# IOM Partnership on Heath and Mobility in East and Southern Africa (PHAMESA)

# End-of-Programme Evaluation


Final Report
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Coxswain Social Investment Plus (CSI+)

## About the Consultants

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## About Coxswain Social Investment Plus (CSI+)

Coxswain Social Investment plus (CSI+) is a development consultancy company dedicated to getting development right and contributing to meaningful social impact. It does this by providing high quality services to international organizations, governments, civil society and the private sector across Africa.

The company focuses on tailored approaches to research, strategic planning, monitoring and evaluation as well as skills development, resource mobilization and institutional change management intended to change behaviors, lives and bottom lines.

CSI+ was founded in 2005 in Johannesburg and maintains regional offices for Southern and East Africa (Johannesburg), Northern Africa and Middle East (Tunis) and West and Francophone Africa (Lagos). Each regional office has a regional director with overall managerial and programmatic responsibilities and a core staff representing talent and expertise relevant to the region.

CSI works through a pan-African network of over 400 local consultants who have solid expertise and experience in a variety of areas. All our consultants adhere to our "Business Integrity Management Policy and Code of Conduct" which guides all our assignments. As a result, CSI+ has a strong track record of outstanding client satisfaction from international development organizations, the private sector and NGOs.

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## *List of Abbreviations*

ACMS: African Centre for Migration and Society
AMODEFA: Associação Moçambicana para Desenvolvimento da Família
APHRC: African Population and Health Research Centre
ART: Antiretroviral therapy
AU: African Union
CBTA: Cross Border Traders Association
CHIPS: National Strategy on Combination HIV Prevention
CHW: Community health worker
COALIZAO: Coalition for Mozambican Youth
COMESA: Common Market for Eastern and Southern Africa
CSO: Civil Society Organization
DAC: Development Assistance Committee
EAC: East Africa Community
EOP: End-of-programme-evaluation
EU: European Union
FGD: Focus group discussion
GA: General Assembly
HCT: HIV counselling and testing
HEARD: Health Economics and HIV/AIDS Research Division
HIV: Human immunodeficiency virus
IBBS: Integrated Biological and Behavioural studies
IDP: Integrated Development Plan
IEC: Information, education and communication
IGAD: The Intergovernmental Authority on Development
ILO: International Labour Organization
IOC: International Olympic Committee
IOM: International Organization for Migration
KABP: Knowledge, Attitudes, Beliefs and Practices
M&E: Monitoring and Evaluation
MOH: Ministry of Health
MRF: Missions with Regional Functions
NAC: National Aids Council
NGO: Non-governmental organization
NOPE: National Organization of Peer Educators
OECD: Organisation for Economic Co-operation and Development
OSBP: One-Stop Border Posts
OSF: Open Society Foundation
PEPFAR: The President's Emergency Plan for AIDS Relief
PHAMESA: Partnership on Health and Mobility in East and Southern Africa
PHAMSA: Partnership on HIV and Mobility in Southern Africa
RATESA: Regional Support Team for East and Southern Africa (UNAIDS)
RBA: Rights Based Approach
REC: Regional Economic Community
SADC: Southern African Development Community
SBBC: Social Behaviour Change Communication
SDCB: Service Delivery and Capacity Building
SIDA: The Swedish International Development Agency
SMT: Senior Management Team
STI: Sexually transmitted infection
SWABCOHA: Swaziland Business Coalition on HIV and AIDS
TB: Tuberculosis
TDAZ: Truck Drivers Association of Zambia
UN: United Nations
UNCTS: United Nations Country Teams
UNAIDS: Joint United Nations Programme on HIV/AIDS
UNDP: The United Nations Development Programme
UNFPA: The United Nations Population Fund
UNGASS: United Nations General Assembly Special Session on HIV/AIDS
UNHCR: United Nations High Commissioner for Refugees
UNICEF: United Nations Children's Fund
USAID: United States Agency for International Development
USAID RHAP: Regional HIV and AIDS Programme
USD: United States Dollars
USRP: United States Refugee Program
WFP: United Nations World Food Programme
WHA: World Health Assembly
WHO: World Health Organization

## *Executive Summary*

**Part 1. Evaluation Scope & Methodology**
This evaluation is being undertaken to ensure accountability and learning and inform the next phase of PHAMESA. It examines achievements, assesses the programme in terms of its effectiveness, efficiency, relevance and design as well as its impact and sustainability, it consolidates lessons learned and provides specific recommendations aimed at moving the programme forward. The evaluation is anchored in a methodology that uses document reviews, interviews with key informants, on-site visits to selected countries (South Africa, Mozambique, Kenya and Uganda), focus group discussions with beneficiaries and an online survey.

**Part 2. Programme Context & Overview**
PHAMESA has evolved in scope, scale and structure from two previous programmes known as PHAMSA I and PHAMSA II. It is anchored within a policy and institutional context that guides the programme and its components, including the WHA resolution 61.17 and IOM Migration Health programme areas. PHAMESA is a unique programme, which cuts across two regional offices and whose overall management lies within the South Africa country office. Specific countries have benefited from operational start-up funds, while others received seed funding with the aim of having PHAMESA play a catalytic role in mobilising resources among stakeholders in country and at a regional level.

**Part 3. Findings on Relevance and Design:** Why PHAMESA?
In a region characterised by high mobility and the world's worst epidemics of HIV and TB, having a regional programme focusing on migration and health is critical. It also contributes directly to fulfilling global commitments on the health of migrants. At a design level, PHAMESA provides a good balance between (i) a standard approach in line with global WHA priorities and IOM programme areas and (ii) a flexible approach based on country needs and gaps that enables each country to meet and prioritise its own needs. However, the way the programme provides this flexibility needs to be carefully managed to ensure proper ownership of the programme. An important aspect of the design of the programme is around the catalytic role it plays in brokering partnerships. In terms of the design of the intervention logic, the existing PHAMESA framework has several challenges. The most important is that PHAMESA is currently managed by objectives and interventions and does not articulate overall programme results. This significantly limits the programme's capacity to monitor and manage results at different levels. More importantly, it poses fundamental challenges when it comes to demonstrating progress in relation to the overall programme.

**Part 4. Findings on Effectiveness and Impact:** What has PHAMESA achieved?
The evaluation examined results at the level of change in knowledge and capacity where the programme is able to show clear and consistent results. At the level of behaviour and institutional change, the picture is more mixed with more progress being witnessed in Southern Africa where the programme has been going for longer but also in countries where all components collectively contribute to the results. At the level of impact, this is experienced mainly in South Africa where the programme has been in existence for nearly 10 years and changes are being felt at the level of people's quality of life.

**Part 5. Findings on Efficiency:** How is PHAMESA managed?
Despite important efforts to establish management processes and structures to improve programme implementation, PHAMESA has evolved as a regional programme in terms of scope, coverage and structure but is limited by management systems and procedures that are no longer suitable. The programme is also anchored in a centralised

management structure, linked to one country office, which limits the level of collective ownership and
accountability. There is a real opportunity for PHAMESA to benefit from more efficient management systems and structure.

**Part 6. Findings on Sustainability & Cross-Cutting Issues:** What does PHAMESA leave behind? According to respondents to the online survey, PHAMESA's greatest added value involves (i) increasing the visibility of migrant populations, (ii) increasing partnerships around resources and expertise, and (iii) facilitating policy formulation and implementation both at national and regional levels. These contribute to a more general added value identified by the evaluation around sustainability. The design of the programme and the ways in which the programme components are implemented takes careful consideration of sustainability. In addition, the human rights based approach in which PHAMESA is anchored is an important one to capitalise on. Linked to this is the promotion of gender within PHAMESA interventions, which has the potential to be strengthened and addressed more consistently.

**Part 7. Recommendations**

**1. Results Based Management**

PHAMESA is currently managed by objectives and interventions. It does not articulate overall programme results and does not have systems in place to monitor or manage results.

1.1. In order to measure and report on results, PHAMESA must start to **manage around results** which includes planning, monitoring, budgeting and reporting around results. This will help the programme become more integrated and demonstrate more meaningful impact.

1.2 As a first step, PHAMESA must go back to the drawing board to establish a common **theory of change** to establish the changes it wants to contribute to based on the problem identified (and not based on objectives, i.e. what we want to do, or interventions, i.e. how we do it).

1.3. The theory of change should be the basis for the development of a **results based logic framework** that identifies results (or changes) at the different levels: output, outcome and impact.

1.4. Underlying Results Based Management is the key principle of **collective accountability**. Planning with all relevant players to ensure ownership and accountability is key to the planning process.

1.5. The results based logic framework will be the basis on which to identify measurable and meaningful indicators as well as baselines and targets for each indicator. Measuring progress is dependent on the establishment of baselines for each indicator so as to enable the programme to measure progress over time. This will form the basis for **results based monitoring and evaluation plan.**

1.6. Results need to be managed throughout the management cycle including the budgeting stage. **Results based budgeting** will need to replace the activity based budgeting.

1.7. In terms of **human resources**, positions and job descriptions need to reflect the management of results. Appropriate management functions should be established to lead this process. Job descriptions should be performance based or at the very least clear on what specific result(s) the job is aiming to contributing to.

**2. Management Processes**

Management systems and procedures to support the effective programme implementation and expansion of PHAMESA need to be strengthened.

2.1. The process of **strategic planning** should be systematic, consistent and inclusive. Systems should be in place to allow for collective accountability and ownership of the programme. This means a more decentralised approach and management of the programme.

2.2. It is important to nurture an internal culture of **monitoring**, reporting, sharing and learning. More regular internal narrative reports, such as those used in East Africa, promote a culture of reflection and sharing of lessons learned outside of official reporting requirements.

2.3. Monitoring should be a more **integrated process** that takes within planning and with programme staff.

2.4. Collectively developing meaningful and measurable **indicators and baselines** for the overall programme is critical for measuring progress and advancing the programme as a whole.

2.5. There is an opportunity for improved **internal communication**. One platform that may be relevant and useful is KARL (http://karlproject.org) which is an open source web system for collaboration, organizational intranets, and knowledge management

2.6. **Learning** should be promoted across the regions. The same way in which South Africa is a learning site for the Southern Africa, a learning site could also be identified and invested in East Africa.

2.7. As PHAMESA enters a new phase, there is an opportunity to adopt a more strategic and decentralised approach to **resource allocation**. Funding at country level should be anchored within the IOM country strategies that country level stakeholders can mobilise around. This means establishing a system of planning that involves IOM country offices and Chiefs of Missions more closely. In addition, the programme should also be anchored more closely with the regional strategies of the IOM regional offices in both Southern and East Africa

2.8. Also on **resource allocation**, PHAMESA needs to strike a balance between (i) prioritising countries and sites and making sufficient funds available for these and (ii) supporting all countries to fulfil their obligations to the WHA resolution on migrant health by providing financial as well as capacity support determined by and aligned to the IOM country strategy.

## 3. Management Structure

The overall internal PHAMESA management structure has largely evolved to reflect the programme's components. There are several challenges with the current management structure which need to be addressed in moving forward.

3.1. In this regard, as PHAMESA moves into a new phase, it would benefit from revising its current management structure to accommodate a structure that reflects **management functions** to ensure the achievement of overall programme results instead of only programme components. This proposed revision of the management structure would also be more in line with the new proposed results framework of PHAMESA, which looks to be results based instead of based on programme components. The programme components would then form part of the interventions or activities that collectively lead to results.

3.2. It is recommended that a **Senior Management Team (SMT)** be established, which would include senior regional staff from each of the regional teams as well as relevant staff from selected country offices including migration health country coordinators. This SMT should establish clear terms of references aimed at providing guidance on overall programme planning, monitoring, budgeting, reporting, etc. The role of the team and its individual members should be clearly stated. This would help to address the challenges around collective ownership and accountability.

3.3. An **organisational arrangement** should be explored to ensure that: (i) PHAMESA is not associated with a country office and (ii) PHAMESA is not headed by a country chief of mission.

3.4. PHAMESA would benefit from **clarifying the roles** and authorities of each regional teams and the relationship between the two for the benefit of the overall programme

## 4. Programme Components

### 4.1. Service Delivery and Capacity Building.

- This evaluation has found that the real value of SDCB is around capacity building of governmental and non-governmental entities;
- The approach around SBCC and gender responsiveness should continue to be promoted and adapted to different countries and in East Africa;
- In ensuring access and use of services, SBCC needs to be seen as one element within "HIV combination prevention" as outlined in the global UNAIDS Investment framework. In this regard, it is important for PHAMESA to promote the other activity areas as well as the social and programme "enablers" (see UNAIDS Impact Investment Framework 2011).

### 4.2. Research and Information.

- It is important that the rich baseline generated at the beginning of the programme be complemented with end-of–programme data to fully measure progress in knowledge and behaviour. In this regard, it would be useful to conduct similar studies or even rapid assessments such as KABP with targeted communities to compare levels of knowledge as well as the extent of the original problem and whether it has been mitigated or not.
- Most Indicators are process or activity based and do not have baselines.

### 4.3. Advocacy and Policy Development

- It is critical for advocacy efforts to be clearly defined using similar criteria so as to provide clear and consistent guidance and for the programme to be better able to be measure progress across the board. A useful guide in this regard is the "Guide to measuring advocacy and policy, ORS, 2001"

### 4.4. Regional Coordination.

- Regional coordination can only benefit from having a more solid overall programme where its **role** in terms of facilitating regional work but also in support to countries should be made more clear.
- With the wealth of experience accumulated over the recent years around regional coordination on migration health in Southern Africa, it would be useful to **document lessons learned** including models and approaches used either with one specific stakeholder such as SADC or on a specific issue such as TB in the mining sector. This would be useful for learning purposes but also would benefit current similar efforts in East Africa.
- There is a real opportunity for PHAMESA II to be increasingly shaped by the specific migration health dynamics and experiences in **other sub-regions** including East Africa as well as the Indian Ocean and the Horn of Africa.

## 5. Sustainability and Cross-Cutting

5.1 **Capacity building** interventions with national and local government departments and service providers to design and manage their own programs in a sustainable basis should be continued in the next phase of PHAMESA, especially in those countries where this capacity is still weak.

5.2. It is important to continue to emphasise the need for PHAMESA to provide support in a sustainable way by avoiding parallel processes that may not have the potential to be **absorbed** by government service providers.

5.3. Ensure that **gender** is more integrated within the results framework and indicators of PHAMESA as it enters a new phase

5.4. Integrate **environmental** aspects when conducting baseline assessments with partners and beneficiaries

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# PART 1. Evaluation Scope & Methodology

## 1.1. Evaluation Objectives

**Rationale.** The International Organisation for Migration (IOM) is conducting an end-of-programme evaluation (EOP) of its Partnership on Health and Mobility in East and Southern Africa (PHAMESA). The EOP is primarily intended to provide accountability and learning for programme staff and donors. It is being undertaken as the programme comes to an end and coincides with planning for the next phase of PHAMESA.

**Purpose.** The purpose of the evaluation is in line with the learning and accountability functions of evaluations as defined in the OECD Development Evaluation standards. Specifically, the EOP aims to: (i) provide accountability of funding to donors; (ii) provide lessons to improve the programme; and (iii) inform the next phase of the programme.

**Objectives.** The evaluation set itself the following specific objectives:

- To examine achievements (focusing on outcomes and outputs) against what was planned (including baselines and targets);
- To assess the programme in terms of its effectiveness, efficiency, relevance and design as well as its impact and sustainability;
- To consolidate lessons learned by highlighting what has worked and what can be improved; and
- To provide observations and recommendations.

## 1.2. Scope Evaluation

The scope of the evaluation is defined in terms of the programme funds, duration of the programme, geographical coverage, target groups, and interventions or "components" defined by the programme.

| PHAMESA Programme Scope | |
|---|---|
| **Overall Objective** | To contribute to the improved standard of physical, mental and social wellbeing of migrants by responding to their health needs throughout all phases of the migration process, as well as the public health needs of host communities using IOM's network |
| **Key Components** | 1) Improved service delivery and capacity building;<br>2) Advocacy for policy development;<br>3) Research and information dissemination;<br>4) Improved regional coordination; and<br>5) Governance and control. |
| **Target Groups** | Mobile workers, labour migrants, forced migration and irregular migrants, including those in an irregular status as well as asylum seekers, refugees and other displaced persons; the more comprehensive concept of "Spaces of Vulnerability" is used to target entire communities affected by migration. |
| **Geographical Coverage** | 18 Countries in East and Southern Africa: Angola, Botswana, Djibouti, DRC, Ethiopia, Kenya, Lesotho, Mauritius, Mozambique, Namibia, Tanzania, Somalia, South Africa, South Sudan, Swaziland, Uganda, Zambia and Zimbabwe |
| **Duration** | 1 July 2010 – 30 June 2013, 36 Months (plus 6 months extension until Dec 2013) |

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|---|---|
| **Budget** | USD 9,189,600 |
| **Donors** | SIDA, plus additional funding mobilised from the Netherlands for TB in the mining sector in Southern Africa (USD 5 mil) |
| **Partners** | Regional Economic Communities (SADC, COMESA, EAC, IGAD), National AIDS Councils, Ministries of Health, Ministries of sectors dealing with mobile and migrant workers (Maritime, Agriculture, Transport, Public Works, Mining, Home Affairs, etc.), private sector companies, unions, UN Partners (UNAIDS, WHO, ILO, UNHCR, UNICEF, WFP), and international and local NGOs. |

### 1.3 Evaluation Design

**Criteria.** The evaluation applies the five OECD DAC criteria for evaluating development assistance: relevance, efficiency, effectiveness, impact and sustainability. Specific questions were developed to further define each criterion. Due to the duration of the programme, specific emphasis was placed on relevance and design, efficiency and effectiveness.

**Questions.** A set of guiding questions for this evaluation was developed using the OECD DAC criteria to guide the desktop research, interviews and observations during field visits. Some questions were modified from the original proposed questions included in the inception report (Annex 1).

**Intervention logic and findings.** The evaluation describes and assesses the programme intervention logic which is based on objectives and interventions. It proposes a new results logic framework in order to allow for the full measurement of results at different levels, particularly outputs and outcomes.

### 1.4. Evaluation methods and information sources

The methods used for this evaluation are a combination of (i) document reviews, (ii) semi-structured interviews, (iii) focus group discussions, (iv) observations from site visits, and (iv) online surveys.

**Document Review.** The evaluators reviewed a wide range of documents covering programme design, implementation, and monitoring and evaluation as well as financial, administrative, management and programmatic documents, and country level documents. A set of documents were initially identified and provided by programme staff at regional and country level and other documents were identified and requested by the evaluation team, which were duly provided. All documents were assessed for validity and reliability (Annex 2).

**Interviews with Key Informants.** In close collaboration with IOM, an initial list of key informants was identified for this evaluation which evolved during the evaluation (see table below). All contacts were assessed for validity and reliability and on some occasions it was determined by the evaluators that specific contacts were not relevant to the evaluation. The evaluators conducted face-to-face and telephonic interviews with a wide range of stakeholders using semi-structured interviews. Key informants were initially contacted by email and were followed either by another email or a phone call if a number was available (see Annex 2 for a full list of key informants; See Annex 3 for Interview guides).

| | |
|---|---|
| **IOM** | PHAMESA staff; IOM country and regional offices involved in the programme; IOM MH Geneva; etc. |
| **Donors** | SIDA; Dutch; USAID/ PEPFAR/TEBA; SADC, UN |
| **Implementing Partners** | See Annex 2 and Country Assessments |
| **REC** | SADC, EAC, IGAD |
| **Government** | Relevant Ministries or Departments in each country including health; Immigration and border control, Transport, Local Government; National AIDS Control Councils; National AIDS and STI Control Programmes; National TB Management Programmes for some countries |
| **United Nations** | Relevant UN agencies at country and regional level |
| **Research and Academic Institutions** | African Population and Health Research Centre (APHRC); University of Nairobi; Great Lakes University of Kisumu; University of Witswatersrand African Centre for Migration and Society (ACMS) |
| **Private Sector** | Global Business Coalition on Health |
| **Beneficiaries** | Representatives of migrant workers, their family members, asylum seekers, refugees and displaced persons, communities affected by migration. |

**Focus Group Discussions**. Focus group discussions were conducted primarily with beneficiaries during country visits. A total of nine focus groups discussions were conducted and a total of 86 beneficiaries interviewed (41 in South Africa, 17 in Uganda, 14 in Kenya and 14 in Mozambique). The main criterion used for the selection of beneficiaries was availability. The same questions were used in all the focus group discussions (see Annex 3 for the Focus Group Discussion Guide).

**Site visits.** The evaluators conducted site visits in four selected countries -- Mozambique, South Africa, Kenya and Uganda. The focus of the site visits was to get first-hand experience of the programme by speaking to beneficiaries as well as to observe implementation and management processes and results on the ground. The selection of the specific sites was made in consultation with IOM staff and based on the most relevant projects that best reflected the scale and scope of the PHAMESA programme.

Sites visited in each country:

- South Africa – Musina, Hoedspruit, and Mopani; Polokwane and Pretoria
- Mozambique – Maputo, Ressano Garcia and Xai-Xai
- Uganda – Kampala, Kiryadongo, Lyantonde and Rakai
- Kenya – Eastleigh in Nairobi

An additional four countries were assessed remotely – Mauritius, Namibia, Tanzania and Zambia. Tanzania had originally been selected for a visit but the evaluators suggested replacing it with Uganda after a rapid review demonstrated that Tanzania does not have any direct beneficiaries, which was one of the primary reasons for conducting the site visits.

**Online Survey.** An online SurveyMonkey was administered to all relevant IOM staff, implementing partners and technical partners at regional and country level. The aim of the SurveyMonkey was to provide an additional layer of back up to the evaluation findings. The survey was developed in a way that could be understood by both internal IOM staff and external partners (including explaining terminologies). The survey was not meant to be exhaustive or address all the

evaluation questions. Instead, it was meant to provide qualitative data based on a few pertinent questions related to the evaluation's guiding questions (see Annex 4 for the SurveyMonkey questions and findings).

### 1.5. Quality assurance

**Triangulation.** Quality control was exercised throughout the evaluation process. The evaluators made every effort to triangulate findings based on the different sources of information available, including documents, interviews, observations and surveys. In triangulating the findings from different sources, the evaluators assessed patterns between (i) what people were saying, (ii) what was being reported and (iii) what they were seeing and hearing. Where specific examples or quotes are used in the evaluation report, it is to articulate or illustrate a trend or common finding and is not meant as a stand-alone finding.

**Validity of Findings:** The findings included in part 3-6 have been made based on a combination of document reviews, online survey results, interviews with key informants, and observations. Specific examples to substantiate these findings are included throughout the report. References to specific pieces of data to back up these examples are made where relevant. The result is a set of key findings and lessons learned that are highlighted in red throughout the report. Some of these findings and lessons learned have led to recommendations. Several findings and lessons learned lead to the same recommendation. A summary table linking findings and recommendations is included in the last section under recommendations (part 7).

**Validation by IOM.** Relevant IOM staff were given the opportunity to comment on findings through two sets of initial presentations and overview of findings. The evaluation report reflects these collective comments. A formal set of consolidated and anonymous comments were provided based on the first draft of the evaluation report. This included a document with general comments and a copy of the draft report with comments in track changes. Each of these comments were pulled out and addressed individually in a table included in annex 10 of this final report.

**Independence.** The evaluators were independent from any functions of the IOM were able to provide objectivity and neutrality. The evaluators worked under the CSI+ Business Policy on Code of Conduct (Annex 5). The evaluation process made every effort to show sensitivity to the gender, beliefs, manners and customs of all stakeholders and the process was undertaken with integrity and honesty. The rights and welfare of participants in the evaluation were protected.

**Confidentiality.** The anonymity and confidentiality of individual informants was protected and requests to not be cited were respected. All interviews were conducted in confidence and in a closed environment (whether by phone or face-to-face). No respondent was mentioned by name.

### 1.6. Evaluation process and limitations

The evaluation benefited from a free and open process facilitated by the IOM South Africa office in Pretoria. Every effort was made by IOM to provide requested information, facilitate meetings and accommodate the evaluators as needed. A mutual degree of flexibility and accommodation was exercised by both the IOM and the evaluators in order to get the most out of this evaluation.

The only area of confusion observed by the evaluators was around the quality assurance process of the evaluation. At the inception of the evaluation process, a reference group was established to provide quality assurance and guidance. After this initial interaction with the reference group, there was no further mention of the reference group and instead, the evaluation team was introduced to an external consultant to IOM as the person overseeing the quality assurance of the evaluation process and who continued to oversee the process until the end.

From the start, it was recognised that the evaluation was to be conducted within a very tight timeframe. This presented significant limitations in terms of: (i) the lack of time to process and analyse information, (ii) the need to constantly prioritise documents and key informants and (iii) limitations to the level of depth that could be achieved. As much as the evaluators tried to work within the set time constraints (see detailed schedule in Annex 6), some deliverables were impossible to complete on time. For example, after finishing site visits to East Africa the team only had one day to come together to discuss findings, triangulate information, make their analysis and write up their note on final findings. This was simply not possible and a one week extension was requested and granted.

There seemed to be different expectations on some of the deliverables. For example, because of the tight schedule it was agreed to provide IOM with a note on initial findings and a note on final findings to allow IOM to share some direction with SIDA. However, the process that accompanied the note on final findings was similar to a process that follows a draft report. In hindsight, one overview of initial findings would have been sufficient followed by a presentation on the final report.

## PART 2. Programme Background and Overview

### 2.1. Policy context

The global policy context around migration and health was previously underpinned by a human rights based approach, which focused primarily on the rights of migrants. However, this has evolved in recent years into a more public health based approach, which is centred on the health of migrants as a response to global health challenges. There have been a number of landmark global initiatives, including the:

- ✓ Resolution 61.17 on the Health of Migrants, 61st World Health Assembly, 2008;

- ✓ Declaration of Commitment on HIV/AIDS, United Nations General Assembly Special Session on HIV/AIDS (UNGASS), 2001;
- ✓ 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.

At a regional level, migration and health has been addressed within the context of communicable diseases and specifically within the response to HIV and AIDS. Key policies adopted by the AU and regional economic communities, such as SADC and EAC, as well as donors such as SIDA have helped to contextualize and guide the response to migration health. These include the:

- ✓ African Union Abuja Declaration on HIV/AIDS, TB & Other Related Infectious Diseases, 2001;
- ✓ SADC HIV and AIDS Strategic Framework, 2008 -2015;
- ✓ SADC Declaration on HIV/AIDS, 2003 (referred to as 'Maseru Declaration');
- ✓ SADC Policy Framework on Population Mobility and Communicable Diseases;
- ✓ EAC Regional Integrated Multi-sectoral Strategic Plan for HIV&AIDS 2008–2012; and
- ✓ SIDA's International HIV/AIDS policy efforts '*The Right to a Future'* 2008.

## 2.2 The institutional context

At an institutional level, IOM's global Migration Health Department in Geneva is responsible for the provision of policy guidance and technical assistance to the regional and country missions, while leading or engaging in global initiatives and policy dialogues on Migration Health.

**IOM's Vision on Migration Health:** Migrants and mobile populations benefit from an improved standard of physical, mental and social wellbeing, which enables them to substantially contribute towards the social and economic development of their home communities and host societies.

### IOM's Strategic Objectives on Migration Health

IOM's strategic objectives on migration health are derived from the 2008 WHA Assembly Resolution on the health of migrants. This recommended action in four key areas, which were further operationalized and agreed upon during the 2010 Global Consultation on the Health of Migrants that was organised by WHO, IOM and the Government of Spain:

1. Monitoring migrant health;
2. Enabling conducive policy and legal frameworks on migrant health;
3. Strengthening migrant friendly health systems; and,
4. Facilitating partnerships, networks and multi-country frameworks on migrant health.

At a programmatic level, IOM's Migration Health strategy consists of three areas:

1. **Migration Health Assessments** to ensure that migrants benefit from health assessment services as well as travel assistance for migrants;
2. **Health promotion** to ensure equitable access to quality health services for migrants and mobile populations; and
3. **Health of Migrants in Crisis** to ensure that health is addressed as an integrated and cross cutting component of IOM's humanitarian response.

PHAMESA features within the health promotion area but overlaps with the other two areas depending on the specific context.

### 2.3. PHAMESA at a glance

The IOM's PHAMESA programme is the only regional programme responding to the health needs of migrants and communities affected by migration in East and Southern Africa. The high levels of communicable diseases in the region, particularly HIV, TB and STIs, combined with complex mobility patterns translates into a real need to pay special attention to how migrant communities can access quality health care and prevention services.

The PHAMESA programme has evolved in scope, scale and structure from two previous programmes known as PHAMSA I and PHAMSA II (see table below). These originated as HIV prevention initiatives for specific migrant populations and sectors in Southern Africa. The programme has since expanded into a more comprehensive public health response programme targeting migrants or communities affected by migration – referred to as 'spaces of vulnerability' – in both Southern and East Africa.

| | PHAMESA | PHAMSA II | PHAMSA I |
|---|---|---|---|
| **Overall Objective** | To contribute to the improved standard of physical, mental and social wellbeing of migrants by responding to their health needs throughout all phases of the migration process, as well as the public health needs of host communities using IOM's network. | To contribute to the reduction of HIV incidence and the impact of AIDS among migrant workers and their families in selected sectors in the SADC region. | To reduce the vulnerability of mobile populations to HIV and AIDS in the SADC region, by bringing together relevant stakeholders to develop programmes for mobile populations. |
| **Key Components** | 1. Improved service delivery and capacity building;<br>2. Advocacy for policy development;<br>3. Research and information dissemination;<br>4. Improved regional coordination; and<br>5. Governance and control. | 1. Advocacy for policy development;<br>2. Research and learning;<br>3. Regional coordination and technical cooperation; and<br>4. Pilot projects | 1. Policy development;<br>2. Information dissemination;<br>3. Capacity development;<br>4. Research; and<br>5. Advocacy |
| **Target Groups** | Mobile workers, labour migrants, forced migrants and irregular migrants, including those in an irregular status as well as asylum seekers, refugees and other displaced persons; the more comprehensive concept of 'Spaces of Vulnerability' is used to target entire communities affected by migration. | Migrants and mobile workers, including those from the following sectors: (i) construction workers, (ii) transport workers, (iii) farm workers, (iv) fisher folk, (v) mineworkers, (vi) informal cross border traders, and (vi) border officials, | Sectors: (i) Commercial agriculture; (ii) Public works/construction; (iii) Mining; and (iv) Uniformed services sector. |

| | | | |
|---|---|---|---|
| | | including police and immigration officials. | |
| **Coverage** | 18 countries in East and Southern Africa – Angola, Botswana, Djibouti, DRC, Ethiopia, Kenya, Lesotho, Mauritius, Mozambique, Namibia, Tanzania, Somalia, South Africa, South Sudan, Swaziland, Uganda, Zambia and Zimbabwe. | All 15 SADC countries | 8 SADC countries – Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. |
| **Duration** | 1 July 2010 – 30 June 2013, 36 Months (plus 6 months extension until Dec 2013) | March 2007 – October 2010 | January 2004 – December 2006 |
| **Budget** | USD 9,189,600 (plus USD 5 mil on TB in mining from the Netherlands) | USD 6.5 million (SEK 45.5 million) | USD 2,058,000 + Euro 400,000 |
| **Donors** | SIDA<br>Plus funding on TB in the mining sector from the Netherlands | SIDA (Regional Swedish-Norwegian HIV/AIDS Team for Africa)<br>Plus USAID RHAP funding to do regional research, and SADC HIV Special Fund to do research on ports | SIDA: USD 2million<br>EU via SADC Secretariat: Euro 400,000<br>Dutch Regional AIDS Programme: USD 58,000 |
| **Partners** | Regional Economic Communities (SADC, COMESA, EAC, IGAD), National AIDS Councils, Ministries of Health, Ministries of sectors dealing with mobile and migrant workers (Maritime, Agriculture, Transport, Public Works, Mining, Home Affairs, etc.), private sector companies, unions, UN Partners (UNAIDS, WHO, ILO, UNHCR, UNICEF, WFP), and international and local NGOs | SADC Secretariat (HIV/AIDS unit), national government ministries, NACs, UNAIDS RST, UN at national level, sectors employing mobile workers, TEBA Development, Hoedspruit Training Trust, Sonke Gender Justice Network, Sibambene Development Communications, CHAMP, Royal Swaziland Sugar Corporation | Relevant stakeholders from the SADC Secretariat, SADC governments, sectors employing mobile workers, NGOs, academia and international organisations in the SADC region |

## 2.4. Implementation and management arrangements

**Implementation.** The PHAMESA programme is implemented through four key components, which are aligned to IOM's global programmatic areas: (i) Research and Information Dissemination, (ii) Advocacy for Policy Development, (iii) Health Service Delivery and Capacity Building, and (iv) Strengthening Inter-country coordination and partnership. PHAMESA's intervention logic is based on these four programmatic areas. A fifth component looks at the internal governance and control of the programme.

The support provided by SIDA goes to the core structure of the programme (approximately 60%) and to programme activities (approximately 40%). Under this funding agreement, PHAMESA is meant to serve as a catalyst to secure additional funding to further address specific sectors, geographic locations or results areas as outlined in the PHAMESA project proposal document.

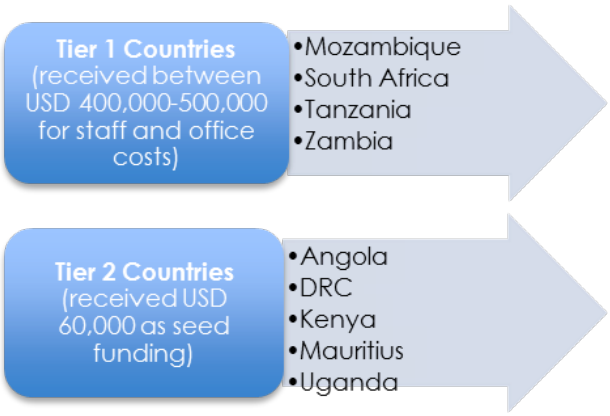
**Management Arrangements.** The country office in Pretoria is the executing agency for PHAMESA and functions as the main management site of the programme, ensuring implementation of the entire programme as well as all activities in South Africa and Southern Africa. The country office in Pretoria is also

responsible for overall coordination, reporting to the donor agencies, and channelling funding to the Nairobi country office and countries in the Southern African region. The Nairobi country office is responsible for implementing regional activities and overseeing the development, implementation and monitoring of country missions' programmes in East Africa. The Nairobi country office reports to the Pretoria country office. The head of the Pretoria country office is the IOM Chief of Mission for South Africa[1] and the head of PHAMESA (see organogram in Annex 7).

**Country Selection.** The two country offices are responsible for regional activities in their respective regions, as well as managing the activities of specific country missions:

- Nairobi country office – Kenya, Tanzania and Uganda
- Pretoria country office – Angola, DRC, Lesotho, Mauritius, Mozambique, Namibia, South Africa and Zambia.

There is no articulated strategy or criteria for the selection of PHAMESA countries. However this evaluation concluded that the selection of countries was based on a combination of (i) existing IOM country capacity and (ii) previous experience with PHAMSA I and II. Resources were allocated to countries in the following way:




IOM also planned to continue to offer technical support to IOM missions in other countries not covered by PHAMESA, namely all countries under IGAD and SADC such as Burundi, Djibouti, Ethiopia, Rwanda, Somalia, Sudan, and Madagascar.

The tier 1 countries (Mozambique, South Africa, Tanzania and Zambia) received between USD 400,000-500,000 to cover operational costs. Tier 2 countries (Angola, DRC, Kenya, Mauritius and Uganda) received seed funding (staff and office costs) of up to USD 60,000 to set up migration health activities and develop projects, which could then be used to secure future funding. In addition, PHAMESA also supported work in Somalia, Ethiopia, South Sudan, and Djibouti. A system of

[1] The position of IOM Chief of Mission for South Africa has been an 'acting' position over the past three years and is currently being advertised (December 2013).

concept notes was developed to allow countries to motivate for funding according to interventions they wanted to embark on.

Under PHAMESA, Migration Health Coordinators were expected to be placed in each country, pending funding availability, except for Lesotho and Swaziland, which would be overseen by the South Africa PHAMESA Coordinator. Namibia recently joined IOM as a Member State, and an IOM country office was only established in 2011. Up to that point, South Africa oversaw activities in Namibia. Zimbabwe is only indirectly included in the PHAMESA programme (i.e., via the provision of technical assistance, coordination and collaboration) and specific activities were not planned under the PHAMESA umbrella due to its specific socio-political situation and the need for humanitarian and emergency health interventions.

## PART 3. Findings on Relevance and Design: Why PHAMESA?

### 3.1. Responding to a Need

Migration health is a critical issue in East and Southern Africa because of the high levels of mobility in the region combined with the world's largest HIV and TB epidemics in the world. As a result, regional and national health targets increasingly recognise mobility and migrant populations as a key focus in the response. Indeed, mobile populations and migrant communities have been identified as critical populations in most national and regional responses to HIV and AIDS in both East and Southern Africa. In several cases, PHAMESA has been instrumental in ensuring that migrants are recognised as a key population in regional and national responses to specific public health challenges, including HIV and AIDS, STIs and TB.

| | HIV National Plans and Policies | Inclusion of Migrants |
|---|---|---|
| **Southern Africa** | | |
| South Africa | National Strategic Plan on HIV, STIs and TB 2012-2016 | Migrant populations are identified as a key population group |
| Mozambique | National Strategic HIV and AIDS Response Plan 2010 – 2014 | Highly mobile populations are identified as a key population group for tailored interventions |
| Zambia | National AIDS Strategic Framework 2011-2015 | Mobility and migration is identified as a key factor contributing to HIV and AIDS. Labour migration and mobility is one of the six key drivers of HIV identified in the national strategic plan. |
| Namibia | National Policy on HIV/AIDS | Mobile populations are identified as vulnerable key populations |
| Mauritius | National Strategic plan on HIV 2012-2016 | Mobile populations identified as key population |
| **East Africa** | | |
| Kenya | Kenya National AIDS strategic plan 2009/10-2012/13 | Mobile populations are identified as a group vulnerable to HIV infection |
| | National Strategy on HIV & AIDS, STI Programming along Transport Corridors in Kenya | Entirely dedicated to mobile populations and developed through IOM's leadership. |

| | | |
|---|---|---|
| Tanzania | National multi-sectoral strategic framework on HIV and AIDS 2009-2012 | Mobile populations and migrant workers are amongst the key target groups identified in the prevention strategy |
| Uganda | National Strategy on Combination HIV Prevention (CHIPS) for high-risk migrant and mobile populations 2012-2016 | Entirely dedicated to migrants and mobile populations; |
| | The National HIV Prevention Strategy for Uganda 2011-15 | No specific reference to migrant communities but inclusion of truck drivers and sex workers (considered as mobile populations) |

In Southern Africa, several recent initiatives have highlighted the extent of the problem of migration and health, including the 2009 SADC Framework on Communicable Diseases and Population Mobility, the 2012 SADC Declaration on TB in the Mining Sector and the 2011 SADC Cross-border Initiative on HIV. As will be examined in a later section, PHAMESA (or its predecessor PHAMSA) has directly contributed to each of these and to supporting SADC more generally on migration and health.

In East Africa, recognition of the need to address communicable diseases among mobile populations is growing. Since the establishment of the EAC Multi-sectoral Technical Committee of Experts on Migration Health and Migration Human Resources for Health, there has been close collaboration between the EAC and IOM through PHAMESA, including on HIV programming in the transport sector, as well as the One-Stop Border Posts (OSBP) initiative with the EAC Secretariat Health Department.

From the evidence gathered by IOM and partners at global, regional and country levels (see section 2.1), a strong case has been made for the need to address migration and health as a necessary step towards achieving the development targets of the region and of specific countries.

PHAMESA is the only regional programme focusing on migration and health both at a strategic and technical level in East and Southern Africa. PHAMESA's geographical scope across East and Southern Africa, its focus on 'spaces of vulnerability' and its wide range of partnerships, including with governments, NGOs, the private sector, academia and the media, are all aspects that make the programme unique in responding to this need in a holistic manner. From the sample of partners and beneficiaries that were interviewed for this evaluation, nearly 100% regarded PHAMESA as a unique programme that is able to facilitate strategic and technical partnerships, coordination, advocacy, research and capacity building on migration and health.

Beyond the region, PHAMESA directly contributes to the implementation of the WHA resolution on the health of migrants by providing a platform as well as technical and strategic support to signatory countries to fulfil their commitments around migration and health.

### 3.2. Relevance of programme objectives.

PHAMESA includes overall and strategic programme objectives as well as long and short term goals as outlined below:

The **overall programme objective** of PHAMESA is to 'contribute to improved standards of physical, mental and social wellbeing of migrants by responding to their health needs throughout all phases of the migration process, as well as the public health needs of host communities, using IOM's network of regional and country missions, and partnerships with Regional Economic Communities, National AIDS Councils, Ministries of Health, Ministries of sectors dealing with mobile and migrant workers, private sector companies, unions, UN Partners, and international and local NGOs'.

In addition, PHAMESA has a **strategic objective** to 'improve the standards of physical, mental and social wellbeing of migrants, host communities and their families by responding to their health needs throughout all phases of the migration process, as well as the public health needs of host communities by programme end-date'.

PHAMESA also has a **long term goal** to 'improve the management of migration health and decrease vulnerability to HIV in the context of Migration Health among selected migrant populations' in the selected countries.

It plans to achieve this through a series of **short term goals** under each of the five following 'distinct, yet inter-related' components[2].

**PHAMESA Short Term Goals**

| | |
|---|---|
| *1.1)* | *To facilitate, provide and promote equitable access to comprehensive health services (health promotion, disease prevention and care) for migrants, without discrimination on the basis of gender, age, religion, nationality or race.* |
| *2.1)* | *To advocate for regional, national and sectoral policies that contribute to the improved standard of physical, mental and social well being of migrants.* |
| *2.2)* | *To facilitate a conducive environment for policy development through increased awareness of and support for the importance of addressing Migration Health.* |
| *3.1)* | *To strengthen the understanding of Migration Health.* |
| *3.2)* | *To mainstream Migration Health as a research agenda and national statistical plans* |
| *4.1)* | *To strengthen and harmonise IOM's Migration Health programmes.* |
| *4.2)* | *To complement and strengthen mutual outputs of PHAMESA, regional partners and donors and make efficient use of available resources through partnerships, strengthened networks, coordination and collaboration.* |
| *5.1)* | *To facilitate efficient and effective PHAMESA programme management.* |

In determining whether the programme objectives are relevant to the priority needs in the region, we first need to examine how those needs have been

[2] *PHAMESA 2010-2013 Final Proposal, March 2010*

identified and how they have informed the programme's objectives. According to IOM's Health Strategy for East and Southern Africa 2012-2017, there are four key factors that justify the need to consider migration and health (including the source of information to back up these factors):

- High levels of migration in East and Southern Africa, both cross-border and internal (2009 UNDP Human Development Report);
- High prevalence of communicable diseases such as HIV, TB, cholera, malaria and measles (2010 World Health statistics; UNAIDS 2008 Report on the global HIV/AIDS Epidemic);
- Struggling public healthcare systems and migration of health workers (2011 IOM Migration and Health in SADC: A review of Literature; 2007 Clark et al, Returning Home to Die: Circular Labour Migration and Mortality in South Africa); and
- Increasing recognition that healthy migration is required to achieve development targets in East and Southern Africa (2011 IOM Migration and Health in SADC: A review of Literature).

Against this background, the programme objectives are relevant to the need in so far as they address a general problem. However, the way in which the programme's intervention logic has been designed makes it difficult to see clear linkages between the specific need and how that informs the specific response of the programme. More on this will be addressed in section 3.4.

### 3.3. Relevance of the programme design

The design of PHAMESA – as it is interpreted by this evaluation – consists of two levels: (i) the conceptualisation and approach of the programme, and (ii) the intervention logic of the programme (examined in the next section 3.4).

In terms of the conceptualisation and approach of the programme, PHAMESA demonstrates a good balance between (i) a **standard approach** in line with global WHA priorities and IOM programme areas and (ii) a flexible approach based on **country needs** and gaps that enables each country to meet and prioritise its own needs. However, the way the programme provides this standard approach and this flexibility needs to be carefully managed to ensure collective ownership and accountability of the programme at all levels.

An important aspect of the design of the programme is around **partnerships**. This is an aspect that was highlighted by partners across the board as a key success factor of the programme. Through PHAMESA, IOM has positioned itself as a real partnership broker on the issue of migration and health in the region. The description of one partner pinpoints what many interviewees expressed in different ways – 'IOM leads from behind by empowering partners with information on the problem and involving everyone in the solution.' These partnerships take place at different levels and lead to different levels of results:

| Examples of Partnerships and their Achievements | |
|---|---|
| Partnership between IOM, the Dutch and SADC in Southern Africa on TB and mining | Funds mobilised (USD 5 million) to support countries Lesotho, Mozambique, South Africa, Swaziland and Tanzania to implement the SADC Declaration on TB in the Mining Sector |
| Partnership between IOM, USAID/PEPFAR, local government, selected service providers and commercial farm owners in Limpopo, South Africa | Improved wellbeing of farm workers evidenced by decreased rates of mortality and illness among of farm workers in selected farms |
| Partnership between the Government of Mozambique, IOM, UN Joint Team on HIV, Teba and Amimo | Ensuring services are available for miners and their family |
| Bi-regional partnership in East Africa between REC, IOM, UN, NACs and MOHs on OSBP | Facilitating and Strengthen national and regional coordination on addressing migration health |
| Partnership between IOM and private sector clinics in Uganda | Resulted in improved and friendly health service provision for sex workers, truckers and migrants in HIV hotspots in Uganda |
| Partnership between the district health management team and Eastleigh wellness centre (IOM clinic) in Kenya | Increased immunization coverage and increased access to health services for migrants |

These examples of partnerships initiated by PHAMESA demonstrate a catalytic role of the programme in brokering strategic partnerships. The programme, however, is not in a position to measure the result of such partnerships with the existing intervention logic and indicators.

The ability of the programme to successfully broker partnerships generates buy in and ownership which feeds into an important element of **sustainability** in the design of the programme. If we take the example of one of the longest standing interventions in South Africa which PHAMESA has inherited from PHAMSA I and II, Hoedspruit Training Trust (HTT) known as Hlokomela, its community health workers are currently being integrated into the district health system. This demonstrates at least the potential for PHAMESA to become sustainable across the board. Again, the challenge of the programme is to be able to measure specific efforts towards sustainability and demonstrating progress towards this.

The design of the PHAMESA programme is **different from other IOM programmes** in terms of bringing two regional offices together. Also in terms of content, although it officially falls under health promotion, it overlaps with both health assessments and health in emergencies, particularly in the context of East Africa. IOM can learn a lot from the PHAMESA programme both in terms of inter-regional programming but also in terms of an integrated approach to migration health.

### 3.4. Relevance of the intervention logic

While there is clear evidence around the extent of the problem (as outlined in section 3.1 as well as the number of studies and research conducted in the

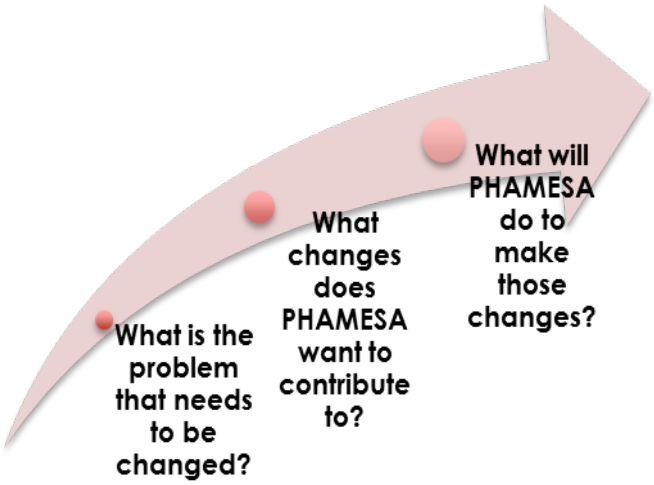
region[3]) there is less clarity on the specific evidence that informs PHAMESA's objectives and interventions. As far as the evaluation can tell, these objectives and interventions are informed by IOM's global programme areas alone. There is an assumption that collectively these should come together to have some kind of result but those results are not defined in any logical way or based on any explicit evidence. In short, the existing PHAMESA intervention logic is not clear on how the local research and information available on migration and health in Southern and in East Africa shapes the programme and how the objectives and interventions are meant to lead to results.

Establishing an evidence based strategy based on (i) identifying the problem, (ii) the changes that need to happen and (iii) how the programme will contribute to these changes is known as a **"theory of change"** which is currently missing within PHAMESA.

**Theory of Change**
defines all building blocks required to bring about a given long-term goal
*(www.theoryofchange.org)*

Once we refer to "change" we can no longer plan and manage according to objectives and interventions. Objectives limit us to measure only what we do, focusing on the "how" as the entry point instead of the "what." It provides the perspective of the doer instead of the people whose lives will be changed which is fundamental to a human rights approach.

In order to start measuring change PHAMESA needs to begin planning and managing for results. A logic chain of results needs to make clear the links between the problem (a combination of sound evidence and analysis), the different levels of change that need to take place (answering the 'so what' question) and what needs to be done to achieve change at these different levels.




More specifically, the following challenges have been observed with the PHAMESA logic framework:

[3] *Examples: Emerging Good Practices in Migration and HIV Programming in Southern Africa, IOM March 2011; Health vulnerabilities study of mixed migration flows from the East and Horn of Africa and the Great Lakes region to Southern Africa, IOM 2013; Migration and Heath in SADC: A Review of the Literature, IOM 2010*

1. At an overall programme level, it is not clear what changes PHAMESA is contributing to and at what level these changes should be (see box below defining **levels of changes**)
2. Because the programme is not based on results, it is difficult to **measure progress** in terms of overall results
3. The PHAMESA logic framework does not demonstrate any **logical linkages** between outputs and outcomes.
4. There is no clear **documented and evidence based cause and effect relationship** demonstrating how one outputs lead to outcomes.
5. The logic framework uses a **combination of approaches and terminologies,** including objectives, results and indicators, which are not consistent with common understandings, particularly when it comes to output and outcome results, indicators and targets.

**Defining Levels of Change**

- Change in quality of life (Impact Results)
- Institutional and behavioural change (Outcome Results)
- Change in knowledge and capacity (Output Results)

As a first step towards establishing a meaningful and measurable logic framework, it is important for PHAMESA to:

- Identify the different levels of change it wants to contribute to based on evidence demonstrating cause and effect, i.e. establishing a Theory of Change;
- Define logical chains of output, outcome and impact level results, i.e. by asking the 'so what' question after each level of result;
- Define meaningful and measurable indicators for each level of results; and
- Identify a set of interventions based on the four programmatic components of PHAMESA;

**Results based management** requires for the entire management cycle to be geared towards results – from results based planning to results based monitoring (part of the four steps outlined above) to results based budgeting to ensuring that human resources are managed towards results.

A **Result** is a **Change** we want to see at a certain level

### 3.4. Relevance of the programme expansion

The expansion of the programme from PHAMSA I and II to PHAMESA involved both opportunities and risks, which needed to be managed efficiently. Naturally, with the expansion of the programme comes **expansion of its scope**. This is not only in relation to wider geographical coverage but also in terms of addressing different contexts, migration dynamics (such as economic migration versus internal displacement) and health burdens. It is also about expanding the scope in terms

of the people being targeted by the programme from sectors or sites to 'spaces of vulnerability', which is a concept that may be more relevant or useful in some areas than in others.

Due to the evolution of PHAMESA from PHAMSA I and II, the scope of the programme and the design of its interventions – as well as the technical support content and approach - seems to stem mainly from Southern Africa and South Africa in particular. As PHAMESA enters a new phase, there is an opportunity for the programme to be increasingly shaped by the migration health dynamics and experiences in East Africa as well as the Indian Ocean and the Horn of Africa.

## **PART 4. Findings on Effectiveness and Impact:** What has PHAMESA achieved?

### 4.1. Identifying results to measure

PHAMESA achieves results by providing support to stakeholders and partners through a combination of clearly defined interventions and approaches around capacity building, advocacy, research and coordination at country and regional level. These collectively reinforce each other to maximise impact on migration health. However, the actual results from these interventions do not fully appear using the existing logic framework as outlined in the previous section.

In order to measure RESULTS or CHANGES brought about by the programme, we need to move away from stating what we want to do (i.e. objectives) and instead state the results we want to see. This requires asking the critical question 'so what?' for each intervention embarked on. We promote access to services, we advocate for policies, we increase understanding on migration health – to what end exactly?

In order to be able to start measuring programme results, this evaluation has pulled existing programme objectives and indicators outlined in Annex 8 and turned them into a results based intervention logic illustrated in Annex 9. This allows for the evaluation to be in a better position to measure the programme's effectiveness at the levels of: (i) change in knowledge and capacity; (ii) institutional and behavioural change; and (iii) quality of life. This was found to be a more useful way to determine progress and do full justice to the programme.

The lack of appropriate indicators and in most cases the absence of baseline hindered the measurement of progress. The evaluation placed existing programme indicators under relevant results and in some cases proposed relevant indicators. In practice, several of the same indicators would contribute to different results (e.g. indicators around advocacy, research and capacity building may all contribute to ensuring access to services) but for the sake of this framework they have been put in the most logical place.

| *Results Based Intervention Logic used for End-of-Programme Evaluation* | | *Corresponding PHAMESA Indicators (Annex 1)* |
|---|---|---|
| **1.** | **Change in Knowledge and Capacity** | |
| 1.8. | Increased knowledge and awareness of health rights and services among mobile populations and migrant communities | -- |
| 1.9. | Increased capacity of health workers to provide services to migrants | 1.2 |
| 1.3 | Increased Information on Migration Health available and promoted | 3.1 (1-3), 3.2 |
| 1.4. | Increased understanding of migration health among key stakeholders | 3.1 (4), 3.3, 2.1 (1,3) |
| 1.5. | Increased resources mobilised for migration and health | 4.1 (2) |
| **2.** | **Institutional and Behavioural Change** | |
| 2.1. | Access to and use of quality services by migrants and communities affected by migration | 1.1 |
| 2.2. | Improved legal and policy environment addressing migration and health at regional, national and local levels | 2.1 (2) |
| 2.3. | Improved coordination at regional, nation and local levels on migration health | 2.2, 4.1 (-2) |
| 2.4. | Efficient and effective use of resources on migration health | -- |
| **3.** | **Change in Quality of Life** | |
| 3.1. | Improved physical, mental and social wellbeing of mobile populations and migrant families in selected countries in East and Southern Africa | -- |

The following sections examine these different levels of results by assessing relevant indicators and baselines, including if they exist or not, providing relevant analysis based on information collected by the evaluation, and using specific country and regional level examples to illustrate these findings.

## 4.2. Measuring output level results: Change in knowledge and capacity

The first level of change takes place at a knowledge and capacity level. In terms of timeframe, these are the most immediate results that can be measured as a direct result of the programme's interventions. These are known as output results.

### *Increased knowledge and awareness of health rights and services among mobile populations and migrant communities*

**Note on measurement:** Since there are no results on the level of increased knowledge and capacity of beneficiaries, there are no indicators to measure progress in this area. The evaluation uses anecdotal information collected during site visits from interviews and discussions with beneficiaries.

Initial research has been effective in providing baseline information on knowledge and behaviour among migrant communities in selected countries. The HIV Integrated Biological and Behavioural studies (IBBS), which were conducted in several sites or 'spaces of vulnerability' in South Africa, Kenya and Somalia[4], provide important baseline information in this regard. To measure how PHAMESA

[4] *In Mozambique, IOM was also involved in the formative stage of an IBBS conducted by CDC*

has contributed to progress in knowledge and capacity so far, it would be useful for the programme to conduct similar studies or even rapid assessments, such as KABP studies, with similar communities to compare levels of knowledge as well as the extent of the original problem and whether it has been mitigated or not.

Other assessments have been conducted – such as an "Assessment of Health and Social-Economic Vulnerabilities of Rodriguans in Mauritius," a "Baseline Assessment of Community-based Responses to HIV/AIDS in Mine worker communities of origin" in Mozambique and an "Assessment of Mobile Banking Opportunities in Migrant Communities" in Zambia – which all provide some level of baseline information on the knowledge and capacity of specific target groups or communities. These have been used mainly to increase awareness among stakeholders and mobilise stakeholder support and less to actually measure progress among beneficiaries themselves. Without a uniform baseline for the entire programme it is not possible to compare information across countries and to have an overall picture of the state of knowledge and capacity in relation to migrant health in the region. This reinforces the importance of identifying programme level results together with specific indicators and baselines.

In the four countries where onsite visits were conducted (South Africa, Mozambique, Uganda and Kenya) interviews were conducted with beneficiaries, change agents, service providers, implementing partners and technical partners, including government. According to these interviews, it was clear that the programme directly contributes to increasing the knowledge and awareness of beneficiaries targeted by the programme in terms of their health rights and services. One of the key factors reported as a reason for this – especially in South Africa, Mozambique and Uganda – was the use of social behaviour change communication and the peer-to-peer communication using change agents.

In **South Africa**, five focus group discussions were conducted with 41 beneficiaries from three service providers (Centre for Positive Care, Hlokomela and ChoiceTrust). 95% of these beneficiaries shared a 'significant change' story at a personal level and within their workplace, which resulted from increased knowledge and capacity.

*"Knowing that I do not have to have sex with the farm supervisors in order to keep my job"*

*"If I get sick I know immediately what to do and where to go"*

*"I have acquired new knowledge that I use to help my colleagues as well as my friends and family back home"*

***- Testimonies from farm workers at Moroi Farm in Musina, Limpopo Province***

It should be noted that the change experienced by the majority of beneficiaries met by the evaluators in South Africa went well beyond increased knowledge and capacity. The fact that service providers, employers and government officials in South Africa all report significant increases in testing, adherence to treatment and demand for condoms and other prevention services is an indicator that change is taking place not only at the level of knowledge but also at the level of behaviour.

Although **Zambia** was not visited, similar changes were reported in a recent evaluation of cross border traders and truck drivers trained as change agents as

part of a project to address the 'health and HIV vulnerabilities of cross border traders and truck drivers in Lusaka and Central provinces in Zambia'.[5] Truck drivers and cross border traders reported an increased level of understanding of migration health risks and rights.


In **Uganda**, discussions with sex workers and fisherfolk in Rakai district revealed increased knowledge around the importance of HIV testing and referral, where they are made aware of other general health risks. Truck drivers also reported being better equipped to know what to look out for in terms of 'friendly service' clinics, which in Uganda have been branded using a symbol designed collectively by beneficiaries, the Ministry of Transport, the Ugandan AIDS Commission and IOM.

In Eastleigh clinic in **Kenya**, clients also reported increased awareness, which was evidenced by an increase in the number of clients coming for services. This increase was mainly attributed to the involvement of communities in outreach efforts. In this particular case, direct attribution to the PHAMESA programme – rather than IOM in general – is difficult since the clinic is an IOM clinic and PHAMESA provides minimal, albeit complementary, support linking health promotion to health assessments.

In **Mozambique**, discussions with the 'Activistas' in Xai-Xai highlighted several benefits from the knowledge and training they are receiving. They are now able to make better decisions for themselves, such as living positively, and are better able to understand the different aspects of positive prevention. They also reported being better equipped to encourage others to take better decisions around living positively.

Lastly, in **Mauritius**, while no assessments have been conducted yet, partners report that IEC material and DVDs shown to people from the outer island of Rodrigues before they travel has helped to increase awareness about the importance of being well prepared before moving to the main island, and about understanding and responding to the different risks involved.

[5] *Addressing the health and HIV vulnerabilities of cross border traders and truck drivers in Lusaka and Central provinces in Zambia, IOM Zambia change agents training outcome evaluation, July 2013*

### *Increased capacity of health workers to provide services to migrants*

| PHAMESA Indicators | PHAMESA Targets | Status at End-of-Programme (Aug 2013)[6] | *So What?*[7] |
|---|---|---|---|
| **Number of IOM Health Promotion and Service Delivery Model Training Curricula and Training Materials Developed** | The Health Promotion and Service Delivery Model training curricula & training materials developed or adapted in 6 countries | 16 training curricula and materials have been developed and adapted in Kenya, Lesotho, Mozambique, South Africa, Swaziland, Uganda and Zambia | *What have these trainings led to? Changes in knowledge, behaviour, policy, practice? Whose lives have been changed through these trainings?* |
| **Number of Individuals Capacitated as per the IOM Training Curricula** | 690 individuals trained as per the IOM training curricula | 2,468 individuals including government officials, health care workers, representatives of civil society and local Implementing Partners, and change agents have been trained to support the provision of migrant sensitive health services | *Have these trainings led to migrant sensitive health services? How do we know?* |
| **Percentage of Individuals Six Months after Capacity Building Interventions Who Report Enhanced Capacity** | 75% of individuals who completed the training later report enhanced capacity | 1 survey was undertaken in Tanzania | This is a good indicator to measure the level of capacity built as a result of the trainings |
| **Number of Technical Assistance provided to Stakeholders** | On-going technical assistance provided to 18 sites and ad hoc support to stakeholders | 144 sites in various countries in East and Southern Africa | *What has changed as a result of this? Whose lives have been affected and at what level?* |

An important component of PHAMESA is the capacity building of implementing partners or service providers as well as technical partners, including relevant government departments, to provide adequate services to migrant communities. PHAMESA interventions recognise the importance of establishing partnerships and working closely with relevant government departments (i.e. MOHs), communities, businesses and academic institutions to increase long term capacity to provide services to migrants. That having been said, it is important to continue to emphasise the need for PHAMESA to provide support in a sustainable way by avoiding parallel processes that may not have the potential to be absorbed by government service providers.

In **South Africa**, PHAMESA has contributed to training a wide range of state employees, including officials from the police, immigration, health and social

[6] Information from this column is taken from the latest PHAMESA Database of indicators (from July 2010 – Aug 2013) unless specified differently such as observations from this evaluation based on a combination of document review, interviews and on site observations

[7] In light of the guidance provided under section 3.4 on page 22 on the importance of the "So What" question, a column has been included in these tables to articulate the type of questions we should be asking ourselves in order to get the maximise the value of PHAMESA.

services, about migration and health with an important focus on gender. According to the Office of the Premier in Limpopo province[8], these trainings have made a dramatic difference in improving the health of migrants in targeted areas, such as Musina (Zimbabwe border), including changing negative attitudes towards migrants which in South Africa is very pertinent given recent xenophobic violence.

Community Health Worker (CHW) is a new denomination within the Health Department in South Africa which is in need of large scale capacity building. PHAMESA is directly contributing to this by providing training to CHWs through the establishment and empowerment of 'change agents' in selected 'spaces of vulnerability'. The training provided to change agents on Social Behaviour Change Communication (SBCC) has helped to significantly enhance the work of CHWs, including contributing to progress towards national HIV testing and treatment targets. For example, with Hlokomela in Hoedspruit – one of the four service providers supported by PHAMESA in South Africa – the local department of health took a decision (during the time of the evaluation visit) to absorb the Hlokomela health workers into government structures. This demonstrates an important element of sustainability with local institutions having the capacity and resources to continue services beyond the duration of PHAMESA.

In **Uganda**, PHAMESA supported clinics in key hotspots to not only provide migrant-friendly services but also to deliver 24-hour services so that truck drivers would not have to disrupt their work schedule or wait in long lines. PHAMESA selected peer educators (change agents) from the targeted groups (transport workers, commercial sex workers, fishermen, Ministry of Transport and Works staff) and these peer educators have been leading community outreach efforts. Since the start of the community campaigns, the private clinics have received more clients and government facilities have also experienced an increase in referrals and services.

In **Kenya**, PHAMESA is training Kamkunji District Health Managers to provide friendly-services and to include migrants in their planning and programmes. Although this is just starting, Eastleigh is seen as a model of excellence. This is largely due to the fact that members of the Eastleigh migrant community are involved in providing outreach and translation services in the community through change agents and community radio shows. In this regard, there has been a noticeable increase in the uptake of services by the community, particularly in accessing TB treatment from an average of 300 clients per month prior to December 2012 (approximately 42% of whom were migrants) to an average of 1,543 clients per month in 2013 (approximately 46% of whom were migrants).

[8] *See also: Special IOM Report for the Limpopo Office of the Premier, April 2013*

### *Increased information on migration health available and promoted*

| PHAMESA Indicators | PHAMESA Targets | Status at End-of-Programme (Aug 2013) | *So What?* |
|---|---|---|---|
| **Number of Research Projects on Migration Health Conducted and Disseminated** | 21 research projects conducted and disseminated | 38 research projects conducted | *Have these research projects led to any changes?* |
| | 6 peer reviewed articles published | Exact numbers not available but indication *that this is being reached:*<br>- *Mozambique reported recently publishing in the Intl Journal of Health Services*<br>- *Somalia IBBS was peer reviewed and published in an article titled "HIV prevalence and and characteristics of sex work among FSW in Hargeisa Somaliland, Somalia" in AIDS Volume 24 Supplement 2 July 2010* | *Have these articles led to any changes?* |
| | 11 research projects presented at conferences | Exact numbers not available but Indication that this has been exceeded | *Have these research projects presented at conferences led to any changes?* |
| **Number of New Research and/or Academic Collaboration Established** | Migration Health integrated into 1 academic curriculum | 2 | *What results has this led to?* |
| | 8 MOUs developed with research institutions and academia | 6 | *What results has this led to?* |
| | 7 thesis facilitated | 7 | *What results has this led to?* |

PHAMESA has been effective in increasing the evidence base on migration health by promoting research at country and regional level, and by raising the overall profile of health rights and services for mobile populations and migrant communities among relevant stakeholders, including governments, service providers, media, academia and the private sector.

Guidance provided to countries on migration health research has been noted as a major added value of the programme. The 'Guide for Putting the East & Southern Africa Migration & Health Research Strategic Response into Action 2012-2017' provides practical guidance on identifying research priority areas, building capacity for effective research implementation, bridging the gap between research, policy and programming, and establishing and managing partnerships to strengthen evidence based programming both at country and regional level. Linked to this guidance, a capacity building workshop was conducted in 2012 with 30 IOM research project teams from East, West, Southern and the Horn of Africa to enhance the capacity of country teams to identify and pursue research opportunities.

IOM and the African Population and Health Research Centre (APHRC) recently signed a cooperation agreement to engage jointly in migration health research on the **African continent** to document health cases of migrants and mobile populations, and to generate health evidence that will support policies.

In **East Africa**, PHAMESA is collaborating with academic institutions (University of Nairobi and Great Lakes University of Kisumu in Kenya, and Makerere University in Uganda) to promote migration health as a research topic. This will help to generate better data and information on migration and health, and increase information-sharing, coordination and collaboration within the research community and partners in the region. The partnership includes an internship and fellowship programme for students and integrates migration and health into different academic curricula.

In **Southern Africa**, PHAMESA has partnered with national academic and research institutions to conduct regional research on the Health Vulnerabilities of Mobile Populations and Affected Communities in Selected Ports of Southern Africa. Another study on the "Health Vulnerabilities Study among Populations in Mixed Migration Flows from the East and Horn of Africa and the Great Lakes Region to Southern Africa" is currently being undertaken which is generating much interest among stakeholders in the region and complementing the work of the IOM regional office on mixed migration.

Research has been identified as one of the main entry points for PHAMESA at country and regional level for informing advocacy, policy development, coordination, resource mobilisation and ultimately improved services. Translating this research into concrete results including increased awareness and improved policy is an explicit aim of the programme with good indicators to measure this (see next section).

| **Examples of Research leading to Results** | |
|---|---|
| In **Kenya**, the IBBS conducted among migrant female sex workers | led to a service delivery partnership with a PEPFAR implementing partner NOPE, which provides clinical services funded through UNAIDS. |
| In **South Africa**, the IBBS conducted among farm workers | led to significant press coverage, which had an impact on advocacy efforts to address the issue of health within the commercial agriculture sector. |
| In **Mauritius**, the assessment of vulnerabilities among the Rodriguan community | led to the nationwide launch and dissemination of the study by the Prime Minister's Office through national TV and local press. |
| In **Mozambique**, the Southern Corridor research | led directly to a grant from UNAIDS for a project to support vulnerable communities along the southern corridors, and was also used by the primary recipient of the Global Fund Round 9 phase 2 programme prevention component to identify the communities for implementation. |

### *Increased awareness and understanding of migration health among key stakeholders*

| PHAMESA Indicators | PHAMESA Targets | Status at End-of-Programme (Aug 2013) | *So What?* |
|---|---|---|---|
| **Number of Key Research Recommendations Translated into Policy and Programming** | 50% of individual IOM country research findings reflected in individual IOM country programming and/or national response | Exact numbers not available but Indication that this has been exceeded | This is a good indicator to measure the level of capacity built or institutional change as a result of the research |
| **Number of Information, Communication and Awareness Interventions Developed and/or Disseminated** | 1 Migration Health Department (MHD) information and communication plan developed and implemented for East & Southern Africa | 7 | *What result does this lead to?* |
| | 8 information and communication interventions developed and implemented for East and Southern Africa | 117 by IOM and 192 by others (Although there is no uniform criteria on this so not valid). | *What result does this lead to?* |
| **Number and Type of Advocacy Interventions Initiated and Facilitated by IOM** | 52 advocacy interventions initiated and/or facilitated | 511 (although Criteria for 'advocacy intervention' unclear so not valid) | *What result does this lead to?* |
| | 1 advocacy material/tool kit developed | Information not found | *What result does this lead to?* |

In **Southern Africa**, increased understanding of migration health developed much earlier on and was most likely attributable to IOM's initial efforts with PHAMSA I and II. Although there are no indicators to measure increased awareness and understanding at regional level among key stakeholders (including government, service providers, RECs and UN agencies) this can be demonstrated through the following: coordination mechanisms, multi-stakeholder initiatives, resources mobilised, and policies developed. Progress in all these areas has been achieved. Most of these materialised during the implementation of PHAMESA in Southern Africa.

| Title | IOM Support | Description | Date/Duration |
|---|---|---|---|
| SADC Policy Framework for Population Mobility and Communicable Diseases in the SADC Region | Provided technical expertise and coordination (under PHAMSA II) | Policy Framework | April 2009 |
| SADC Global Fund HIV Cross Border Initiative Project | Chairs the Research and M&E Committee, and the Phase II Writing Task Team. | 5-year programme | July 2011 |
| SADC Declaration on TB in the Mining Sector | Coordinated support leading to the declaration | Declaration | Aug 2012 |
| Dutch funding of USD 5 million to implement the SADC Declaration | Mobilised funding | Funding | 2013-2015 |

| | | | |
|---|---|---|---|
| Joint IOM-USAID Regional Consultation on HIV and Aids Prevention and Management Services for the Road Transport Sector in Southern Africa. | Organisation and mapping of services | Regional Consultation | 2011 |
| SADC Human Resources for Health (HRH), which will inform the coordinated implementation of the SADC Strategic Framework on HRH 2007-2019 | Provided technical support to SADC | Research | 2007-2009 |
| IOM, ILO, UNAIDS, HEARD workshop on 'Development, Transport Infrastructure & HIV: Mobilising Evidence for the Southern Africa Transport Sector HIV/AIDS and TB Responses' | Co-facilitated and provided technical expertise | Workshop | Sept 2011 |
| SADC/Donor/UN Coordination Meeting on Migration and Health/HIV in Southern Africa | Lead facilitator | Annual Meeting | 2010,2011, 2012,2013 |
| Research on Health Vulnerabilities of Mobile Populations and Affected Communities in Selected Ports of Southern Africa | Lead institution | Once-off research | 2012-2014 |

In **East Africa**, an increased understanding of migration health is starting to develop among key stakeholders, such as governments, academic institutions, RECS and CSOs, which is evidenced by a growing recognition of the need to address migration and health, and greater eagerness to work in partnership with IOM to make this happen. However, migration and health in East Africa is anchored within a very different context. Health promotion has much more of an overlap with basic migration health assessments as well as with health in emergency situations, which creates a different dynamic and different opportunities. In this regard, there seems to be a need to have much more 'home grown' information, systems and approaches, which cater to this context.

At a country level, there are several indications that awareness of migration and health issues has increased. In **Mauritius**, there has been an increased understanding of the key issues around migration and health, which has created a growing momentum to address this beyond Mauritius and across all Indian Ocean islands in partnership with the Indian Ocean Commission. In **Namibia** and **Zambia**, the establishment of a Technical Working Groups on specific Migration Health issues, which is led by the government in partnership with IOM, has been catalytic in providing leadership and creating momentum in this area.

The establishment of Migration Health Forums in **South Africa** and in **Kenya** is also an important indication of the importance of migration health at national and local government levels. In **Mozambique**, the work of PHAMESA – through the technical working group on cross-border mineworkers – has led to mineworkers being able to access treatment where they work in South Africa and to continue this treatment when they return home, which they would not have been able to do before.

### *Increased resources mobilised for migration and health*

| PHAMESA Indicators | PHAMESA Targets | Status at End-of-Programme (Aug 2013) | *So What?* |
|---|---|---|---|
| **Number of Bilateral and/or Regional Projects Developed, which Secured Funding** | 2 bilateral and/or multilateral projects secured funding | TB in the mining sector in Southern Africa (Dutch, USD 5 Million 2013-2017);<br><br>IOM provided technical support to EAC, IGAD and COMESA on the application of HIV Combination Prevention Model within the transport sector, which led to a joint funding proposal to the European Union | This is a good indicator to demonstrate results at an institutional level through resources being mobilised |
| ***At least 1 project developed which secured funding in each country*** *(Suggested new indicator)* | | 53 country project proposals submitted and 30 funded. Additional resources were also leveraged in some countries | *What have the projects achieved?* |

PHAMESA was designed to encourage the mobilisation or leveraging of additional resources for migration health. This has been more successful in some countries (Kenya, Mozambique, South Africa and Uganda) than in others (Angola, DRC and Tanzania). Out of the first tier countries that received significant funds from PHAMESA, Tanzania has not been successful in mobilising or leveraging any external or internal funding. This will be examined more closely in the section on efficiency.

At a regional level in Southern Africa, PHAMESA was able to mobilise USD 5 million from the Dutch Government to implement activities related to TB in the mining sector for 2013-2017. In East Africa, IOM provided technical support to EAC, IGAD and COMESA on the application of HIV Combination Prevention Model within the transport sector, which led to a joint funding proposal to the European Union (EU).

Below is a table capturing the amount of resources mobilised (IOM takes the lead in mobilizing funds which it manages including mobilizing in-house funds such as through concept notes) and leveraged (IOM has played a role in mobilizing the funds which are managed by external partners) against those provided by PHAMESA.

| Country/Region | PHAMESA Funds (USD) (Staff and Office costs as of 31-08-13) | Mobilised (USD) (including Concept Notes) | Leveraged (USD) |
|---|---|---|---|
| **SOUTHERN AFRICA and South Africa**[9] | 5,966,908.72 | 11 million (USAID/PEPFAR) | Indication of leveraged funds but no cumulative figure |
| **Mozambique** | 514,502 | 145,000 through Concept Notes<br>1.7 million through UN MPTF & UNAIDS and EIDHR<br>150,000 for AMODEFA from the Ministry of Communications and transport | 6 million<br>(USAID Teba) |
| **Mauritius** | 21,120.44 | 119,969 through Concept Note | None |
| **Namibia** | Unavailable | 90,000 through Concept Note | None |
| **Zambia** | 514,502.03 | 105,000 through Concept Note<br>185,000 (SIDA) | None |
| **Angola** | 63,000.19 | None | None |
| **Swaziland** | None | 36,000 | None |
| **Lesotho** | None | 180 000 (Teba) | None |
| **EAST AFRICA** | 2,249,685<br>(2,404,645.90 for regional office) – 154,960 for Kenya office) | Concept Notes for other countries to be assessed (Djibouti, Ethiopia, Somalia and South Sudan) | EU proposal on HIV Combination Prevention Model within the transport sector |
| **Kenya** | 154,960 | 185,313 from PHAMESA<br>530,200 (from UN Joint team, Irish aid and others | None |
| **Uganda** | 106,817 | 171,699 | 549,264 (JUPSA) |
| **Tanzania** | 477,747 | None | None |
| **DRC** | 62,999.88 | None | None |

[9] *The evaluation could not find documentation to clearly distinguish between (i) SA budget, (iii) Southern Africa regional budget and (ii) PHAMESA overall budget*

## 4.3. Measuring outcome level results: Institutional and behavioural change

Once knowledge and capacity have been enhanced, the next level of change is at a behavioural and institutional level. This is where practice is changed at a systematic level and is the type of change that can be measured at the end of a 3-5 year programme, such as PHAMESA. These are known as outcome results.


***Drawings by farm workers on the walls of a farm in Hoedspruit***

### *Access and use of quality services for mobile populations and migrant communities*

| PHAMESA Indicators | PHAMESA Targets | Status at End-of-Programme (Aug 2013) | *So What?* |
|---|---|---|---|
| **Number of Sites Providing Sensitive Health Services for Migrants and Communities Affected by Migration** | 18 sites providing accessible health services for migrants and communities affected by migration | 758 sites in various countries in East and Southern Africa | *Are migrants using the services?* |
| **Number of Networks of Strategic Partnerships Strengthened/Improved to Fill Programming Gaps** | 17 networks of strategic partnerships identified, strengthened and improved to support programming gaps | 85 (Although the criteria for defining networks needs to be clarified) | *Are these networks and partnerships supporting programming or policy gaps?* |
| **Number of Beneficiaries Directly Reached Through the IOM Health Promotion and Service Delivery Model** | 76,000 beneficiaries directly reached through the IOM Health Promotion and Service Delivery Model | 178,413 | *Does this mean they have access and are using services?* |
| **Percentage of Beneficiaries and/or Clients Reporting Sensitive and Accessible Services** | 22 beneficiary or client satisfaction surveys conducted | 1 in Kenya at the Drop clinic for migrant FSWs; In Uganda satisfaction surveys completed in 8 clinics in Arua, Gulu, Kasese, Lyantonde, Rakai districts | *What do we want to know from these surveys? That migrants are accessing and using services?* |

At this level, we examine the extent to which the PHAMESA programme is able to contribute to the access and use of quality services for mobile populations and migrant communities. This evaluation found that PHAMESA achieves this in countries that have benefited from a collection of interventions (particularly those around service delivery and capacity building) but not in those where only one component of the programme has been implemented. It is also important to clarify that IOM does not deliver services but build the capacity of service providers to ensure that these services are improved, accessed and used by local institutions. In the specific sites where PHAMESA is present in Kenya, Mozambique, South Africa and Uganda, there is evidence that that migrants populations are able to access improved health services.

The service delivery and capacity building framework developed and used by IOM provides clear parameters for project design and implementation using Social and Behaviour Change Communication (SBCC), which is a rights based and participatory approach that seeks to promote positive change through peer to peer communication. The framework has evolved to respond to emerging trends on the ground informed particularly from experiences in Southern Africa (South Africa and Lesotho). PHAMESA has supported the region and individual countries to be equipped to implement the framework through extensive material, guidance and capacity building.

In **South Africa**, service delivery and capacity building through SBCC in commercial agriculture farms have created a lasting impact among beneficiaries and change agents on commercial farms. Among the beneficiaries interviewed the majority reported significant behaviour change, including going for HIV testing, sticking to one partner, adhering to treatment and having more general access to primary health care services. The graph below is based on information gathered from change agents in **Zambia** and demonstrates the value of behaviour change communications compared to other forms of prevention interventions:


In ensuring access and use of services, IOM should continue to promote SBCC as an effective approach but should also promote this approach as part of a larger framework of HIV combination prevention interventions as outlined in the 2011 UNAIDS Investment Framework.

*ART Clinic in Rakai province in Uganda*

In **Uganda**, although resources were small, the partnerships created, the awareness generated, and the services provided by PHAMESA have had a significant impact in terms of promoting the migration health agenda. HIV Counselling and Testing (HCT) served as an entry point for general access to services. Through community awareness campaigns more people went for testing and as a result there has been a general uptake in health services. In Rakai, prior to the community campaigns, 500 patients were receiving ART. After just one campaign session, the number increased to 1,200 active ART patients.

In **Kenya**, polio campaigns and community outreach programmes carried out through the Eastleigh Wellness Centre have improved immunization coverage. PHAMESA interventions included engaging religious and community leaders and selecting health workers from the community. During the first round of campaigns, coverage was 65% and this has since increased to 100%. Also in Kenya, following the IBBSS on Migrant Female Sex Workers in Nairobi, advocacy was carried out for migrant female sex workers through press releases, conferences, printing and dissemination of the IBBSS report. An evaluation conducted with this same group revealed that 70%[10] reported improved access to health services.

In **Mozambique**, through IOM's partnership with government, organizations working with miners and their families (i.e. AMIMO and THEBA), and the community are now working in concert to ensure services are available for miners and their family. This supports the National HIV Positive Miners Technical Working Group including through an assessment of the health challenges faced by Mozambican mine workers, while they are in South Africa and also on their return to Mozambique. As a result of IOM's interventions, the Mozambican government is advocating for legislation that addresses the health needs of mineworkers, including providing health passports. The health passport concept has been successful among farm workers in **South Africa** and there are now plans to institutionalise this within government health services.

*Sister Lea Swart of Hlokomela holding a 'health passport'*

[10] *PHAMESA Annual 2012 Report.*

### *Improved legal and policy environment addressing migration and health at regional, national and local levels*

| PHAMESA Indicators | PHAMESA Targets | Status at End-of-Programme (Aug 20130) | *So What?* |
|---|---|---|---|
| Number of Regional, National and/or Sectoral Policy Instruments that Integrate Migration Health Concerns. | 4 regional, national, and/or sectoral policy instruments integrate Migration Health concerns | 32 | This is a good indicator providing important information on results |

An enabling legal and policy environment for migration health comes as a result of a combination of interventions, including evidence based advocacy. There are different levels of understanding and interpretation of advocacy within PHAMESA which leads to challenges in measuring progress around advocacy and what results it leads to. It is important that advocacy efforts are clearly defined so as to provide clear and consistent guidance, be measured across the board. This involves agreeing on standard criteria for what qualifies as advocacy efforts, which may require defining these efforts in more detail and specifying how they should be measured.

PHAMESA has contributed to including migrants as key populations in a number of national health policies and plans, such as the **South African** National Strategic Plan on HIV, TB and STIs, the recent **Kenyan** National Strategy for HIV & AIDS and STI programming in Transport Corridors, the **Mauritian** National Strategic Plan on HIV and AIDS 2012-2016, and the **Tanzanian** National Multi-sectoral HIV prevention strategy 2009-2012 (see table from section 3).

In **Uganda**, IOM coordinated the development of the National Strategy on Combination HIV Prevention (CHIPS) for high-risk migrant and mobile populations, which is now part of a district strategic plan. In **Somalia**, IOM facilitated a stakeholders meeting in the Puntland region on HIV and AIDS stigmatisation, which led to the development of action plans for different stakeholders, including religious leaders who agreed to openly discuss HIV in mosques.

In **Southern Africa**, IOM facilitated country consultations in Lesotho, Mozambique and Swaziland, which informed the SADC Declaration on TB in the mining sector signed in August 2012. Following the adoption of the Declaration, the development of national action plans was then facilitated by IOM in Mozambique, Swaziland and Zambia. In East Africa, partnerships have been established with the purpose of strengthening coordination and policy on migration health in the transport sector.

### *Improved coordination at regional, nation and local levels on migration health*

| PHAMESA Indicators on National Coordination | PHAMESA Targets | Status at End-of-Programme | *So What?* |
|---|---|---|---|
| Number of New National Coordination Mechanisms for Migration Health Established with the Support of IOM | 7 new national coordination mechanisms for Migration Health established | 2 Migration Health Forums in South Africa<br>3 National Coordination Mechanisms (1 Migration Health Forum and 2 TWG)<br>1 TWG in Zambia<br>1 TWG in Namibia<br>1 TWG in Uganda | This is a good outcome level indicator and could be complemented with another indicator measuring results from such mechanisms |
| Number of Existing National Coordination Mechanisms Addressing Migration Health | 16 existing national coordination mechanisms now addressing migration health | Exact figure unavailable but indication that this has been achieved | *Coordination to what end?* |
| Number of National Partnerships Formalized (exclude partnerships with Academic Institutions - see RID) | 11 MOUs formalising government partnerships for joint programming | Exact figure unavailable | *MOUs to what end?* |
| **PHAMESA Indicators on Regional Coordination** | PHAMESA Target | **Status at End-of-Programme** | |
| Number of Bilateral and/or Regional Projects Developed | 6 bilateral and/or multilateral projects developed. | Exact figure unavailable but indication that this has been achieved | This is a good indicator but would need to include other indicators to measure results of projects |
| Number of Regional Partnerships Formalized | 3 partnerships formalised | Exact figure unavailable but indication that this has been achieved (i.e. SADC and Dutch on TB, IOM and NGOs on ports in Southern Africa and IGAD, EAC, COMESA and IOM on HIV prevention model in transport sector) | *Partnerships to achieve what?* |

PHAMESA has been catalytic in initiating and facilitating coordination around migration health at national and local levels. The establishment of a Migration Health Forum in Vhembe district in **South Africa** has gone a long way to facilitate coordination, prioritisation and general awareness of migration health issues among all relevant stakeholders. These Forums are now being replicated in different parts of the country, including a new Migration Health Forum launched in September 2013 in Mopani and discussions are underway for possible future forums in the Waterberg and Ekhuruleni districts. A Migration Health Forum was also established in **Kenya.**

Regional Coordination is critical (i) to address cross-border issues and (ii) to provide a supportive regional environment for countries to strengthen their efforts on migration and health. In **Southern Africa**, there are two formal regional coordination mechanisms in place – an annual donor meeting and the regional partnership forum on migration and health. Regional coordination in Southern

Africa also happens on a number of different platforms that IOM participates in, including the UN Regional team (RATESA). In **East Africa,** there is no formal coordination mechanism at regional level but on-going support is provided to RECs, including IGAD, EAC and COMESA, for example through the recent multi-stakeholder meeting held in Tanzania in October 2013.

***Efficient and effective use of resources on migration health***

**Note on Measurement:** There are no indicators to measure efficient and effective use of externally mobilised resources but this would be relevant in terms of measuring overall programme results and also as a way to "monitor migration health" as one of the WHA pillars.

It was not possible within the scope of this evaluation to measure the extent to which external resources mobilised and leveraged through PHAMESA are being efficiently and effectively used (such as TEBA in Mozambique and the joint UN flagship GBV programme in Zambia funded by SIDA through UNDP) but this is something that should be examined.

There was sufficient information to rapidly assess the USAID/PEPFAR funded Ripfumelo project in South Africa. Based on the visit to the project sites as well as the document review, it is clear that Ripfumelo has evolved into an effective programme that is having a lasting impact on communities and the country as a whole as well as the potential to tap into public-private partnerships. There are several lessons to be learned from Ripfumelo, which need to be documented (see South Africa Country Assessment Annex 9). In terms of efficiency, the absorption of funds on the ground and on paper was adequate although an exhaustive review would help to determine this further.

## 4.4. Measuring Change in Quality of Life: Impact level results

***Improved physical, mental and social wellbeing of mobile populations and migrant families in selected countries in East and Southern Africa***

**Note on Measurement**: There are no indicators and no criteria to measure improved wellbeing. This should easily be measured using national and regional health targets.

Change in quality of life is usually measured after a number of years and is usually not attributable to one programme or one initiative alone but to collective efforts at national and regional level. These are known as impact level results.

While it is premature to measure the long term impact of the PHAMESA programme as a whole, it is possible to identify aspects of the programme that demonstrate the potential for such impact at an overall programme level.

In **South Africa**, where IOM has its longest running interventions on migration and health promotion dating back to 2004, there are indications that lives are being

saved and that the services provided are having a wide ranging impact including on local HIV and TB targets.

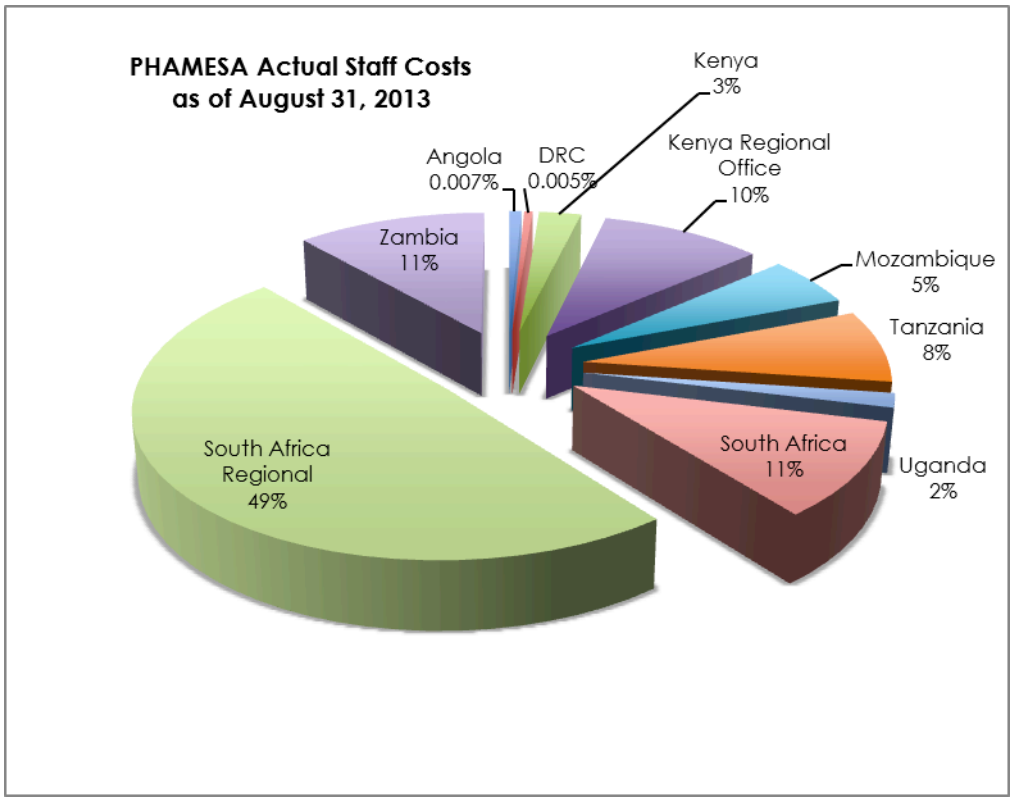
Lives being saved and improved is a major indicator of improved physical wellbeing. On one farm visited, the owner of the farm claimed that before the Ripfumelo programme there were between 2-3 fatalities a year and this has dropped to 0 since the start of the project on his farm two years ago. Anecdotal information further reveals that similar patterns are apparent on 1-2 other farms nearby. Additional data and further documentation is required to determine whether these cases are part of a wider trend.

In terms of mental and social wellbeing, beneficiaries are reporting improved career opportunities, such as moving into better and higher paying jobs. The impact on women is particularly visible. There has clearly been a significant empowerment of women, which both men and women report benefiting from. There has been a drastic reduction in sexual harassment on the farms with several farms having made any type of fraternisation a sackable offence (e.g. Westfalia Farm). Women were also more likely to report improved health and general lifestyle.

## PART 5. Findings on Efficiency: How is PHAMESA managed?

### 5.1. Resource allocation and management

PHAMESA is a 'projectised' regional programme, which means that it is 100% dependent on external funds. PHAMESA received USD 9,189,600 from SIDA of which an estimated 60% has gone to staff and operational costs distributed across the regions and countries as illustrated below.




IOM's resource allocation and management is quite particular and needs to be unpacked in order to better understand the context in which PHAMESA is anchored.

IOM country missions or country offices are entirely dependent on external funds, including for all staff costs from Chief of Mission downwards. IOM regional offices however are funded through IOM's internal core funding to provide technical and strategic support to countries. Until recently IOM regional offices were not able to manage regional programmes (which are dependent on external funds) but this was changed as of July 2013. The IOM regional office for Southern Africa will now be managing regional programmes, including the Populations, Refugees and Migration (PRM) programme in selected countries in the region. There is one IOM core-funded migration health expert based in the regional office in Dakar, Senegal, who currently covers all of Africa. There are plans to place an additional migration health expert within the regional office for Southern Africa in early 2014.

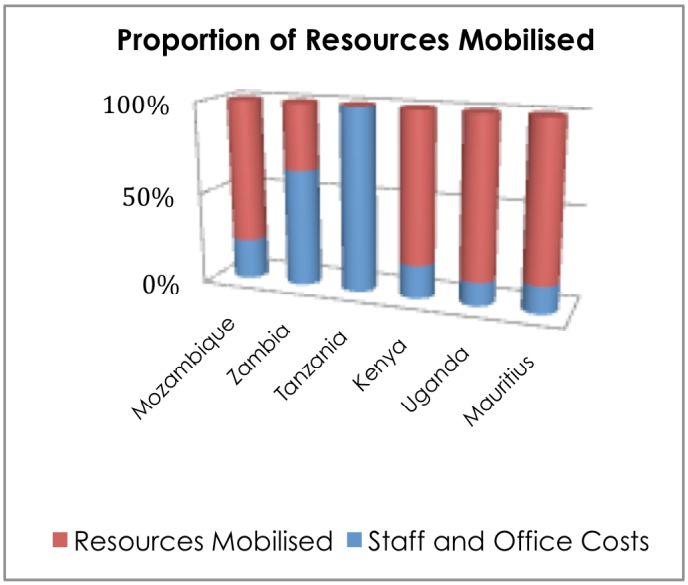
According to online respondents, the major limitation of PHAMESA is the "lack of **sufficient** funding available to the project" which "limits the programme's plans which end up being short term." This funding problem is also evidenced in the "stipends paid to change agents, which leads to lack of motivation from staff and thus limits the programme's effectiveness." This leads to "limited impact on the policy environment and on the sustainability of the programme." This perception was echoed by approximately 50% of the IOM staff interviewed during country visits.

In terms of **accountability and transparency**, PHAMESA has undergone regular annual financial audits. The PRISM system provides a way for staff members to manage their finances and is reported to be a functional system by most respondents. When it comes to programmatic resource allocation (using the concept note approach), transparency is not optimal since these resources are not mobilised based on previous collective planning processes and decision making is centralised. Also in terms of transparency, it was difficult for the evaluation to get a clear and comprehensive picture of how PHAMESA staff and operational costs are being allocated or to ascertain how much total staff time and level of effort goes into PHAMESA. Several staff members from the South Africa office provide a percentage of their time to PHAMESA but this percentage fluctuates on a monthly basis and is not recorded from what the evaluation could gather.

In addition to the staff and office costs provided to Tier 1 and Tier 2 countries, the programme encouraged countries to mobilise resources with stakeholders in country and in-house through concept notes. While the evaluation recognises that IOM considers resource mobilisation as mobilising resources external to PHAMESA, it examined the act of mobilizing resources both in-house and externally.

Taking three Tier1 countries and three Tier2 countries as shown in the graph below, the evaluation observed a mixed picture in terms of the efficient use of resources using resource mobilisation as a proxy indicator. The graph also shows that PHAMESA has been more catalytic in some countries than in others when it comes to **resource mobilisation**.

The graph also shows demonstrates that there is no direct correlation between the provision of staff and office costs and the ability to mobilise resources. Instead, this evaluation has found that capacity to mobilise resources and efficiently use seed funding (in the form of staff and office costs) depends on buy-in from the IOM country office as well as on the donor environment in each country which varies greatly. There is a real potential for the programme as a whole to have a stronger and more uniform catalytic effect in terms of resource mobilisation both internally and externally.




TIER 1

- In **Mozambique,** where USD 514,502 was provided for staff and office costs, a total of USD 145,000 was mobilised through concept notes and an additional USD 1,700,000 was mobilised from stakeholders in country.
- In **Zambia,** where USD 514,502 was provided, USD 105,000 was mobilised through concept notes and USD 185,000 through SIDA in country.
- In contrast, in **Tanzania,** where USD 477,747 was provided, no resources were mobilised among stakeholders in country or through PHAMESA.

TIER 2

- In **Uganda,** where USD 106,817 was provided as seed funding, USD 171,699 was mobilised through concept notes and USD 549,264 was leveraged through the UN Joint Team on HIV and AIDS.
- In **Kenya,** where USD 154,960 was provided, USD 68,527 was mobilised through concept notes.
- In **Mauritius**, where USD 21,120 was provided as seed funding, USD 119,969 was mobilised through concept notes.

The introduction of the concept note approach came about to allow countries to motivate for resources based on their identified needs, gaps and priorities. This approach has both advantages and disadvantages. On the one hand, it provides countries with a degree of flexibility and freedom to decide on what is needed. On the other hand, it is dependent on already existing capacity to motivate for funding and assumes a full understanding of the approach and a degree of confidence in using it. It also assumes that such a concept note is anchored within an overall country strategy, which has not been the case.

As PHAMESA enters a new phase, there is an opportunity to adopt a more strategic and decentralised approach to resource allocation. Funding at country level should be anchored within the IOM country strategies that country level stakeholders can mobilise around. This means establishing a system of planning

that involves IOM country offices and Chiefs of Missions more closely. In addition, the programme should also be anchored more closely within the strategies of the IOM regional offices in both Southern and East Africa.

Ultimately, PHAMESA needs to strike a balance between (i) prioritising countries and sites and making sufficient funds available for these, and (ii) supporting all countries to fulfil their obligations under the WHA resolution on migrant health by providing financial and capacity support, determined by, and aligned to, each IOM country strategy.

### 5.2. Management systems and procedures

The fact that PHAMESA is a programme that has evolved from previous programmes with a narrower scope, coverage and structure has its advantages and disadvantages. The advantages come from an approach and interventions that are grounded in experience. The disadvantages come from inheriting management processes and structures that are no longer inappropriate. While PHAMESA is evolving as a regional programme in terms of scope, coverage and structure, it remains stuck in management systems and procedures focused on interventions or components. It is also anchored in a centralised management structure which overlaps with that of the South Africa country office and which limits the level of collective ownership and accountability. For example, the person responsible for managing this end-of-programme evaluation is from the South Africa country office which demonstrates important authority over a major management function of PHAMESA.

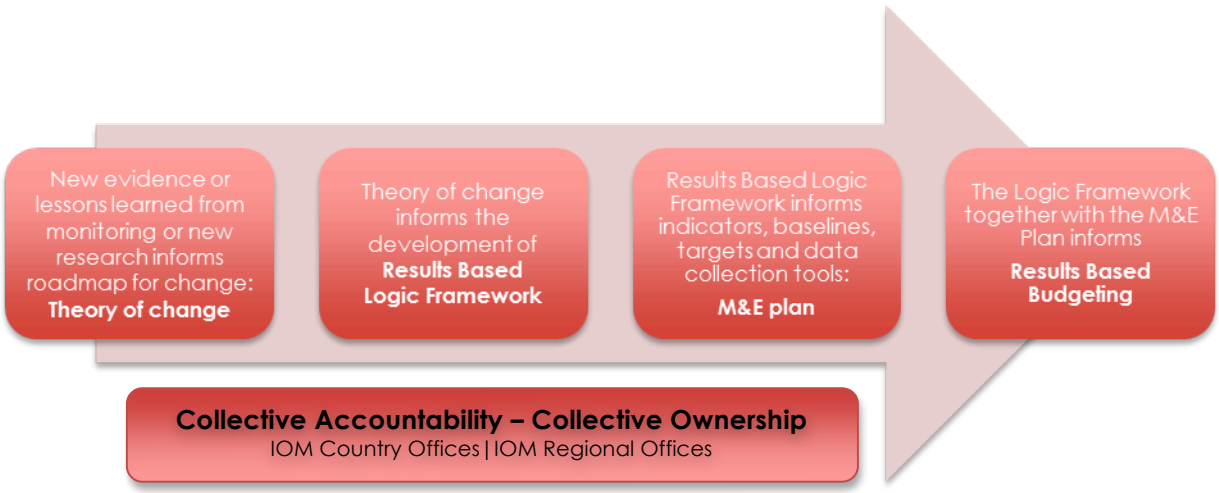
It is important to note that IOM does not have a blueprint or previous experience that can inform the optimal management of a regional programme as unique as PHAMESA, which cuts across two IOM regional offices. The guidance that is available draws mainly from the IOM Project Handbook, which informs project management world-wide.

**Strategic planning.** In planning the development of PHAMESA, a series of consultations took place with the two regional teams and country staff to agree on the scope and size as well as key interventions of the programme. Country strategic planning processes around migration and health promotion were initiated but never finalised nor formalised and not used to justify resource allocation. A concept note approach was introduced for countries to motivate for funding for specific interventions. Annual work plan meetings with all PHAMESA staff (regional and country level) were facilitated and monitoring visits were undertaken to countries. The logical intervention framework and indicators were revised in 2011 and are currently being revised again in preparation for a possible PHAMESA II.

Despite these efforts, strategic planning within PHAMESA is weak – both at an overall programme level and at a sub-regional and country level. Challenges with planning have been observed at two levels: (i) the process of planning and (ii) the quality of planning. The quality of planning refers to the challenges mentioned around the logic framework in the previous section. The process of planning refers

to the management functions and systems in place, which allow for a collective programme planning process to occur. The current systems for planning and decision making around planning processes do not allow for collective ownership or collective accountability. The management systems and procedures to support effective programme implementation and expansion need to be strengthened.

One of the most common recommendations from respondents of the online survey was the need to consistently 'engage with all relevant players at all levels of planning, implementation, monitoring and evaluation'. Planning strategically is the linchpin of an efficient programme. It provides the parameters for the logic framework, budgeting, monitoring and reporting. The process of planning should be systematic, consistent and inclusive. Systems should be strengthened and in some instances established to allow for collective accountability and ownership of the programme. This means a more decentralised approach to the management of the programme. What we mean by a decentralised approach is more collective decision making. What we mean by management are the core functions around planning, implementation, monitoring and reporting on the programme.




**Implementation and capacity building.** The technical support provided around programme implementation is excellent. Nearly 90% of all country level IOM staff members interviewed commend the technical support they receive, particularly with regards to research and service delivery.

However, when it comes to capacity building for programme management the support from the regional programme is less clear, including on which people the programme relies on for key management functions. This resonates with one of the lessons learned from the PHAMSA II evaluation, which was that 'Project success is dependent on both technical output/quality as well as organisational competence to manage/deliver; in a complex, regional project, the latter requires significant strategic management capacity at the regional level, as well as close collaboration between regional and national management structures'.

Because PHAMESA is managed in relation to interventions or components, there is a weak sense of an overall programme with collective results, which the different components feed into and which country offices see themselves contributing to. Once this is addressed at a regional level, there will be an opportunity for the regional programme to provide capacity building around programme management, including:

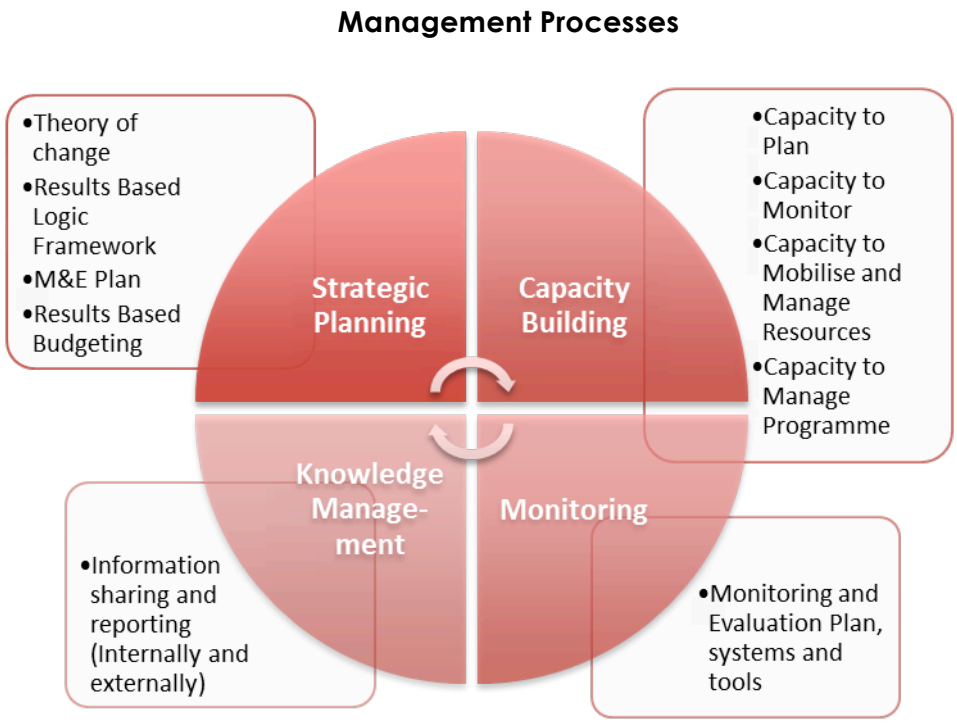
- Capacity to Plan for PHAMESA in country X/sub-region X;
- Capacity to Monitor PHAMESA in country X/sub-region X;
- Capacity to Mobilise and Manage Resources in country X/sub-region X; and
- Capacity to Manage PHAMESA Programme (and not single components/interventions) in country X/sub-region X

**Monitoring.** Monitoring should be a more integrated process that takes within planning and with programme staff. The importance of having meaningful and measurable indicators and baselines is critical for measuring progress and advancing the programme as a whole. Moreover, it is important that monitoring is used as an internal learning and not only for obligation purposes only. The same goes with reporting – it is important that there is a culture of internal reporting, sharing and learning. Regular internal narrative reports, such as those used in East Africa, promote a culture of reflection and sharing of lessons learned outside of official reporting requirements.

**Knowledge management.** This evaluation has found that there is satisfactory knowledge management when it comes to external communications and information sharing with stakeholders but a weak internal culture of communication, information sharing and learning.

PHAMESA currently does not have an internal platform for regular information sharing, engaging on specific issues and learning. There is an opportunity to ensure more internal sharing and learning. PHAMESA would benefit from establishing a common internal platform to promote learning and sharing in-house. One platform that may be relevant and useful is KARL (http://karlproject.org), which is an open source web system for collaboration, organizational intranets, and knowledge management. Developed by the Open Society Foundations (OSF), it was first introduced to the market in 2008, and is now used by many international organizations, such as OXFAM GB, OSF, and more to establish online communities within an organization.

In a programme like PHAMESA, learning is necessary to inform reprogramming and expansion. In this regard, as PHAMESA gains more experience from East Africa, learning should be promoted across the entire region. Also, the same way in which South Africa is a learning site for Southern Africa, a learning site could also be identified and invested in for East Africa.




### 5.3. Management structure

The overall internal PHAMESA management structure has largely evolved to reflect the programme's components. The organisational management structure of PHAMESA is reflected in the PHAMESA organogram as well as the South Africa country office organogram for Migration Health (Annex 7b). There are several challenges with the current management structure which are described below.

**Internal PHAMESA management structure.** There is a lack of clarity around the overall programme management functions in terms of (i) overseeing overall strategic planning processes, (ii) providing overall support to implementation and monitoring, (iii) providing overall administrative and financial management support, and (iv) ensuring internal and external communication. Based on (i) the job descriptions and programme organigram reviewed, (ii) the relevant planning and monitoring documents, (iii) interviews with PHAMESA staff and (iv) first hand observations on how PHAMESA is managed (i.e. including this end-of-programme evaluation), this evaluation found a lack of clarity on explicitly articulated roles and responsibilities – including decision making authority and accountability - around key management functions such as those mentioned above.

As far as the evaluation can gather, key management processes are the responsibility of the head of PHAMESA (whose official title is Senior Regional Coordinator Migration Health for the Pretoria country office) with the support of a 'Governance and Control' staff position and in consultation with PHAMESA

regional staff. According to the TOR for the "Governance and Control" position, the three main functions include:

- ✓ Organise and facilitate Migration Health Strategy Meetings;
- ✓ Contribute to donor reports including coordinating inputs from other IOM offices;
- ✓ Provide and facilitate technical assistance to IOM MH staff in East and Southern Africa on Governance and Control matters, including M&E.

This demonstrates limited scope to provide overall programme management functions. The delegation of full management functions of the overall programme cannot be established. This leads to levels of frustration on all sides.

Firstly, at the level of the regional office, this creates a significant workload for the head of the programme and a lack of synergy and unity within the programme. And secondly, at the country and global level, this creates uncertainty in terms of who to engage with on the overall programme aside from the PHAMESA head. There are no designated managers with clear authority and accountability for the key management functions mentioned above.

In this regard, as PHAMESA moves into a new phase, it would benefit from revising its current management structure to accommodate a structure that reflects **management functions** to ensure the achievement of overall programme results instead of only programme components. This proposed revision of the management structure would also be more in line with the new proposed results framework of PHAMESA, which looks to be results based instead of based on programme components. The programme components would then form part of the interventions or activities that collectively lead to results.

It is recommended that a **Senior Management Team (SMT)** be established, which would include senior regional staff from each of the regional teams as well as relevant staff from selected country offices including migration health country coordinators. This SMT should establish clear terms of references aimed at providing guidance on overall programme planning, monitoring, budgeting, reporting, etc. The role of the team and its individual members should be clearly stated. This would help to address the challenges around **collective ownership and accountability.**

**PHAMESA and IOM South Africa Country Office**. Another concern around the management structure has to do with the fact that the PHAMESA programme sits within the IOM South Africa country office. This has created frustrations among the staff of the IOM South Africa office as well as regional PHAMESA staff. A number of staff from the South Africa office are providing a certain percentage of their time to PHAMESA, which is never predetermined. Meanwhile, PHAMESA staff members who are responsible for regional mobilisation are regarded as national staff, which affects the way PHAMESA is perceived at a regional level. More generally, this situation has an effect on the level of buy-in from other IOM country offices, which this evaluation regards as an important factor in the success of PHAMESA in country.

The PHAMSA II evaluation cautioned against this arrangement, noting that 'IOM is discussing the idea of placing regional projects under country offices, i.e. PHAMESA would sit under the South Africa national office. This would be an unfortunate development and could add significant challenges to the project's successful delivery'. According to the respondents from the online survey, one of the top three limitations of PHAMESA has to do with the "problem with coordination both at a national and regional level, where organisational structures are not clear and there seems to be a centralisation of the programme in South Africa."

Equally important, in terms of accountability, is the fact that the head of PHAMESA is also the IOM Chief of Mission for South Africa. In addition to putting a lot of responsibility on one person, this situation has the potential to create conflicts of interest since both PHAMESA and the country office depend on external funding.

In this regard, this evaluation suggests that an arrangement be found to ensure that: (i) PHAMESA is not associated with a country office and (ii) PHAMESA is not headed by a country chief of mission.

**The two regional teams.** The PHAMESA programme coincided with IOM's restructuring, whereby East Africa became subsumed within the Southern Africa office and then went back to being a regional office. This did not facilitate the establishment of clear lines of responsibility and authority in relation to PHAMESA – a unique IOM bi-regional programme that was just starting up. Despite these challenges, which were exacerbated by human resource issues (including staff turnover, short term contracts and a general lack of capacity), PHAMESA was successful in gradually building a full and capacitated team in East Africa. With this in place, there seems to be an opportunity to clarify roles, responsibilities and authority between the two regional teams.

While the programme organogram demonstrates a clear delineation between the two teams, in practice decisions around key management issues – including planning, implementation, budget allocation, monitoring and administrative and financial management (as was experienced first-hand though the management of this evaluation) – are made in Pretoria. There are pros and cons to this situation but the main challenge is not having a clear picture of the specific roles, responsibilities and authority in each region. In moving forward, PHAMESA would benefit from clarifying the roles and authorities of each regional team and the relationship between the two.

**The Pretoria regional team and Southern Africa country offices.** Based on documents reviewed and interviews held, there is an indication of fragmentation between the regional team and the country offices in Southern Africa around programme management (but not around technical support which is going well). Despite the processes in place, there seems to be a disconnect between the regional programme and country offices around strategic planning, prioritisation, monitoring and communication, which ultimately affects buy-in at country level. The main reason given for this is a perception that management and decision making are too centralised and not sufficiently inclusive.

It should be noted that the management support provided by the regional team in Nairobi to the country offices in East Africa seems to work well mainly because there are less countries and they are starting with more or less similar capacity so it is easier to manage. It is also clear from the management documents at a regional and country level that there is a direct synergy and close engagement between country needs and regional support in terms of planning, monitoring and reporting. These management processes and approaches may be worth looking into as good practice that could benefit the Southern Africa region.

## PART 6. Findings on Added Value, Sustainability and Cross-Cutting Issues: What does PHAMESA leave behind?

PHAMESA's added value, according to respondents from the online survey, lies in the following top three areas:

1. Firstly, that PHAMESA **increases the visibility of the migrant population** through its advocacy and raising awareness. As such, the programme is able to raise profile of migrant health needs and thus reach vulnerable communities.
2. Secondly, the programme has **increased partnerships around resources and expertise,** allowing for a comprehensive approach to health in the designated regions.
3. Thirdly, the way in which the programme has established itself has facilitated **policy formulation and implementation both at national and regional levels.** This ultimately leads to direct impact in terms of service delivery for the target mobile population.

These points were all confirmed by the triangulated findings from this evaluation and contribute to a more general added value identified by the evaluation around sustainability.

**Sustainability** is a key aspect of the PHAMESA programme. The design of the programme and the ways in which the programme components are implemented takes careful consideration of sustainability. It is an aspect which has been identified by this evaluation as a key success factor and which needs to be capitalised on, monitored better and documented in PHAMESA II.

Both at a regional and country level, IOM through PHAMESA has been successful in significantly increasing the capacity of partners to address migration health including with government departments and service providers. In some cases such as long standing programmes in South Africa, we are starting to see local government structures absorb projects aimed at migration health. In this regard, capacity building interventions with national and local government departments and service providers to design and manage their own programs in a sustainable basis should be continued in the next phase of PHAMESA, especially in those countries where this capacity is still weak.

Linked to sustainability, PHAMESA explicitly integrates and promotes a **Human Right's Based Approach** (HRBA) within all its components – research, advocacy, capacity building and coordination. For example, when carrying out advocacy campaigns there's a need to look at the legal framework in a specific context. In Kenya for example, PHAMESA helped revise the Internally Displaced Population (IDP) and Refugee Bill.

An important indirect result from the PHAMESA programme in all countries assessed is the change in negative attitude of migrant communities. Increased awareness on migration and health issues helps to address negative attitudes towards migrants including discrimination. In South Africa, local government officials acknowledged a major change in attitude towards Zimbabweans crossing the border at Musina for work as a result of the IOM health promotion work.

Efforts are also made to ensure that migrant communities benefit from equal access to services as others and that there is no "targeted discrimination" where migrants could end up having disproportionately better access to services. Facilities need to provide quality, comprehensive services to migrants and at the same time the programme raises awareness for migrants in terms of what they entitled to. Throughout the programme interventions there is an emphasis in countering negative attitudes towards migrant communities.

The integration and promotion of **gender** has been an important aspect of the programme that has been enforced in some countries (such as South Africa, Mozambique and Uganda) more than others. Efforts made by the PHAMESA programme to build capacity and provide relevant technical expertise to ensure gender responsiveness among partners has been significant. However, not all partners have been able to integrate let alone promote this into their work.

South Africa is an example where gender responsiveness has been a major success of the programme. Several factors led to this including the fact that it was strongly incorporated into the design from the onset because it was not only an overall priority for SIDA which is funding PHAMESA but is also a requirement from PEPFAR which provided additional funding for Ripfumelo, the South African PHAMESA project. The technical expertise provided by IOM on gender by partnering with experts such as Sonke Gender Justice has led to the Ripfumelo project in South Africa having visible impact on women's empowerment, men accessing and using clinics, families addressing health issues as a family, and less incidences of gender based violence.

There is an opportunity to ensure that gender is more integrated within the results framework and indicators of PHAMESA as it enters a new phase. In this way, reporting on specific aspects of gender responsiveness could be a drive to make the transition between theory and practice for certain partners (beyond disaggregating data between men and women). For example, the issue of male involvement in Southern Africa is a major challenge that could be explicitly targeted.

There is no explicit effort around **environmental** integration but indirect opportunities have been identified to integrate and promote environmental issues as part of "healthy environments" within the selected sites. In the commercial agriculture farms in South Africa one of the issues that came up repeatedly during interviews with beneficiaries was the fact that people were now more attentive to their environment and that the desire to feel healthier naturally led to wanting to live in a clean environment with no waste and litter around. In Uganda and Kenya, the issue of biosafety procedures in the clinics was tackled by health workers not just as an aspect to be addressed but as a general issue and not necessarily linked to migrants. There may be an opportunity to integrate environmental aspects when conducting baseline assessments with partners and beneficiaries in order to have a better understanding of the situation and possibilities for environmental change through existing PHAMESA interventions.

## PART 7. Recommendations

Based on the findings and lessons learned highlighted in the evaluation in red, a set of recommendations has been articulated to take PHAMESA forward in an effective and efficient manner. Below is a summary table showing the linkages between the findings and recommendations followed by a more detailed articulation of the recommendations.

| | Finding / Lesson Learned | Recommendation | Pg |
|---|---|---|---|
| **1.** | ***Results Based Management*** | | |
| | - At an overall programme level, it is not clear what changes PHAMESA is contributing to and at what level these changes should be<br>- The PHAMESA logic framework does not demonstrate any **logical linkages** between outputs and outcomes.<br>- Because the programme is not based on results, it is difficult to **measure progress** in terms of overall results<br>- There is no clear **documented and evidence based cause and effect relationship** demonstrating how one outputs lead to outcomes.<br>- The logic framework uses a **combination of approaches and terminologies,** including objectives, results and indicators, which are not consistent with common understandings, particularly when it comes to output and outcome results, indicators and targets. | - In order to measure and report on results, PHAMESA must start to **manage around results** which includes planning, monitoring, budgeting and reporting around results. This will help the programme become more integrated and demonstrate more meaningful impact. | Pg 23 |
| **2.** | ***Management Processes*** | | |
| | ***Planning.***<br>- Challenges with planning have been observed at two levels: (i) the process of planning and (ii) the quality of planning. The quality of planning refers to the challenges mentioned around the logic framework in the previous section. The process of planning refers to the management functions and systems in place, which allow for a collective | - Systems should be strengthened and in some instances established to allow for collective accountability and ownership of the programme. This means a more decentralised approach to the management of the programme. What is meant by a decentralised approach is more | Pg 44 |

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|---|---|---|---|
| | programme planning process to occur. The current systems for planning and decision making do not allow for collective ownership or collective accountability. | collective decision making. What we mean by management are the core functions around planning, implementation, monitoring and reporting on the programme. | |
| | ***Implementation / Capacity Building***<br>- The introduction of the concept note approach came about to allow countries to motivate for **resources** based on their identified needs, gaps and priorities. This approach has both advantages and disadvantages. On the one hand, it provides countries with a degree of flexibility and freedom to decide on what is needed. On the other hand, it is dependent on already existing capacity to motivate for funding and assumes a full understanding of the approach and a degree of confidence in using it. It also assumes that such a concept note is anchored within an overall country strategy, which has not been the case. | - As PHAMESA enters a new phase, there is an opportunity to adopt a more strategic and decentralised approach to **resource allocation**. Funding at country level should be anchored within the IOM country strategies that country level stakeholders can mobilise around. This means establishing a system of planning that involves IOM country offices and Chiefs of Missions more closely. In addition, the programme should also be anchored more closely with the regional strategies of the IOM regional offices in both Southern and East Africa<br>- Also on **resource allocation**, PHAMESA needs to strike a balance between (i) prioritising countries and sites and making sufficient funds available for these and (ii) supporting all countries to fulfil their obligations to the WHA resolution on migrant health by providing financial as well as capacity support determined by and aligned to the IOM country strategy. | |
| | ***Monitoring***<br>- PHAMESA currently does not have an internal platform for regular information sharing, engaging on specific issues and learning. There is an opportunity to ensure more internal **sharing and learning** (same as below)<br>- Because the programme is not based on results, it is difficult to **measure progress** in terms of overall results<br>- Without a uniform baseline for the entire programme it is not possible to compare information across countries and to have an overall picture of the state of knowledge and capacity in relation to migrant health in the region. This reinforces the importance of identifying programme level results together with specific **indicators and baselines**.<br>- | - It is important to nurture an internal culture of monitoring, reporting, **sharing and learning**. More regular internal narrative reports, such as those used in East Africa, promote a culture of reflection and sharing of lessons learned outside of official reporting requirements.<br>- Monitoring should be a more **integrated process** that takes within planning and with programme staff.<br>- Collectively developing meaningful and measurable **indicators and baselines** for the overall programme is critical for measuring progress and advancing the programme as a whole. | |
| | ***Knowledge Management.***<br>- PHAMESA currently does not have an internal platform for regular information sharing, engaging on specific issues and learning. There is an opportunity to ensure more internal sharing and learning. | - PHAMESA would benefit from establishing a common internal platform to promote learning and sharing in-house. One platform that may be relevant and useful is KARL (http://karlproject.org), which is an | |

| | | | |
|---|---|---|---|
| | | open source web system for collaboration, organizational intranets, and knowledge management. | |
| **3.** | ***Management Structure*** | | |
| | - **Internal PHAMESA management structure**. There is a lack of clarity around the overall programme management functions in terms of (i) overseeing overall strategic planning processes, (ii) providing overall support to implementation and monitoring, (iii) providing overall administrative and financial management support, and (iv) ensuring internal and external communication. Based on (i) the job descriptions and programme organigram reviewed, (ii) the relevant planning and monitoring documents, (iii) interviews with PHAMESA staff and (iv) first hand observations on how PHAMESA is managed (i.e. including this end-of-programme evaluation), this evaluation found a lack of clarity on explicitly articulated roles and responsibilities – including decision making authority and accountability - around key management functions such as those mentioned above. | - As PHAMESA moves into a new phase, it would benefit from revising its current management structure to accommodate a structure that clearly reflects roles, (including authority and accountability) around **management functions** for overall programme results. | Pg 47 |
| | - **The Pretoria regional team and Southern Africa country offices.** Based on documents reviewed and interviews held, there is an indication of fragmentation between the regional team and the country offices in Southern Africa around programme management (but not around technical support which is going well). Despite the processes in place, there seems to be a disconnect between the regional programme and country offices around strategic planning, prioritisation, monitoring and communication, which ultimately affects buy-in at country level.<br>- | - A **Senior Management Team (SMT)** be established, which would include one senior team member from each of the sub-regional offices and one senior team member from two country offices with clear terms of references aimed at providing guidance on overall programme planning, monitoring, budgeting, reporting, etc. | |
| | - **The two regional teams.** While the programme organogram demonstrates a clear delineation between the two teams, in practice decisions around key management issues – including planning, implementation, budget allocation, monitoring and administrative and financial management (as was experienced first-hand though the management of this evaluation) – are made in Pretoria. There are pros and cons to this situation but the main challenge is not having a clear picture of the specific roles, responsibilities and authority in each region. | - PHAMESA would benefit from **clarifying the roles** and authorities of each regional teams and the relationship between the two for the benefit of the overall programme | |

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| | - **PHAMESA and IOM South Africa Country Office**. Another concern around the management structure has to do with the fact that the PHAMESA programme sits within the IOM South Africa country office. This has created frustrations among the staff of the IOM South Africa office as well as regional PHAMESA staff. A number of staff from the South Africa office are providing a certain percentage of their time to PHAMESA, which is never predetermined. Meanwhile, PHAMESA staff members who are responsible for regional mobilisation are regarded as national staff, which affects the way PHAMESA is perceived at a regional level. More generally, this situation has an effect on the level of buy-in from other IOM country offices, which this evaluation regards as an important factor in the success of PHAMESA in country.<br>- | - An **organisational arrangement** should be explored to ensure that: (i) PHAMESA is not associated with a country office and (ii) PHAMESA is not headed by a country chief of mission. | |
| ***4.*** | ***Programme Components*** | | |
| | ***Service Delivery and Capacity Building***<br>- The **service delivery and capacity building (SDCB) framework** developed and used by IOM provides clear parameters for project design and implementation using Social and Behaviour Change Communication (SBCC). PHAMESA has supported the region and individual countries to be equipped to implement the framework through extensive material, guidance and capacity building.<br>- An important component of PHAMESA is the **capacity building** of implementing partners or service providers as well as technical partners, including relevant government departments, to provide adequate services to migrant communities. | - This evaluation has found that the real value of **SDCB** is around capacity building of governmental and non-governmental entities;<br>- The approach around **SBCC and gender responsiveness** should continue to be promoted and adapted to different countries and in East Africa; | pg 29 |
| | ***Research and Information***<br>- Research has been identified as one of the main entry points for PHAMESA at country and regional level for informing advocacy, policy development, coordination, resource mobilisation and ultimately improved services. Translating this research into concrete results including increased awareness and improved policy is an explicit aim of the programme with good indicators to measure this. | - It is important that the rich baseline generated at the beginning of the programme be complemented with end-of–programme data to fully measure progress in knowledge and behaviour. In this regard, it would be useful to conduct similar studies or even rapid assessments such as KABP with targeted communities to compare levels of knowledge as well as the extent of the original problem and whether it has been mitigated or not. | Pg 26 |
| | ***Advocacy and Policy Development.***<br>- An enabling legal and policy environment for migration health comes as a result of a combination of interventions, including evidence based **advocacy.** There are different levels of understanding and interpretation of advocacy within PHAMESA which leads to challenges in measuring progress around advocacy and what | - It is critical for advocacy efforts to be clearly defined using similar criteria so as to provide clear and consistent guidance and for the programme to be better able to be measure progress across the board. A useful guide in this regard is the "Guide to measuring advocacy and policy, | Pg 38 |

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| | results it leads to. | ORS, 2001" | |
| | ***Regional Coordination***<br>- PHAMESA has been catalytic in initiating and facilitating coordination around migration health at national and local levels.<br>- Regional Coordination is critical (i) to address cross-border issues and (ii) to provide a supportive regional environment for countries to strengthen their efforts on migration and health. | - Regional coordination can only benefit from having a more solid overall programme where its role in terms of facilitating regional work but also in support to countries should be made more clear.<br>- document lessons learned including models and approaches used either with one specific stakeholder such as SADC or on a specific issue such as TB in the mining sector.<br>- There is a real opportunity for PHAMESA II to be increasingly shaped by the specific migration health dynamics and experiences in East Africa as well as the Indian Ocean and the Horn of Africa. | |
| 5. | ***Cross-Cutting Issues*** | | |
| | - **Sustainability** is a key aspect of the PHAMESA programme. The design of the programme and the ways in which the programme components are implemented takes careful consideration of sustainability. It is an aspect which has been identified by this evaluation as a key success factor and which needs to be capitalised on, monitored better and documented in PHAMESA II. | - Capacity building interventions with national and local government departments and service providers to design and manage their own programs in a sustainable basis should be continued in the next phase of PHAMESA, especially in those countries where this capacity is still weak. | Pg 51 |
| | - PHAMESA explicitly integrates and promotes a **Human Right's Based Approach** (HRBA) within all its components | - It is important to continue to emphasise the need for PHAMESA to provide support in a sustainable way by avoiding parallel processes that may not have the potential to be absorbed by government service providers. | Pg 51 |
| | - The integration and promotion of **gender** has been an important aspect of the programme that has been enforced in some countries (such as South Africa, Mozambique and Uganda) more than others. Efforts made by the PHAMESA programme to build capacity and provide relevant technical expertise to ensure gender responsiveness among partners has been significant. However, not all partners have been able to integrate let alone promote this into their work. | - Ensure that gender is more integrated within the results framework and indicators of PHAMESA as it enters a new phase | Pg 52 |
| | - There is no explicit effort around **environmental** integration but indirect opportunities have been identified to integrate and promote environmental issues as part of "healthy environments" within the selected sites | - Integrate environmental aspects when conducting baseline assessments with partners and beneficiaries | Pg 52 |

**1. Results Based Management**

PHAMESA is currently managed by objectives and interventions. It does not articulate overall programme results and does not have systems in place to monitor or manage results.

1.1. In order to measure and report on results, PHAMESA must start to **manage around results** which includes planning, monitoring, budgeting and reporting around results. This will help the programme become more integrated and demonstrate more meaningful impact.

1.2. As a first step, PHAMESA must go back to the drawing board to establish a common **theory of change** to establish the changes it wants to contribute to based on the problem identified (and not based on objectives, i.e. what we want to do, or interventions, i.e. how we do it).

1.3. The theory of change should be the basis for the development of a **results based logic framework** that identifies results (or changes) at the different levels: output, outcome and impact.

1.4. Underlying Results Based Management is the key principle of **collective accountability**. Planning with all relevant players to ensure ownership and accountability is key to the planning process.

1.5. The results based logic framework will be the basis on which to identify measurable and meaningful indicators as well as baselines and targets for each indicator. Measuring progress is dependent on the establishment of baselines for each indicator so as to enable the programme to measure progress over time. This will form the basis for **results based monitoring and evaluation plan.**

1.6. Results need to be managed throughout the management cycle including the budgeting stage. **Results based budgeting** will need to replace the activity based budgeting.

1.7. In terms of **human resources**, positions and job descriptions need to reflect the management of results. Appropriate management functions should be established to lead this process. Job descriptions should be performance based or at the very least clear on what specific result(s) the job is aiming to contributing to.

**2. Management Processes**

Management systems and procedures to support the effective programme implementation and expansion of PHAMESA need to be strengthened.

2.1. The process of **strategic planning** should be systematic, consistent and inclusive. Systems should be in place to allow for collective accountability and ownership of the programme. This means a more decentralised approach and management of the programme.

2.2. It is important to nurture an internal culture of **monitoring**, reporting, sharing and learning. More regular internal narrative reports, such as those used in East Africa, promote a culture of reflection and sharing of lessons learned outside of official reporting requirements.

2.3. Monitoring should be a more **integrated process** that takes within planning and with programme staff.

2.4. Collectively developing meaningful and measurable **indicators and baselines** for the overall programme is critical for measuring progress and advancing the programme as a whole.

2.5. There is an opportunity for improved **internal communication**. One platform that may be relevant and useful is KARL (http://karlproject.org) which is an open source web system for collaboration, organizational intranets, and knowledge management

2.6. **Learning** should be promoted across the regions. The same way in which South Africa is a learning site for the Southern Africa, a learning site could also be identified and invested in East Africa.

2.7. As PHAMESA enters a new phase, there is an opportunity to adopt a more strategic and decentralised approach to **resource allocation**. Funding at country level should be anchored within the IOM country strategies that country level stakeholders can mobilise around. This means establishing a system of planning that involves IOM country offices and Chiefs of Missions more closely. In addition, the programme should also be anchored more closely with the regional strategies of the IOM regional offices in both Southern and East Africa

2.8. Also on **resource allocation**, PHAMESA needs to strike a balance between (i) prioritising countries and sites and making sufficient funds available for these and (ii) supporting all countries to fulfil their obligations to the WHA resolution on migrant health by providing financial as well as capacity support determined by and aligned to the IOM country strategy.

**3. Management Structure**

The overall internal PHAMESA management structure has largely evolved to reflect the programme's components. There are several challenges with the current management structure which need to be addressed in moving forward.

3.1. In this regard, as PHAMESA moves into a new phase, it would benefit from revising its current management structure to accommodate a structure that reflects **management functions** to ensure the achievement of overall programme results instead of only programme components. This proposed revision of the management structure would also be more in line with the new proposed results framework of PHAMESA, which looks to be results based instead of based on programme components. The programme components would then form part of the interventions or activities that collectively lead to results.

3.2. It is recommended that a **Senior Management Team (SMT)** be established, which would include senior regional staff from each of the regional teams as well as relevant staff from selected country offices including migration health country coordinators. This SMT should establish clear terms of references aimed at providing guidance on overall programme planning, monitoring, budgeting, reporting, etc. The role of the team and its individual members should be clearly stated. This would help to address the challenges around collective ownership and accountability.

3.3. An **organisational arrangement** should be explored to ensure that: (i) PHAMESA is not associated with a country office and (ii) PHAMESA is not headed by a country chief of mission.

3.4. PHAMESA would benefit from **clarifying the roles** and authorities of each regional teams and the relationship between the two for the benefit of the overall programme

**4. Programme Components**

**4.1. Service Delivery and Capacity Building.**

- This evaluation has found that the real value of SDCB is around capacity building of governmental and non-governmental entities;
- The approach around SBCC and gender responsiveness should continue to be promoted and adapted to different countries and in East Africa;
- In ensuring access and use of services, SBCC needs to be seen as one element within "HIV combination prevention" as outlined in the global UNAIDS Investment framework. In this regard, it is important for PHAMESA to promote the other activity areas as well as the social and programme "enablers" (see UNAIDS Impact Investment Framework 2011).

**4.2. Research and Information.**

- It is important that the rich baseline generated at the beginning of the programme be complemented with end-of–programme data to fully measure progress in knowledge and behaviour. In this regard, it would be useful to conduct similar studies or even rapid assessments such as KABP with targeted communities to compare levels of knowledge as well as the extent of the original problem and whether it has been mitigated or not.
- Most Indicators are process or activity based and do not have baselines.

**4.3. Advocacy and Policy Development**

- It is critical for advocacy efforts to be clearly defined using similar criteria so as to provide clear and consistent guidance and for the programme to be better able to be measure progress across the board. A useful guide in this regard is the "Guide to measuring advocacy and policy, ORS, 2001"

**4.4. Regional Coordination.**

- Regional coordination can only benefit from having a more solid overall programme where its **role** in terms of facilitating regional work but also in support to countries should be made more clear.
- With the wealth of experience accumulated over the recent years around regional coordination on migration health in Southern Africa, it would be useful to **document lessons learned** including models and approaches used either with one specific stakeholder such as SADC or on a specific issue such as TB in the mining sector. This would be useful for learning purposes but also would benefit current similar efforts in East Africa.
- There is a real opportunity for PHAMESA II to be increasingly shaped by the specific migration health dynamics and experiences in **other sub-regions** including East Africa as well as the Indian Ocean and the Horn of Africa.

**5. Sustainability and Cross-Cutting**

5.2 **Capacity building** interventions with national and local government departments and service providers to design and manage their own programs in a sustainable basis should be continued in the next phase of PHAMESA, especially in those countries where this capacity is still weak.

5.5. It is important to continue to emphasise the need for PHAMESA to provide support in a sustainable way by avoiding parallel processes that may not have the potential to be **absorbed** by government service providers.

5.6. Ensure that **gender** is more integrated within the results framework and indicators of PHAMESA as it enters a new phase

5.7. Integrate **environmental** aspects when conducting baseline assessments with partners and beneficiaries

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## ANNEX 10: CSI+ RESPONSES TO IOM COMMENTS ON PHAMEDSA EVALUATION REPORT

| IOM General Comments | CSI+ Response to General Comments |
|---|---|
| 1. There is need to link findings with recommendations; in particular the number and also the specificity of some recommendations do not match with the scope of the evaluation (rather limited in time and means) and findings presented; maybe a summary table with main findings and related recommendations would be useful. | Table developed to clarify linkages between findings and recommendations on pg 52 |
| 2. For the validity of the evaluation, findings need to be substantiated by facts or in reference to specific data collected during the evaluation e.g. "PHAMESA has been effective in increasing the evidence base on migration health by promoting research at country and regional level…"; "partners report that IEC material and DVDs shown to people from the outer island of Rodrigues before they travel has helped to increase awareness…". | The findings included in this evaluation have been made based on a combination of document reviews, online survey results, interviews with key informants, and observations. Specific examples to substantiate these findings are included throughout the report. References to specific pieces of data to back up these examples are made where relevant .We feel that this process and level of detail brings a satisfactory level of validity to the findings. See pg 11 for added text to clarify the process on the validity of findings. |
| 3. Since the restructuring it is the South Africa country office that is the executing agency - with overall responsibility for implementation – IOM no longer has MRFs (missions with regional functions). | Corrected. |
| 4. On page 8 there is a list of partners interviewed/ reached during the evaluation. ILO is missing from the UN list yet for Zambia, this was one of the partners interviewed and whom we have been working closely with on labour migration and health. | Clarified. |
| 5. Page 16 – on Zambia it should reflect that labour migration and mobility is one of the six key drivers of HIV identified in the national strategic plan. | Added. |
| 6. On page 37 – SIDA funded IOM Zambia project is actually a joint UN flagship GBV programme which was funded by SIDA through UNDP as the fund recipient. | Added. |
| 7. On page 41 there is information on the funds disbursed for operational costs and the funds mobilized. The evaluator combined both the local mobilized funds (PHAMESA funds mobilized through concept notes to the regional office) and funds mobilized from other non PHAMESA streams. These should | Noted and clarified. The evaluation examined the act of mobilizing resources whether in-house or externally as responding to a similar capacity and need. |

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| be viewed separately and not lumped up as one since the CN is really from the same basket, while the funds mobilized outside of PHAMESA in some instances reflect how well the programme has been able to demonstrate need/ problem to other stakeholders to warrant funding. | |
| 8. The report has a specific comment on M&E: it would be useful to have more tangible recommendations on how to strengthen the operationalization of the results framework. | Recommendations on monitoring added. |
| 9. On management structure and function, it is not clear what the evaluators are recommending, and maybe the example of how it is working better in East Africa need to be presented much more clearer to help with the understanding; It is a bit vague for me. | There is no recommendation on a management structure that is better in east Africa - the recommendation looks at clarifying roles of authority between the two regional teams. |
| 10. On the change agents stipends (page 39-40). That paragraph is not clear: is it that payment of stipends is making the programme effective or not effective? Or the other way round. | Corrected. The misplacement of quotation marks in this paragraph led to a lack of clarity. All the statements in this paragraph are statements taken from the online respondents to demonstrate different levels of issues linked with funding challenges. See also results from Survey Monkey in Annex. |
| 11. Would it be possible to add lessons learned section under the executive summary as it is one of the key objective of the evaluation as per TOR and it needs to be highlighted. | Lessons learned are captured as part of the findings and have been highlighted more clearly in the table linking findings and recommendations. |

| IOM Consolidated Comments | CSI+ Response to Consolidated Comments |
|---|---|
| 1. South Africa Country office, Pretoria. MRF's do not exist anymore hence any reference to MRF on the report and on the annexes needs to be removed (page 2) | Corrected. |
| 2. 3 levels, those that received significant S&O support (Moz, Zam & Tanz), those that had start up funds (Mau, Kenya, Uganda, South Africa) and others that got operational funds through CN. (page 2) | We have left the original statement which does not contradict this statement which provides additional information which is captured later in the text. |
| 3. This being a a regional office program i don't know how a country coordinator becomes part of senior management...the regional team ensures countries are accountable so i see a conflict of interest if a country is part of top decision making. (page 4) | We disagree. Regional programmes should be accountable to country level implementation, especially the way we understand the functioning of IOM country offices. Successful regional programmes on public health – notably the USAID Regional HIV and AIDS Programme (RHAP) – is evidence of the direct involvement of country offices in the planning, designing, and monitoring of the regional programme. |

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| 4. Please add Madagascar, IOM did some work there too. (page 6) | Added on pg 15 |
| 5. Katy said: "I would prefer 'civil society partners,' since we don't necessarily have implementing partners in the traditional sense (because a lot of what we do with partners is capacity-building)" (page 8) | This is the terminology that was agreed during the time of the inception meeting. |
| 6. Katy: As above, we don't have beneficiaries in the traditional sense of the word under PHAMESA (e.g. much of the time beneficiaries will be recipients of capacity building, or research assistance which includes govt etc) ... maybe change to "Migrants and their representatives" (page 8) | This is the terminology that was agreed during the time of the inception meeting. |
| 7. Since the restructuring it is the South Africa country office that is the executing agency - with overall responsibility for implementation - There are no such things as MRFs (missions with regional functions) any more. (page 14) | Corrected. |
| 8. Phamesa regional coordinator based in Pretoria - Erick is the head of Phamesa and is acting as SA chief of mission a.i. The chief of mission position has been advertised last month and the recruitment process should be completed in the next 6 months (page 14) (page 14) | This is new information that we have reflected in a footnote on page 15. |
| 9. Though these were the focus countries, PHAMESA also had presence in Somalia, Ethiopia, South Sudan, Djibouti (page 14) | Added on pg 15 |
| 10. the 400,00-500,000 was for staff and office ( S&O) not operational costs (page 15) | Staff and office costs are operational costs as defined by standard management terminology (see Wikipedia definition of operational costs) but we have changed the terminology to be in line with IOM terminology. |
| 11. It was not a requirement for all countries to recruit MH coordinators as the text implies – only Tanzania, Mozambique and Zambia had funds for MH coordinators – the others hired individuals to specifically operationalize approved CN . Only those with S&O had migration and health coordinators - others had staff recruited under consultant contracts (using operational funds) to support the implementation of specific CN and included some of the migration & health coordinators roles. Mauritius doesn't have a specific person - Davina - does MH, labour migration and other things. (page 15) | See source for this statement below: "It is envisaged that Migration Health Coordinators will be placed in each country, pending funding availability, except for Lesotho and Swaziland, which will be overseen by the Coordinator based in South Africa. " – Final Approved PHAMESA Project Proposal (March 2010) |
| 12. In Kenya, there's a "National Strategy on HIV & AIDS, STI Programming along Transport Corridors in Kenya" which like Uganda's is entirely dedicated to mobile populations. Developed with IOM's leadership. (page 16) | Added. |

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| 13. but it does recognize truckers and sex workers(both mobile pops) as key populations of focus where service delivery needs upscaling. In the last comments Rogers Mutie did provide the page number where this is indicated. (page 16) | Added. |
| 14. Probably good to add partnership with PEPFAR/USAID as a major donor of part of Phamesa (page 19) | Added. |
| 15. TEBA instead of THEBA (page 19) | Corrected. |
| 16. How about the Partnership between IOM and private sector clinics in Uganda that has resulted to improved and friendly health service provision for sex workers, truckers and migrants in HIV hotspots in Uganda? (page 19) | Added. |
| 17. Rogers got some updated data from the Eastleigh clinic contained in the clinic operator's periodic report between December 2012 and July 2013 12,340 clients were served (53.5% of all clients served were migrants from countries neighbouring Kenya but mostly Somalia. (4214 male, 8126 female). This means averagely 1,543 clients per month compared to the previous years average of 300 per month. This increase was a direct result of incorporating health promotion through change agents and community radio(IQRA FM).page 28) | Updated. |
| 18. The Somalia IBBS was peer reviewed and published an article titled "HIV prevalence and and characteristics of sex work among FSW in Hargeisa Somaliland, Somalia" in a journal called AIDS Volume 24 Supplement 2 July 2010(www.aidsonline.com). It was published in October International Journal of Health Services, Volume 43, N.3 http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,7,15;journal,1,172;linkingpublicationresults,1:300313,1 (page 28) | Added. |
| 19. In East Africa: MOUs with academia is Phamesa to generate more evidence and upscale research interest in migration health. e.g. Makerere University is now helping us with research work around health in OSBP and migration profile in Uganda. Nairobi University is giving us opportunities to give lectures/talks on migration and health as well as generate interest in migration and health. These results are at formative stages. (page 28) | Noted. |
| 20. Title of the study is: "Health Vulnerabilities Study among Populations in Mixed Migration Flows from the East and Horn of Africa and the Great Lakes Region to Southern Africa" (page 29) | Corrected. |
| 21. More examples:<br><br>-The Somalia IBBS(2009) was the parent study that laid groundwork for HIV hot spot mapping, strengthened collaboration with Somaliland AIDS commission, and laid ground work really for HIV programming in that region<br>-In Uganda a 2010 study entitled "Health Service Availability | According to the dates provided for these two examples, they were both conducted prior to PHAMESA so cannot be attributed to the programme. |

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| Mapping for MARPs at HIV Hot spots along the Kampala-Juba transport route(April 2010)" provided the evidence and basis for partnership with private clinics that has seen them redesign their service delivery to serve migrants and migrant workers better". (page 29) | |
| 22. The report earlier mentioned that one of the successes of PHAMESA has been to raise the awareness about migrants and their health as came out from interviews with partners- isn't that a result? (page 30) | Agreed. The aim of the "So What" questions next to all the existing indicators is to guide PHAMESA to develop relevant indicators that answer these questions. The aim of the questions is not to get an answer. This has been clarified as a footnote. In line with this comment, one of the indicators we should be looking at with PHAMESA II could be: % Increase among migrants on their awareness of health risks. |
| 23. This is only if we look at tier 1 or tier 2 countries, but there are "other" countries that also received little PHAMESA funds which have been even more successful like Somalia which has raised more than 20 million dollars; Djobouti too, do we need to mention these. (page 32) | Agreed. The evaluation only looked at the tier 1 and 2 and was not in a position to evaluate tier 3 based on the time allotted and information available. |
| 24. It is not clear what is the difference between 'mobilised' and 'leveraged' (page 32) | We used these terminologies as they were described to us but have clarified this in the text: Mobilised (IOM takes the lead in mobilizing funds which it manages including mobilizing in-house funds such as through concept notes); Leveraged (IOM has played a role in mobilizing the funds which are managed by external partners) |
| 25. Total mobilised for Mozambique including concept notes is USD $3,433,158 - USD 150,000 for AMODEFA from the Ministry of Communications and transport (page 32) | We have added the USD 150,000 for AMODEFA but would need a more specific breakdown of the USD $3,433,158 that we can verify in addition to what is included. |
| 26. Correction on the figures presented here:<br><br>Kenya from PHAMESA received a total of 185,313 (in addition to the amount for staff & office). They have raised USD 530,200 (from UN Joint team, Irish aid and others) (page 33) | Corrected. |
| 27. Theo to confirm if it is 78 (page 33) | No confirmation received. |
| 28. Yes, see new figures provided for the Eastleigh clinic for Kenya, in Uganda migrants are using the services too. (page 33) | See comment on question 22.<br>The aim of the "So What" questions next to all the existing indicators is to guide PHAMESA to develop relevant indicators that answer these questions. The aim of the questions is not to get an answer. This has been clarified as a footnote. |
| 29. Drop-in clinic -In Uganda satisfaction surveys completed in 8 clinics in Arua, Gulu, Kasese, Lyantonde, Rakai districts. (page 33) | Added. |
| 30. We call it the service delivery and capacity building framework. | Corrected from original title. |

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| Have I missed the reflection on the material, guidance and capacity building work surrounding the framework that was undertaken at the regional and country levels (page 34) | Sentence added to provide general reflection on SDCP process instead of only results from SDCP. |
| 31. The actual name is " Kenya National Strategy for HIV & AIDS and STI programming in Transport Corridors" (page 36) | Corrected. |
| 32. Can we find another word? 'stark' isn't the best suited to describe the impact Phamesa has had on women. (page 38) | Modified. |
| 33. Are you referring to staff costs only? or all phamesa costs including staff, office and operation costs? not clear. (page 39) | PHAMESA Actual Staff Costs as of 31 Aug 2013. |
| 34. MRFs do not exist anymore (page 39) | Corrected. |
| 35. It is relevant to note that RO are indeed allowed to now manage programmes, however it is not a general practice yet, as it depends on the capacity and willingness of the RO. At the moment the RO in SA have limited capacity to manage large programme. (page 39) | Noted; Does not change the finding. |
| 36. RO SA has started to coordinate a small and short term regional programme (1 million for 1 year) very recently since 31st October 2013. The programme is PRM IV, not USRP. the decision was taken in consultation with the country mission, which is providing financial, administrative and management support as the RO has not at the moment full capacity to do it by itself. (page 39) | Noted; Does not change the finding. Corrected information on PRM programme. |
| 37. This should be broaden to IOM in general, not only Phamesa. (page 39) | That may be the case but the survey was specifically referring to PHAMESA. |
| 38. Sentence not clear: stipends to CA demotivate 'staff'? which staff? IOM's or CA themselves? It is not clear why CA's stipend would demotivate IOM staff- perhaps that statement needs some further unpacking. Also to note that this practice to give stipends to change agents is a decision made at country level, Phamesa regional team does not recommend it. (page 40) | These are direct quotes from the survey findings; Sentence clarified to demonstrate direct quotes. See comment 10 in previous section. |
| 39. This perception should be understood in light of IOM projectized nature, not only in the context of Phamesa. Phamesa is a unique programme in IOM as it provides country missions (which are independent entities) with seeds funds for staff/office and activities. This situation creates high expectations within countries. Phamesa being a limited programme cannot respond to all expectations, which create sometimes frustration at country level. (page 40) | Noted. Does not change the findings. |
| 40. The introduction of the CN was meant to bring transparency to the process of resource allocation. There are clear guidelines and allocation criteria, as well as focal point for this process. The CN or planning process for resource allocation is done closely with the countries through the Phamesa focal point in the country who has to seek approval from his/her chief of mission. | Noted. We are aware of the detailed process and the referring documents. Does not change the finding. |

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| The process of CN is as follows: 1/ a CN is submitted to the technical focal point (advocacy, regional coordination, research/SDCB, m&e, etc) (based in the SA or EA regional team) who is also the focal point for management issues, 2/ the focal point works closely with the country to ensure it is technically sound and in line with Phamesa framework, 3/ the CN is then submitted to a selection panel where are represented all the senior programme managers and coordinators (Erick, Paola, Reiko, Julie, Shikhulile). The inclusion of countries happens at the planning process or development of the concept note. The decision making is done at the regional team level and included 5 persons. the decision making process has to be centralised at the regional team level and cannot include countries as countries are recipient of the seed funds. I have attached template of the CN which include the guidelines and assessment criteria (these criteria stipulate that the proposed activities need to be embedded in the country strategy and approved by the chief of mission) (page 40) | |
| 41. This is a critical issue we need to address at regional (cost shared staff) and country level (national coordinators) (pafe 40) | Noted. |
| 42. To migration health, not Phamesa in particular, although Phamesa constitutes a large part of MH. this is due to the context of projectization where people need to devote extra time to developing MH (page 40) | Noted. Does not change the finding. While this may also be the case with Migration Health, we are referring specifically to PHAMESA. |
| 43. Having worked in both Zambia and Mozambique i think it is important to add that the external funding environment is the most important factor in terms of successful resource mobilisation in phamesa. In some countries there simply isn't donor funding available to be mobilised, especially for IOM in the health sector (not seen as our core work) - and also in "traditional" pepfar countries. ([age 40) | Agreed and added. |
| 44. Just to ensure we have the same understanding. When Phamesa refers to CN, we mean phamesa fund for countries to undertake specific activities. On top of the CN funds, Phamesa gives seed fund to countries to cover staff and office costs of the country mission. Resource mobilized refers to external funds (external to phamesa). (page 40) | Text clarified on pg 42. |
| 45. With the correct figures for Kenya inserted, this bar graph will need to be updated. Kenya definitely has mobilized much more than it received. See comments on page 28 (page 40) | Updated to reflect correction in comment 26. |
| 46. This figure refers to staff and office costs. when phamesa refers to operational costs we mean funding for activities contributing to phamesa objectives (page 41) | Wording changed to clarify staff and office costs. |
| 47. These countries are just examples provided by the evaluation team, right? Maybe you should mention the other countries in Tier 2 without entering into details such as: DRC, Angola, SA, | The evaluation felt that these countries were representative enough to provide the information |

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| which received approximately $60,000 each. What about countries in TIER 3? which did not received staff/office costs but only operational funds (through CN). it is the case of Somalia, Ethiopia, South Sudan, Namibia, Zimbabwe). the amount of the funds they received is indicated in the document sent by Erick on 11th Nov 2013. (page 41) | needed. Given more time, a deeper and more exhaustive analysis could indeed be done. |
| 48. Please clarify what is meant by seed funding vs fund leverages by CN?.All countries only got 60,000 seed funding from PHAMEASA, where are these figures from? (page 41) | Clarified meaning of seed funding in text (staff and office costs); the figure of 60,000 is the figure provided for Tier 2 countries as can be seen from the amount provided to those countries on pg 34. |
| 49. As mentioned above, the preparation of the CN was supported by the regional team focal point to enable those with less capacity to access operational funds. but countries have to request support from the regional team. an email was sent by Erick with clear roles and responsibility and processes. please see attached email. (page 41) | Noted. Does not change the finding. |
| 50. Please refer to criteria assessment of the CN. it is clearly mentioned that countries need to anchored the CN within the country strategy, henceforth it is more than an assumption. However, is is more difficult to ensure this in countries where there is no strategy at country level (which is the case in some IOM country missions) (page 41) | Noted. Does not change the finding. |
| 51. Countries being recipients of phamesa funds (and can also be considered as implementing partners). therefore, we need to ensure a fair process in resource allocation. we cannot involve 1 or 2 countries in the decision of resource allocation since it would be unfair for the others. we cannot include all the countries or it would be unmanageable. in addition to that financial accountability lies under one entity which is the Pretoria country office. this is a requirement of IOM global and SIDA. However, it is clear that we need to develop a more inclusive approach. (page 41) | We disagree. Regional programmes have the capacity to involve countries in how resources are allocated across countries. Using examples of other regional programmes such as the USAID RHAP mentioned in comment 3, countries do not have to be only "recipients" but can take an active part in shaping how the regional programme operates. |
| 52. It is the case in principle (page 41) | Noted; Does not change the finding. |
| 53. as explained before country offices have been involved through coordinator who was supposed to liaise with chief of mission (CoM) and get approval from him/her as well as from the country based RMO to ensure ownership. It is clear from the evaluation that we should ensure more inclusion of the CoM at the planning stage. (page 41) | Noted; Does not change the finding. |
| 54. I think this comment is relevant, but what about responsibilities of country missions? (page 41) | Agreed. It is about having more responsibility at the country mission level to plan around PHAMESA. |
| 55. The management by a country office does not lead automatically to lack of ownership and accountability. However, because the programme is managed by 1 country it has to | Not automatically, but in this case it does. We have used a specific example to demonstrate how |

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| ensure that strategic decisions are made in a transparent manner and with the inclusion of countries (CoM). (page 42) | country office staff have important management authority over PHAMESA. |
| 56. I dont see that as the responsibility of Phamesa to support the country planning process at the country mission level. It is more a responsibility of the RO (regional office) to support this process.(page 42) | We have clarified that we are referring to country planning processes around migration and health promotion. It may not be the responsibility but it would be useful if the country missions could rely on PHAMESA to support them in the country strategic planning process around migration and health promotion – that would be a real added value of PHAMESA. |
| 57. This to me seems to be a participatory process, involving countries and contradict what you have been saying previously (lack of involvement of countries). I am attaching the TOR and report of one of the strategic planning meeting. (page 42) | There is no contradiction. The evaluation calls for consistency in collective ownership and accountability while acknowledging that there have been some efforts to be inclusive.<br>The strategic planning meeting report referred to is a specific source we have drawn on (see annex on list of documents reviewed) for this finding since it does not demonstrate an inclusive or clear planning process and structure. |
| 58. As said before, I dont see the centralised decision making process (management by 1 country office) as necessarily responsible of the issues mentioned here. however, it is clear that the planning process needs to be improved through inclusion of countries in the planning process and better communication on decision making. (page 42) | Noted. Does not change the finding. |
| 59. Phamesa regional team has always tried to involve countries at the programme stages, but it is clear that more efforts need to be done in this area. (page 42) | Noted. Does not change the finding. |
| 60. Based on the above comments, it would be more relevant to say 'to be strengthened' (page 42) | It's actually both – text modified to reflect this. |
| 61. Phamesa cannot be decentralised (managed by several countries). we suggest 'a more inclusive approach especially in regard to chief of missions. (page 42) | Decentratlised approach of the management of PHAMESA does not mean a decentralized PHAMESA. Text clarified to explain this. |
| 62. Capacity in project management is a critical issue in IOM in general, which IOM global has been trying to address in the past 2 years (cf. project development guidelines, training, etc.). I dont see how Phamsa can address all the management capacity gaps of all the country offices, this is not realistic. Phamesa can only provide support within limits. (page 43) | Noted. Does not change the finding.<br>This evaluation and its findings refers to PHAMESA alone and in this case capacity building is referring to the management of PHAMESA, i.e. its planning, implementation, monitoring and reporting. |
| 63. Since Phamesa is one region (east and southern) work reports | Agreed. |

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| should be shared comprehensively not just amongst East Africa if internal learning is to take place. (page 44) | |
| 64. This is done collectively with the coordinators (Erick, Paola) and the regional programme managers/officers (Julia, Reiko, Theo, etc) in SA and EA. (page 45) | There may be people designated to do the work but there is no decision making authority or accountability around these management functions. Reference to individual Job descriptions and PHAMESA organigram. Paragraph modified to ensure clarity. |
| 65. This support is provided by each technical focal point who are also management focal points (provide management support). See email on CN. (page 45) | See comment 64. |
| 66. Phamesa is not providing adm and fin support to countries, this is the reason why it provides seeds funds for staff and office costs. (page 45) | We are referring to support to the regional programme not to country offices. |
| 67. For me it is clear that the management functions have been under the responsibility of the regional team (each manager responsible of planning, m&e, etc.), so not sure i understand what you mean by not clear. what I think is that the management functions have to be less diluted and clearly separated (m&e, planning, knowledge management, resource mob and partnership, etc.) (page 45) | See comment 64 |
| 68. As said above the level of delegation is too high, too much managers involve in the process, what seems to be needed is clear separation of management. (page 45) | It is not about the type of management function but about clear roles linked to decision making authority and accountability. For example, you can have different people working on planning or one person working on planning and monitoring – the importance is making sure that this role is clear and comes with authority and accountability to all those in the programme. |
| 69. For me it is not about delegation (management was done by the whole regional team, not by the general coord only), it is more about separating the management functions with clear roles and responsibilities. (page 45) | See comment 68 |
| 70. This is a good suggestion but this type of structure cannot involve countries in this type of structure since they are recipients and it will cause conflict of interests. (page 45) | We disagree. See comment 3 and 51. |
| 71. In July 2011 by IOM global and country office tried to address this issue by allowing all Phamesa staff in Pretoria and Nairobi to have have included in their title: 'regional health migration team'. (page 46) | This is new information which contradicts information provided by several informants. We would need the source of this information to include it in the report. |
| 72. To migration health, not Phamesa in particular (page 46) | We are referring to PHAMESA staff in particular. |
| 73. The evaluators should mention that this concerns (before the | PHAMESA might be effective in |

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| structural change) did not materialized as Phamesa has been effective quite successful in delivering results (as per these evaluation findings) (page 46) | reaching results but the evaluation is not in a position to assess whether PHAMESA would have been more effective or efficient if it were not managed by a country office. Such a statement would therefore be unsubstantiated. |
| 74. It is important to note that the circumstances did not allow for the recruitment of a chief of mission due to lack of resources until recently (2 months ago the position of CoM has been advertised). (page 46) | This is new information that has been included as a footnote on pg 15; Does not change the finding. |
| 75. There is confusion between RO and country offices, please review this section! (page 46) | Corrected. |
| 76. Please note that the restructuring has not really affected Phamesa. The only change is that the programme is now managed by 2 regional team based in Pretoria country office and Nairobi country office. The SA and EA regional offices have nothing to do with Phamesa management. (Erick) (page 46) | Noted. This is not what we observed so we prefer to leave this sentence as is. |
| 77. Confusion ! the fragmentation is between the regional programme/team (not regional office) and the country offices. Please review the content. (page 47) | Terminology corrected. |
| 78. "IDP" Please write in full as this is the first time this acronym is used. (page 48) | Written in full. |
| 79. Text needs to be aligned (page 50) | Text aligned. |
| 80. Resource allocation to countries has to be partial, hence the decision making of resources by the regional teams. however, it is clear from the findings that Phamesa could be more effective by involving more CoM at the development of CN or strategic planning stage. Personally, I dont think that the CN approach was bad, but it should not be a separate process, it should be linked to a more strategic vision developed and agreed by the regional team and CoM. Also, to motivate countries and increase accountability at country level, the funding (staff, office and operational) should be based on performance by countries. (page 51) | Noted. Does not change the finding. |
| 81. (already the case) ... 'should continue to be anchored (page 52) | The sentence says "should be anchored more closely" which implies it is already but could be strengthened. |
| 82. What i feel is missing in this section it the responsibility and commitment of the chief of missions (see above comment). (page 51) | The commitment of COMs will only happen if they are fully involved throughout the process which is what many of the evaluation findings are pointing to. |
| 83. The SMT is relevant but not with the countries as 1/ they are recipient of funds, 2/ it would be unmanageable to share the management function with all countries 3/ it would be unfair to | We disagree. See comments 3 and 52. |

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| include only 1 or 2 countries, 4/ at the end the financial accountability lies within the programme team not the countries. (page 51) | |
| 84. Regional teams, not regional offices (page 51) | Corrected. |
| | General comment added on pg 12 on quality assurance of evaluation process |