IOM's potential added value.
Relevance Subsection – Consistency with partners' priorities	Availability of mapping of partners' priorities, interventions, added value and gaps in the field of migration and health (page 11)	iii. Implement and disseminate a social network analysis specific to the field of migration and health. This process, which helps to identify stakeholders and their relationships or interactions –can contribute to identify areas of work where they may be duplication of efforts at regional, country or SOV level and areas of work where additional efforts and funding are required. The social network analysis can also feed the development of theories of change (see recommendations iii. and v.).
Relevance Subsection – consistency with beneficiaries' needs	Tailoring the packages of interventions to address the particular needs of diverse groups of migrants and host community members – e.g. men-friendly/youth-friendly interventions (page 12)	iv. Within each SOV map the diverse needs of individuals and population groups. Some individuals/groups within the SOV may face specific needs linked to compounding vulnerabilities. Understanding the specific needs of these individuals/groups can lead to developing tailored interventions and tools to strengthen service provision in public health facilities (e.g. protocols for the provision of migrant-sensitive youth services, job-aids, tailored IEC materials, etc.).
Relevance Subsection –	Strengthening the theory of change to reflect the	v. Open a space to discuss the theory of change which guided the development of PHAMESA II. Assess if any assumptions have changed or require testing;

relevance of the intervention logic	contribution of other stakeholders and the interconnection between different outcomes and outputs (page 13)		identify connections between different outcomes and outputs (integration) and potential interventions that may contribute to achieve integration; and identify (make visible) the role of partners in the achievement of outcomes and outputs.
Effectiveness Subsection Outcome 1	Additional efforts to disseminate the evidence and results from the studies and the national data collection systems (page 13)	vi.	This need will be partially met by the knowledge-sharing platform expected to be launched in 2016. A dissemination plan to inform global, regional, country and SOV level's stakeholders should be in place.
Effectiveness Subsection Outcome 2	Implementation levels of the newly developed/amended policies, strategies, and programmes vary from country to country, and at SOV level (page 14)	vii.	Continue with the implementation of the pilot paralegal work; and identify additional mechanisms to strengthen social monitoring of the implementation of legal and other regulatory frameworks –e.g. participatory budgeting; community score cards; among others, adapted to the specific realities of SOVs where PHAMESA II operates.[lxxxii]
Effectiveness Subsection Outcome 3 – Demand Creation	Improving motivation techniques (inputs) for change agents (page 17)	viii.	As improved motivation techniques for change agents is an ongoing demand, IOM may want to consider the possibility of developing few "packages of inputs" and follow-up their implementation for a period of time, to assess which one(s) are acceptable and sustainable in the contexts where PHAMESA II operates. Lessons learned on motivation techniques may be drawn from the experience of public and private organizations which have involved community health workers in their activities. [lxxxiii]
Effectiveness Subsection Outcome 3 – Enabling the supply	Strengthening referral systems (page 17)	ix. x.	Implement an operational research to identify sustainable mechanisms for improved referrals. Some mechanisms have been implemented to date –e.g. in some settings when a referral is made, the client gets assigned a change agent, who is in charge of accompanying the person in the process/making sure the person receives the desired service. However, these mechanisms may not be sustainable in the long-term and may require adaptations. Develop memorandums of understanding between implementing partners and public facilities to ensure there is a common understanding of the mechanisms and expectations regarding referrals and counter-referrals.
Effectiveness Subsection Outcome 3 – Enabling the supply	Provision of additional training and refresher training and sensitization (page 17)	xi. xii.	Provide guidance and tools to implementing partners and public facilities for the implementation of refresher training and sensitization both for health providers and change agents. Assess the suitability of integrating information on how to address mental health and stigma issues in the new version of the Change Agents Curriculum, building on existing materials by IOM –e.g. the IOM Mental Health Psychosocial Services training materials.
Effectiveness Subsection Outcome 3 – Enabling the supply	Improving the accessibility of services (page 17)	xiii.	Advocate with local authorities for the implementation of task sharing/task shifting to increase the reach of services to migrants and migrant-affected communities. "Task shifting is already being implemented as a pragmatic response to health workforce shortages to various degrees in a number of countries, and there is extensive evidence in the literature that some forms of task shifting have been adopted informally in response to human resource needs throughout history. Task shifting allows moving tasks, where appropriate, to health workers with shorter training and fewer qualifications. By reorganizing the workforce in this way, task shifting can make more efficient use of existing human resources and ease bottlenecks in service delivery"[lxxxiv]. While IOM's niche is not the provision of services, Change agents already identified for demand generation activities and referrals strengthening under PHAMESA II could be trained by other actors –e.g. the government- to implement key services, contributing to address health needs of migrant-affected communities.[lxxxv] Developing partnerships with actors who can build on/expand the role of Change agents could have a direct impact in the accessibility to services.

Effectiveness Subsection Outcome 3 – Enabling the supply	Standardize tool to assess if services are migrant-sensitive (level of compliance with characteristics of migrant-sensitive services included on the SDCB Framework) (page 27)	xiv.	Partner with organizations specialized in the provision of services to develop a standardize tool to assess if services provided within SOVs are migrant-sensitive. This type of tool could be used by implementing partners to conduct an external audit of public health facilities –if authorized/requested by these facilities-; or could be developed as self-assessments to be implemented by managers of health services.
Effectiveness Subsection Outcome 4	Improved follow-up to coordination activities (page 17)	xv.	Assess if additional human resources could be allocated to follow-up on the agreements and action plans made by IOM and partners in the context of coordination activities –forums, taskforces, etc.
Efficiency Subsection Management	Reporting and accountability of regional staff members sitting in country offices (page 21)	xvi.	Reporting: Open a space to discuss potential solutions for the current structure. Suggestions shared by some key informants include either moving the whole PHAMESA II team to the regional office –if that is not possible, having an accountability system at the regional office and the actual implementation in the country office.
Efficiency Subsection Monitoring, Evaluation and Data Quality	Improved monitoring and dialogue with implementing partners (page 21)	xvii.	Assess if additional human resources could be allocated to monitor and follow-up implementing partners efforts. If this is not possible, handling unrealistic expectations of partners, by having an open dialogue, could help to maintain strong partnerships.
	Strengthening data quality (pages 21,22)	xviii. xix. xx. xxi.	Disseminate the updated version of the indicators protocol. Provide additional training on the indicators protocol both to country offices and implementing partners to ensure a common understanding of the indicators and its meaningful use for processes of decision making. Develop an action plan to address issues of completeness, consistency and validity. In terms of consistency, it would be important to manage an error log on system where data errors and solutions are documented. Assess the possibility of adding a monitoring and evaluation role at country level –particularly for countries implementing interventions under outcome three, which requires a higher level of complexity in terms of reporting.
Efficiency Subsection Learning	Creating opportunities to exchange lessons learned (page 22)	xxi. xxii.	Preparation of short webinars (and recording of those for people who cannot attend) can provide a good platform for regional/country level to share their significant achievements and to invite external speakers to share knowledge/innovations in the field of migration and health. Outcome leads who have included inter-country learning/exchange opportunities in their work plans (e.g. Outcome 3) should document these activities and share with other members of PHAMESA II to assess the benefits/advantages/challenges/cost of making this in a more regular basis and for other outcomes.
Efficiency Subsection Other institutional processes	Staff rotation; and delays in the work planning process (page 23)	xxiii. xxiv.	Rotation: the next Senior Management Committee meeting may be an opportunity to discuss how to minimize the impact of these changes in the project implementation. The plan should clearly identify the roles where changes are expected, dates where changes will take place, human resources processes needed and potential risks (e.g. delays in hiring) and a plan for sharing/transferring information to new staff members. Work planning: the process of work planning needs to be shortened –e.g. by preparing and signing off the work plans in the context of a face to face meeting where all relevant staff is involved.
Sustainability Subsection Sustained Funding	Strengthening budget monitoring (page 25)	xxv.	As suggested under recommendation vii., assess the probability and suitability of adding social monitoring mechanisms to ensure sustained funding from governmental partners –e.g. participatory budgeting; community score cards.[lxxxvi]

Annexes

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

Annex 2. Data collection tools

Annex 3. Evaluation Team Bios

[ii] IOM. PHAMESA II Mid-Term Review Terms of Reference. As per contract signed on April 2016. Page 2.
[iii] Ídem. Page 3.
[iv] IOM. PHAMESA II PHAMESA II Annual Report 2014; PHAMESA II PHAMESA II Annual Report 2015.
[v] https://www.oecd.org/development/evaluation/dcdndep/47069197.pdf
[vi] Inception Report PHAMESA II Mid-Term Review –submitted on April 24, 2016, page 8.
[vii] http://betterevaluation.org/approaches. Accessed on June 2016.
[viii] Inception Report PHAMESA II Mid-Term Review –submitted on April 24, 2016, page 9.
[ix] Participants to be invited were selected from the list shared by PHAMESA II Regional Team on May 13, 2016.
[x] In the weeks prior to our visit, six Zambian citizens had died in what appeared to be ritual killings. The country has been experiencing an economic crisis since 2015 and hostility towards migrants has increased, mainly motivated by growing resentment towards foreign national business owners. These business owners, primarily Rwandan refugees, were accused of using magic to benefit their businesses and of being responsible for the killings. In April, 60 foreign-owned shops were looted or destroyed and hundreds of foreigners sought shelter in churches during riots against foreigners.
[xi] Inception Report PHAMESA II Mid-Term Review –submitted on April 24, 2016, page 12.
[xii] WHO. International Migration, Health and Human Rights. Page 11. Geneva. 2013.
[xiii] https://unobserver.iom.int/2030-agenda-sustainable-development. Accessed on June 23, 2016.
[xiv] Sida. Gael Lescornec and Aguil Deng (evaluation team). Endline evaluation PHAMESA I. 2014. Page 24.
[xv] PHAMESA II Annual Report 2015.
[xvi] WHO. International Migration, Health and Human Rights. Page 11. Geneva. 2013.
[xvii] Ibid
[xviii] PHAMESA II Donor Proposal Nov 2013. Page 7.
[xix] PHAMESA II PHAMESA II Annual Report 2014.
[xx] Partnership on Health and Mobility in East and Southern Africa (PHAMESA II PROGRAMME). Baseline Survey Report: Kenya – Uganda – Tanzania Report. 2015. Page 7.
[xxi] PHAMESA II Annual Report 2014.
[xxii] https://www.oecd.org/development/evaluation/dcdndep/47069197.pdf Accessed on June 20,2016.
[xxiii] Information collected through key informant interviews. This information was not included in other data collection methods, therefore cross-check was done by examining the consistency of different data sources from within the same method.
[xxiv] https://health.iom.int/. Accessed on May 31, 2016.
[xxv] Information collected through desk review (annual reports) and cross-checked through key informant interviews with SADC and EAC representatives and IOM staff members.
[xxvi] Regional partners interviewed openly expressed their interest in continuing collaborative efforts with IOM as a key partner in the area of migration and health. As mentioned in the 'Methodology' section, 2 out of 3 sampled were interviewed during the mid-term review process –SADC and EAC.
[xxvii] https://unobserver.iom.int/2030-agenda-sustainable-development. Accessed on June 20, 2016.
[xxviii] http://www.government.se/contentassets/75e7c3cad79e4c6f9fb3e4b164482774/resultatstrategi-srhr---eng-2015_2.pdf Accessed on June 20, 2015.
[xxix] Some of these actors, however, have been involved in the mid-term review process as key informants (semi-structured interviews).
[xxx] Information provided by PHAMESA team during the revision of the first draft of the mid-term review.
[xxxi] Information cross-checked within semi-structured interviews. These findings reflect the views of partner organizations in Lesotho and Kenya. In Zambia, partners did not make explicit comments in this regard.
[xxxii] Within the East Africa region, Kenya is a popular destination for migrants from Ethiopia, Tanzania, Sudan, Somalia, and Uganda. In Southern Africa, South Africa has historically been considered the destination of choice for migrants from Mozambique, Swaziland, Lesotho, Botswana, Zimbabwe, and further afield. However, countries such as Malawi, Mozambique, and Zambia are increasingly being viewed as alternative destinations. When considering trans-continental migration from Africa, available data from 2010 indicates that

more than 90% of migrants from North Africa, 63% from Southern Africa, and 58% from Central Africa migrated to destinations outside Africa (Shimeles, 2010).

[xxxiii] Cross-checked through desk review and key informant interviews with regional and country level PHAMESA II staff members and partner organizations at local levels.

[xxxiv] Need assessments are implemented at country level through the use of different sources of information.

[xxxv] The 2015 PHAMESA II Annual Report offers examples on how the baseline assessment is used at regional level (pages vii and 31) and at country level (page 10-11). However, during the key informant interviews with IOM staff, participants suggested a better use of all research produced under PHAMESA to inform decision making (beyond the baselines).

[xxxvi] Cross-checked through desk review; key informant interviews with regional and country level PHAMESA II staff members, and partner organizations at local levels.

[xxxvii] The *Improving access to healthcare services for migrants, mobile populations and affected communities: capacity building for healthcare providers* resource includes training on the following issues under Module 5: Mental health, Malaria, Infectious diseases, Chronic medication – continued access (TB/HIV), Pregnancy and child birth, Sexual and reproductive health, Sexual and gender-based violence

[xxxviii] Cross-checked through desk review (Annual reports); key informant interviews with regional and country level PHAMESA II staff members.

[xxxix] Redrup Publications. Introducing Person-Centred Care Approaches. Redrup Publications, undated.

[xl] Guttmacher Institute, International Planned Parenthood Federation. Facts on the sexual and reproductive health of adolescent women in the developing world. April 2010 New York: Guttmacher Institute/IPPF; 2010. Available at: www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf; United Nations. International Conference on Population and Development. Programme of Action. Cairo, 1994. Available at: http://www.un.org/ecosocdev/
geninfo/populatin/icpd.htm; World Health Organization. Sixty-fourth World Health Assembly. Youth and
health risks. WHA64.28. 24 May, 2011. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R28-en.pdf.

[xli] www.theoryofchange.org Accessed on June 25, 2016.

[xlii] https://www.oecd.org/development/evaluation/dcdndep/47069197.pdf Accessed on June 20, 2016.

[xliii] PHAMESA II consolidated workplan for 2016 cross-checked through key informant interviews with IOM regional staff members. (Note: the version accessed by the evaluation team does not include the work plan for Tanzania).

[xliv] Information collected through key informant interviews with IOM regional staff members.

[xlv] PHAMESA II consolidated work plan for 2016, cross-checked through key informant interviews with IOM regional staff members.

[xlvi] PHAMESA II Annual Report 2015. Page 19.

[xlvii] Cross-checked through key informant interviews with PHAMESA II country level staff and implementing partners.

[xlviii] PHAMESA II Annual Report 2015. Page 21.

[xlix] Cross-checked through key informant interviews with PHAMESA II regional staff; desk review (PHAMESA II Annual Reports and Healthy Migrants In Healthy Communities, IOM's approach to facilitating community based migration sensitive health systems in Southern and East Africa).

[l] PHAMESA II 2015 - 2017 Master Programme Database.

[li] Cross-checked through key informants interviews with PHAMESA II country staff and implementing partners.

[lii] PHAMESA II Annual Report 2015.

[liii] Cross-checked through key informant interviews with PHAMESA II regional staff and partners and through desk review.

[liv] PHAMESA II Annual Report 2015. Page 24.

[lv] https://www.oecd.org/development/evaluation/dcdndep/47069197.pdf Accessed on June 20, 2016

[lvi] https://www.oecd.org/development/evaluation/dcdndep/47069197.pdf Accessed on June 20, 2016

[lvii] PHAMESA I, End-line Evaluation. 2014. Page 56.

[lviii] Cross-checked through key informant interviews with PHAMESA II regional and country level staff and regional partners.

[lix] In the case of Lesotho, this information was cross-checked through desk review and key informant interviews at local level. In the case of Swaziland, the evaluation team confirmed this finding through project documentation and information provided by the World Bank on its website.

[lx] Cross-checked through key informant interviews with PHAMESA II regional and country level staff; desk review.

[lxi] Information collected through key informant interviews. This information was not included in other data collection methods, therefore cross-check has been done by examining the consistency of different data sources from within the same method.

[lxii] PHAMESA II Annual Report 2015. Page 31.

[lxiii] Cross-checked through key informant interviews with PHAMESA II regional and country level staff; online survey.

[lxiv] PHAMESA II Annual Report 2014. Page 7.

[lxv] Cross-checked through key informant interviews with PHAMESA II regional and country level staff; online survey.

[lxvi] Cross-checked through key informant interviews in Kenya, Lesotho, and Zambia.

[lxvii] https://www.em360tech.com/wp-content/files_mf/1407250286DAMAUKDQDimensionsWhitePaperR37.pdf Accessed on June 23, 2016.
[lxviii] PHAMESA II Annual Report 2015. Page 31.
[lxix] In 1996, IOM implemented a mobility policy for its officials. Additional information on this policy can be accessed at https://www.iom.int/jahia/webdav/shared/shared/mainsite/about_iom/en/council/80/MC_INF_242.pdf
[lxx] https://www.oecd.org/development/evaluation/dcdndep/47069197.pdf Accessed on June 20, 2016
[lxxi] TERG. Sustainability Review of Global Fund Supported HIV, Tuberculosis and Malaria Programmes. 2013 and https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-8-15, Accessed on June 20, 2016
[lxxii] PHAMESA II Annual Report 2015. Page 7.
[lxxiii] Cross-check through key informant interviews in Zambia.
[lxxiv] https://www.ippfwhr.org/sites/default/files/advocacy-budget-eng-final.pdf Accessed on June 29, 2016.
[lxxv] PHAMESA II Annual Report 2014. Page 35.
[lxxvi] Examples from Makerere University in Uganda; University of Zambia; among others.
[lxxvii] http://jspp.psychopen.eu/article/view/96/37 Accessed on June 20, 2016.
[lxxviii] https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-8-15, Accessed on June 20, 2016
[lxxix] In Kenya, Lesotho, Mozambique, Uganda, Swaziland, and South Africa, a total of 1,779 Change Agents have been trained since the start of the project (1,007 female, 387 male; 40 trainees are reported as migrants according to the PHAMESA II 2015 - 2017 Master Programme Database).
lxxx In Kenya, Lesotho, Mozambique, Uganda, Swaziland, South Africa, and Zambia, a total of 1,400 service providers have been trained on migration and health. PHAMESA II 2015 - 2017 Master Programme Database
lxxxi Cross-checked through key informant interviews with PHAMESA II Regional and Country level staff.
lxxxii http://www.worldbank.org/socialaccountability_sourcebook/PrintVersions/Methods%20and%20Tools%2006.22.07.pdf
lxxxiii Access additional information on: https://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-10-38
lxxxiv http://www.who.int/healthsystems/TTR-TaskShifting.pdf . Accessed on July 14 2016.
lxxxv Access additional information on: HIV/STIs: http://www.who.int/workforcealliance/knowledge/resources/taskshifting_guidelines/en/; Maternal and Child Health: http://optimizemnh.org/optimizing-health-worker-roles-maternal-newborn-health/ ; Contraceptives: http://www.who.int/reproductivehealth/publications/family_planning/task_shifting_access_contraceptives/en/ ; Access to safe abortion: http://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/
lxxxvi http://www.worldbank.org/socialaccountability_sourcebook/PrintVersions/Methods%20and%20Tools%2006.22.07.pdf