SRHR-HIV Knows No Borders Project

MIDTERM REVIEW REPORT

"Improving SRHR-HIV Outcomes for Migrants, Adolescents and Young People and Sex Workers in Migration-Affected Communities in Southern Africa - 2016 – 2020"

15 July 2019

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The team from the University of Witwatersrand-School of Public health (WSPH) led by Professor Latifat Ibisomi managed the MTR including overseeing quality regarding triangulation of qualitative data, analysis and drafting of the final report. The primary data collection of the MTR was managed by the research team from University of Stellenbosch Division of epidemiology under the leadership of Professor Peter Nyasulu for whom we extend gratitude. Ms Nonkululeko Ngcobo (IOM) coordinated the MTR process throughout all stages. We thank IOM and SC regional technical teams, in particular, Dr Francis Mulekya (IOM) and Mr Ntiyiso Shingwenyana (SCI) for their guidance, technical review and inputs to this the final draft report.

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AYP	Adolescents and Young People
CA	Change Agent
CMIS	Client Management Information System
CSE	Comprehensive Sexuality Education
DAC	Development Assistance Committee
DHMT	District Health Management Team
DoH	Department of Health
FGD	Focus Group Discussion
GBV	Gender Based Violence
HCF	Health Care Facility
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPRS	Health Patient Registration System
IDI	In-depth Interviews
IEC	Information Education and Communication
INERELA+	International network of religious leaders living with HIV
IOM	International Organization for Migration
IP	Implementing Partner
KII	Key Informant Interviews
MIDSA	Migration Dialogue for Southern Africa
MoH	Ministry of Health
NDP	National Development Plan
NGO	Non-Governmental Organisation
PEP	Post Exposure Prophylaxis for HIV
PrEP	Pre-Exposure Prophylaxis for HIV
RTC	Regional Technical Consultation
SADC	Southern African Development Community
SC	Save the Children, Netherlands
SDP	Service Delivery Point
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SW	Sex Worker
WSPH	University of the Witwatersrand's School of Public Health

EXECUTIVE SUMMARY

Rationale: The purpose of the Mid Term Review (MTR) was to review and evaluate the project approach, progress and results for the project to date against the agreed results framework indicators. The specific objectives of the MTR were: A) to assess the progress of the Sexual and Reproductive Health Rights-HIV project against the overall project objectives (processes, outputs and medium-term effects). B) To assess the effectiveness of strategies and approaches (including the gender and human rights-based approaches) used in the implementation of the SRHR-HIV Knows No Borders Project interventions. C)To assess the extent to which the project has made good use of it's human, financial and technical resources to pursue the achievement of the results defined in the project design document. D) To determine the level at which the project has involved project beneficiaries (cross border migrants, adolescents and young people and sex workers plus host communities). E) To assess the level of coordination, partnership and collaboration between the consortium, implementation partners and other stakeholders in the implementation of the project. F) To document successes, challenges and lessons learned in the project start-up, project implementation and consortium management systems of the project to date. G) To identify project comparative strengths, weaknesses/gaps and opportunities and how these are perceived by the stakeholders for the future of the project. H) To make recommendations for improvements and adjustments for the project going forward at the country and at the regional level.

Methods: This was a process evaluation that was largely qualitative in nature involving data collection through focus group discussions (FGD) and key informant interviews (KII) as well as secondary analysis of project data, information and reports from the six project implementing countries of Lesotho, Malawi, Kingdom of Eswatini, Mozambique, RSA and Zambia. Thematic content analysis was performed on qualitative data and data corroborated with the quantitative findings.

Key findings:

Relevance: Evidence suggests that the IOM and SCI have undertaken activities which build the technical and organisational capacity of their respective national implementing partners and change agents to achieve project set targets and desired outcomes. The project is a more mature consortium, with a clear goal and strategy that remains relevant to the SRHR and HIV needs of migrants, AYPs and sex workers within migration corridoes and in line with SADC and member states health priorities. Interviews with government health officials indicate that the project is aligned with the department of health strategies on SRHR and HIV across the six countries and it is supportive of the national strategies being implemented by Ministry/Department of health on educating the people about their SRHR. During the design of the project, different stakeholders such as health, education, home affairs, social development and gatekeepers were consulted.

Effectiveness: The project has achieved key milestones in increasing access to SRH and HIV services and information, with a total of 260437 beneficiaries reached in the last 3 years, which translates to 83% achievement. The systems are in place to deliver the stated outputs with only CSE lagging but catching up in some countries. Strategies such as the door-to-door, community dialogues, youth clubs and school CSE sessions delivered by the change agents have been proven to be effective. The project has involved project beneficiaries with migrants, sex worker and AYPs participating in the implementation of the activities at all levels. The implementing partners (IPs) have been effective in reaching beneficiaries at community levels and collaborated with local communities and structures to enhance referral and update of SRHR-HIV services.

Areas of possible collaboration between the IPs are still present, and there appears to be continuing value in taking an integrated programme approach. The project has managed to

establish solid relations and partnerships with community organisations as well as gatekeepers at community levels. The gatekeepers support the community dialogues and door to door activities held in their communities by mobilizing the community members and promoting participation. The roll out of Comprehensive Sexual Education (CSE) in most schools is ongoing but effective collaboration and partnership with education departments in schools where CSE is implemented will be critical for its successful implementation. Approaches for delivery of CSE in schools peer-to-peer, parent-to-child, child-to-parent and teacher-child should be improved and contextualised to the different country contexts.

Efficiency: The project effectively selected human personnel to run the project that has expertise and managerial skills in SRHR-HIV and migration programming at the regional and country levels. In terms of finance resources management, the project has been efficient and effective in utilizing its financial resources to achieve the set target outputs. Expenditures on the project were kept as close to the budget as possible. However, due to high operational costs in Malawi on the side of SCI, the project implementation is likely to wind up earlier than expected.

Coordination and collaboration: At the national level, the project collaborates with the Southern Africa Development Community (SADC) and regional civil society organizations such as the International Network of Religious Leaders living with HIV (INERELA+) to effectively engage member states and religious sectors on SRHR-HIV and migration related issues. At the country level, implementing partners work strongly through networks of national partners, national and district platforms made up of government departments and civil society coalitions. However, formal or informal external partnerships across countries and other programmes in the project sites have been more uneven calling and hence the need to be strengthened or formalised. Implementing partners should continue to strengthen partnerships including the media.

Successes and challenges: Several successes have been recorded and these include improvement in knowledge and increased coverage of SRH services among AYPs, migrants and sex workers as well as host community members. However, coverage within countries remains low, with member states requesting for expansion of the project to other major migration and transport corridors within the countries. The project has also been successful in ensuring that the recommendations made at regional and national dialogues were adopted and endorsed by the SADC ministerial meeting at the MIDSA meeting held on 28 June 2019 in Windhoek Namibia, an important milestone in enhancing an enabling environment for the realisation of migrant SRHR rights. Some of the challenges experienced during the implementation of the project include delayed project start due to institutional delays in signing of memoranda of understanding between partnering organisations, delay in execution of baseline survey, increased operational costs for retaining and attrition of change agents, which has been addressed by re-training and continual replacement with new CAs.

Conclusion: Over the last three years, there is evidence to show that the project has made substantial achievements regarding the envisioned outputs. It's also evident that project is on track to achieving the set targets by December 2020 as stipulated in the Project Results Framework. While most of the current strategic approaches are effective, the project should continually adapt new innovative approaches to ensure that successful achievement of the planned outcomes especially at beneficiary levels. Such approaches may include strengthening of integrated approaches with local structures and synergies with other service providers in the implementation sites, deliberate efforts to create more mobile clinics, and HIV/STI testing/treatment centers in cross-border communities in partnerships with the health department.

1.0 INTRODUCTION & CONTEXT

Within the Southern Africa region, populations in communities along migration corridors particularly adolescents and young people, migrants and sex workers and their clients are at risk for poor sexual and reproductive health and HIV outcomes. In response to this situation, the Kingdom of the Netherlands Ministry of Foreign Trade and Development Cooperation of the Netherlands, approved EURO 11.057 million support to IOM, from October 2016 to December 2020.

In 2016, IOM (lead agency), Save the Children Netherlands (SC) and the University of the Witwatersrand School of Public Health (WSPH) formed a consortium called the SRHR-HIV Knows No Borders consortium, to implement a regional project to improve access to quality sexual and reproductive health (SRH) and HIV services and related SRH health outcomes amongst migrants adolescents & young people (AYP), sex workers (SW) as well as non-migrant adolescents & young people, sex workers and other individuals living in migration-affected communities in Southern Africa. This collective effort is implemented in six countries in southern Africa region including Lesotho, Malawi, Mozambique, South Africa, Eswatini and Zambia, and targets migrants, adolescent and young people, sex workers, people living in migration-affected communities, with a primary focus on border communities with high levels of human mobility.

The project aims to contribute to greater freedom of choice for the target populations regarding their sexuality by focusing on the following result areas: (1) demand creation for SRHR-HIV services; (2) facilitating supply of and accessibility to responsive sexual and reproductive health and HIV services; and (3) creating an enabling environment to address the SRHR-HIV information and service needs of the target populations.

2.0 PURPOSE OF MID TERM REVIEW

The Purpose of the MTR was to review and evaluate the project approach, progress and results of the project to date against the agreed results framework indicators. In addition, the MTR provides insights into the project strengths, challenges, weaknesses and opportunities. The findings of the MTR will be used to make refinements and improvements to the project in remaining phase of the project.

2.1 Specific Objectives

The specific objectives of the MTR were:

I. To assess the progress of the SRHR-HIV project against the overall project objectives (processes, outputs and medium-term effects)
II. To assess the effectiveness of strategies and approaches (including the gender and human rights-based approaches) used in the implementation of the SRHR-HIV Knows No Borders Project's interventions/activities.
III. To assess the extent to which the project has made good use of its human, financial and technical resources to pursue the achievement of the results defined in the project design document.
IV. To determine the level at which the project has engaged project beneficiaries (migrants, adolescents and young people and sex workers plus host communities).
V. To assess the level of coordination, partnership and collaboration between the consortium, implementation partners and other stakeholders in the implementation of the project.
VI. To document successes, challenges and lessons learned in the project start-up, project implementation and consortium management systems of the project to date.
VII. To identify project comparative strengths, weaknesses/gaps and opportunities and how these are perceived by the stakeholders for the future of the project.
VIII. To make recommendations for improvements and adjustments for the project going forward at the country and at the regional level.

2.2 Scope of Evaluation

This was a process evaluation that applied qualitative methods of data collection coupled with a desk review of secondary data from relevant project information and reports. However, the methodology for the midterm review does not mirror the same for the baseline survey to allow for comparison of project outcome and impacts. Thus, actual progress towards outcomes/impact will be examined during the end of project evaluation and compared with the findings from the baseline survey.

2.3 Evaluation criteria

We adopted the Development Assistance Committee (DAC) criteria for evaluating programs with specific focus on relevance, efficiency and effectiveness of the various approaches utilised by the project.

3.0 METHODOLOGY

3.1 Design

This was a process evaluation that largely adopted qualitative techniques of data collection through focus group discussions (FGD) and key informant interviews (KII) coupled with secondary data analysis of project data, information and reports. Participants for the key informants and focus group discussions included stakeholders and individuals directly involved in the implementation of the project at the regional, national and community levels. See Table 1 for the details.

3.2 Sampling

The MTR used convenient and purposive sampling strategies to select and recruit participants for the key informant and focus group discussions. In each of the six countries, participants were accessed with support from the IOM and SCI country offices. Details of the number of FGDs and KIIs conducted are shown in Table 1.

TABLE 1: SAMPLING OF PARTICIPANTS FOR THE KIIS AND FGDS BY COUNTRY AND PROJECT SITE

RESPONDENT	**Data collection method**	**COUNTRY**						
		Lesotho	Malawi	Mozambique	South Africa	Kingdom of Eswatini	Zambia	Total
Change agents	FGDs	*2	*2	3	2	3	2	10
Implementing partners	KII	3	2	1	1	0	2	09
Other individuals supporting implementation	KII	1	1	3	1	4	6	16
IOM & SC country Reps	KII	1	0	2	2	3	3	11
SRH officers Government	KII	8	4	3	4	3	1	23
Regional Project Team	KII	2						2

* Key informant interviews with only 2 change agents in Lesotho and Malawi.

3.3 Data collection & analysis

Between February and June 2019, data collection was carried out by a team of evaluators from WSHP (desk review of project data & reports) and Stellenbosch University Division of Epidemiology (qualitative data) in all the six countries and at regional level. Qualitative data were collected using Key informant interviews and focus group discussions. One-on-one interviews were conducted in South Africa, Mozambique, Malawi and Zambia while telephonic interview was used for key informants in the Kingdom of Eswatini and Lesotho. All qualitative data were collected using local languages spoken in the project sites, English and Portuguese, transcribed verbatim and submitted to WSPH for final analysis,

synthesis and report writing. Thematic content analysis was used to analyse the qualitative data. Both quantitative and qualitative data were corroborated and triangulated at analysis and reporting.

3.4 Limitations

The following are the limitations and mitigation strategies experienced from the pre and post-fieldwork phase of the MTR:

- In Lesotho and Malawi, due to inadequate mobilization, only two change agents availed themselves for the interview hence the team conducted KII instead of the FGDs.
- Cyclone Idai and cyclone Kenneth hit Mozambique in the first week of commencement of the MTR field work. IOM/SC teams had to channel their human capital and resources for disaster relief in response to the emergency. This slowed down the progress of data collection in Mozambique and hence taking longer than the scheduled time.
- In some areas, data collection was conducted in English while participants would respond in a combination of English mixed with their local language. This posed a challenge in transcription. As such, translation of the languages from local to English and vice versa might have affected the precision of the information the participants wanted to filter through.
- The interruptions or peer telephone/internet connectivity during skype/telephonic interviews in two of the six countries might have limited the ability to capture adequate information from the participants.

4.0 FINDINGS

In this section, we present the findings from the mid-term review against the stated MTR objectives and provide an analysis of the findings.

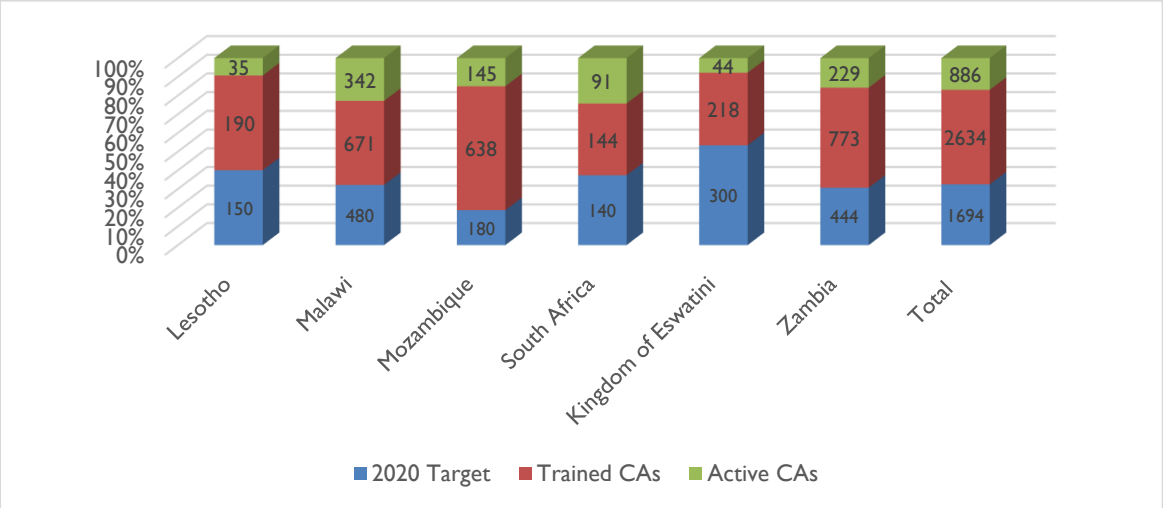
4.1 Progress of the project against the objectives

Objective 1: To assess the progress of the SRHR-HIV project against the overall project objectives (processes, outputs and medium-term effects)

Result Area 1: Increased demand for SRH-HIV service

Our analysis of the change agent database and country reports revealed that 2634 change agents compared to the target of 1694 were trained and capacitated to provide SRHR-HIV health education to the target beneficiaries, which translates to an overall 156% indicator coverage. As of December 2018, a total of 886 change agents were equipped and currently actively engaged in the project activities. A strategy to re-train change agents was adopted across the project sites to take into account of the annual attrition rate of about 24 percent and hence providing extra change agents to replace those that drop out or migrate out of the project implementing sites. Similarly, the change agents been able to reach at least 55% (171,951/31200) of the beneficiaries with SRHR-HIV information. The schools providing learners with comprehensive sexuality education (CSE) are 207 compare to the targeted 150. Figure 1 shows the number of change agents trained between 2016 and 2018 and who are active in the project in relation to the 2020 target.

FIGURE 1: CHANGE AGENTS TRAINED IN THE PROJECT IN RELATION TO 2020 PROJECT TARGET



Despite the above achievements, attrition of change changes was reported to be high in South Africa, Kingdom of Eswatini and Lesotho primarily due to b) failure of an attractive monthly stipend, b) trained change agents taking on more lucrative employment using the skills gain from the project and c) mobility which is integral to the life of the sex workers and migrants and d) ineffective management of change agents expectations by in some project sites. Its important to note that at the project design stage, it was assumed that change agents would work on a full-time voluntary basis, which has not been the case and as such monthly stipends were not factored in the budget. The improvised stipend is not commensurate with what the government policy recommended. In addition, attrition in Kingdom of Eswatini was attributed to inadequate monitoring and management of the CAs, a

finding that was mentioned by most of the CA FGD participants. One of the change agents interviewed had this to say;

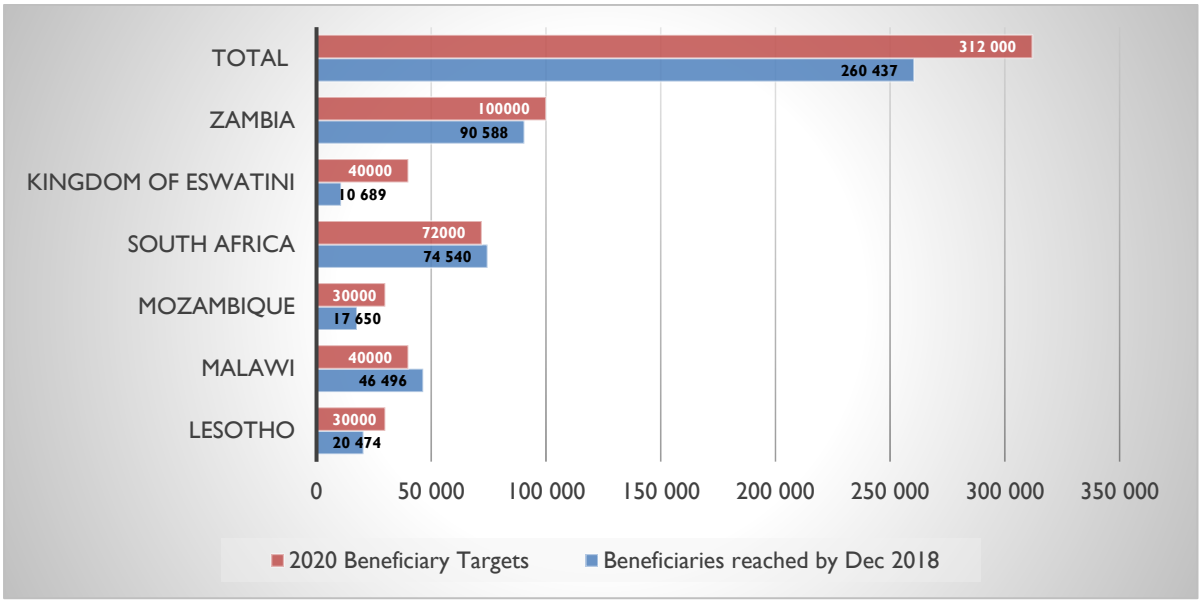
> "The officers responsible for managing us are selfish, self-centered and don't care about us. They don't live up to what they promise to provide us. It is like they do last minute budgeting and yet they don't provide us with the allowance they promise. (CA – Kingdom of Eswatini).

However, the project has addressed the above issue through effective engagement of the change agents by the project leadership during monitoring visits. In the future, the project plans to engage a local community organisation (NGO) to effectively manage the change agents on a day-day-basis. In other countries, such as Lesotho, Malawi, Mozambique, and Zambia, the CAs were satisfied with the current incentives and the way the project is managing their affairs.

Result Area 2: Increased access to and use of SRH-HIV services

Based on analysis of the project data, by December 2018, Change Agents had reached a total of 260437 beneficiaries with SRH and HIV services, which translated to approximately 83% achievement of the overall target. Malawi and South Africa has exceeded the set targets for 2020. Figure 2 shows the details.

FIGURE 2: NUMBER OF MIGRANTS, NON-MIGRANTS, AYP & SWS REACHED WITH SRHR-HIV SERVICES AS OF DECEMBER 2018 IN RELATION TO 2020 TARGETS.



During the last three years, the project has been able to capacitate over 851 individuals from service provider organizations (health and non-health) capacitated to deliver migration, AYP and SWs responsive SRHR-HIV services. These include gate keepers (traditional, religious and community leaders), immigration officials, police and local NGOs as well as government departments within the project countries. The main approach used is training and sensitisations as well as engagement in dialogues.

As result of the strengthened capacity of change agents, a steady improvement in the referrals over the years has been noted with a 97% (18930/19476) successful referral completion rate recorded as of December 2018. Some of the services received including HIV testing, STI screening, FP methods and medical care for common diseases identified during the door to door and peer-to-peer approaches by the trained change agents. This number

excluded those people that the project has been able to reach through outreaches and mobile clinics. However, stock outs of condoms and other SRH commodities were reported in some project sites across countries.

Result area 3: Creating an enabling environment

In regard to ensuring that Migrants, AYP and SWs SRH-HIV rights and needs are institutionalized at local, national and regional levels, the project has since established and supported over 100 community dialogue platforms. These seek to address barriers to SRHR-HIV among migrants, AYP and SWs. A total of 1818 of 2450 (planned target) local, national and regional level policy makers and gatekeepers have been sensitized about SRHR-HIV needs for migrants, AYP and SWs. Two trilateral inter-sectoral cross-border collaboration mechanisms have been established and are being co-convened by government departments. Also, national dialogues have been widely held across all the six countries. Issues and recommendation made at these fora have been escalated to the regional level with SADC member states for adoption.

In summary, with only 16 months left to end of the project cycle, the evaluation team believes that the project targets will be achieved by December 2020. For this to be achieved, more regional technical support from regional and effective planning by countries is needed for countries that seem lag behind.

4.2 Effectiveness of strategies

Objective 2: To assess the effectiveness of strategies and approaches (including the gender and human rights-based approaches) used in the implementation of the SRHR-HIV Knows No Borders Project's interventions/activities.

4.2.1 Door-to-door home visits

The implementation of the SRHR-HIV Knows No Border Project adopted several strategies to effectively reach the intended beneficiaries. One of the most effective strategy in reaching out to beneficiaries is the door-to-door health education approach. This entails visiting homes/households to provide household members with information on SRHR-HIV. It further provides an opportunity to create awareness around available SRHR services and the closest service delivery points where these services can be accessed and received. In Malawi, the change agents reported to having a weekly door-to-door home visit, where teams are given targets that they are expected to reach and if possible exceeded. Across the other countries, CAs mentioned the same strategy is being used to reach the target beneficiaries in their community.

> "Sex workers have been reached through visits to brothels, on the streets and through the door-to-door home visits for those who operate from their homes". (South Africa, CA)

4.2.2 Community Dialogues

Another strategy used to reach beneficiaries with SRHR and HIV information is community dialogues. Across all project countries, a regular cycle of dialogues has been established (weekly, monthly, every two or three months) in most countries through in which, migrants, AYPs, sex workers, community members, Change Agents and the implementing partners meet to discuss and reflect on SRHR and HIV issues that affect them, identify key demand creation topics and key messages to influence demand and supply of services as well as their rights to SRHR-HIV services. The dialogue sessions have helped the community

members to reach a common understanding and workable solutions towards barriers to access to SRH and HIV services. To address barriers to SRHR-HIV among migrants, AYP and SWs, a total of 108 community dialogue platforms has been established in all the project sites. The dialogues have provided an opportunity for the beneficiaries and community stakeholders to freely engage/participate and dialogue on SRH and HIV issues that affect the communities. However, participation of women in community dialogues in Lesotho was minimal due to gender related traditional and cultural norms.

> "Since most of the communities in Lesotho are still very traditional, having mixed participant sessions where both women and men are engaged has been difficult. Therefore, to address this, the change agents conduct discussions separately with women and men" (Key Informant, Lesotho)

In most countries, community dialogues have been used as an entry point for delivery of HIV and SRHR services through outreaches. During the dialogues, participants are provided with services such as HIV testing and condoms. For instance, In Zambia, CAs are stationed at different service delivery points where the information on SRHR, HIV testing, teenage pregnancy and early marriage are provided to beneficiaries. Our analysis shows that community dialogues is a cost-effective approach to reaching and identifying community problems in regard to SRH and HIV and providing timely and effective solutions. However, a more systematic approach to conducting the dialogues is required to maximise results. Adherence to the community dialogue guidelines by country teams and implementing partners is critical to ensuring a standardised approach to dialogue, while taking into consideration the different country contexts. Where possible, dialogues should be stratified by age and sex and must be culturally sensitive. The door-to-door approach can be used as channel of mobilising household members to participate in the dialogues.

4.2.3 Comprehensive Sexuality Education (CSE)

In most project sites, implementation of CSE started in late 2017 while in South Africa, CSE was rolled out in 2018. CSE is implemented mainly in primary schools with the aim of reaching young adolescents with age-appropriate messages. The focus is on sexuality rights, pregnancy prevention and HIV prevention as well as the human anatomy and physiology. Project data revealed that 80% of the schools (n=207) supported under this project provided learners with CSE. CSE has helped reach many adolescents within a short time and this has proved to be cost-effective. Youth led initiatives such as Learners clubs, Health clubs, Soul Buddies Club and Youth Clubs have been established in most schools. The roll out of CSE has been possible through the support from educators (teachers) who had been trained to deliver CSE lessons by the Implementing Partners using the project tailored CSE module and existing national CSE curricula within countries.

Most schools within the project sites provide CSE lessons to AYPs 10-14 years with very few schools in Mozambique and Eswatini. Implementing partners opined that teachers are able to organise open days for the schools where they showcase different interventions and what they are doing in that school with regards to SRHR. In Malawi, there is an improvement in the delivery of sexual education in both schools and out of schools through the health education sections which the change agents are doing and the teachers that have been trained in SRH skills. Some schools in Mozambique developed health corners to offer CSE where learners come and access SRH information.

In the Kingdom of Eswatini, change agents indicated that CSE in schools was being delivered by trained teachers. CAs only interacted with in-school children (learners) in the community based adolescent dialogues that are conducted during weekends. In Zambia, change agents offered CSE sessions in schools under the guidance and in collaboration with the teachers and school administration. Teachers and CAs indicated that CSE has led to

positive behaviour changes among the AYPs about life skills. However, learners felt that they would prefer to receive CSE lessons from their fellow peers or nurses, implying the need to train more learners as peer CSE trainers/facilitators.

4.2.4 Cross border coordination mechanism

Since its inception, the project has established two trilateral cross border coordination mechanisms as follows: Malawi-Mozambique-Zambia, South Africa-Kingdom of Eswatini-Mozambique. These mechanisms are multisectoral and intersectoral in nature bringing together Government and relevant stakeholders involved in the SRH and HIV response and migration to discuss issues of common interest linked to cross border human mobility and health. Participants include delegates from key provincial and district government departments and Civil Society Organizations (CSO) from the participating countries. These forums have Plans of Action with key considerations for strengthening cross-border coordination based on identified challenges and needs. Also, Terms of Reference and standard operating procedures were developed and endorsed by the stakeholders for subsequent adoption by the governments/participating member states.

4.2.5 Project Advocacy strategy

Guided by the project advocacy and communication strategy (2017), the project conducts both upstream and downstream advocacy to promote migrant-AYP-SW inclusive policies and interventions by engaging community, national and regional level policy makers and influencers through the human rights lens. The key message is to ensure that international migrants have access to equal and affordable services as the nationals. At the regional level, regional technical consultation that brought together senior government officials, including representatives from the UN agencies and CSOs were successfully held in 2017 and 2018. These annual regional events provide a regional approach and platform for the SADC countries and key stakeholders to engage on SRHR and HIV challenges for migrants, sex workers and AYPs in migration affected communities and cross-border areas.

Additionally, the event offers an opportunity to create awareness on migration and health (SRHR/HIV). Recommendations from the regional technical consultations (RTC) were adopted at the SADC ministerial meeting during the MIDSA held on 28 June 2019 in Windhoek, Namibia. During the last RTC, countries developed advocacy action plans to address identified gaps and challenges related to SRHR and HIV among migrants, sex workers and young people.

4.3 Efficiency - Use of human, financial and technical resources

Objective 3: To assess the extent to which the project has made good use of its human, financial and technical resources to pursue the achievement of the results defined in the project design document.

Overall, the project has sought to demonstrate value for money, with institutionalised procurement policies and procedures, and clear demonstrations of cost saving efficiencies that have been achieved within regional and country level programming and activities. The project is delivered by a highly skilled and competent team at regional and country levels, with the right mix of both technical and managerial skillsets. The project support staff (enablers) are adequate and staff costs are shared across other projects managed by the institutions. However, staffing gaps exist at regional level (IOM and SC), where the project is

technically managed by one project manager as opposed to the original project structure of having two technical officers, a gap that needs to be addressed in the future.

At country level, some of the project officers were engaged in more than one project and this could impact their overall performance on the SRHR project. In the future, we recommend a minimum of two technical staff to be fully dedicated to the project as planned. In terms of resources management, the project is managed and overseen by the Regional Project Management Unit (PMU) which provides strategic leadership and manager oversight to the project. During the project annual review and planning meetings, all the six countries develop annual budgets and work plans for each year which are then consolidated at the regional level. The country budgets are decentralized and managed by the IOM and SC country offices with technical backstopping by the IOM and SCI regional officers. Strict measures have been put in place to manage the finances of the project. Table 2 provides a snapshot of the project budget and expenditure to date.

The PMU has been very active and held regular meetings to review project performance based on country reports and lessons from the field. The PMU provides regular feedback on project performance to the country project teams for action.

TABLE 2: ANALYSIS OF PROJECT BUDGET AND EXPENDITURE AS OF DECEMBER 2018 (AUDITED)

Management site	Budgeted amount for 2016-2018 (EUROS)	Overall expenses for 2016-2018	**Variance**	**% variance**
Regional				
RO IOM	832817	548 197	284 620	34%
RO SC	877203	774 021	103 182	12%
WITS	159021	170 111	-11 090	-7%
Country level				
Lesotho	341121	245 479	95 642	28%
Malawi	510502	533 438	-22 936	-4%
Mozambique	938496	894 792	43 704	5%
South Africa	865126	785 766	79 360	9%
Kingdom of Eswatini	616558	554 277	62 281	10%
Zambia	778341	771 785	6 556	1%
	5 919 185	**5 277866**	**641 319**	**11%**

Findings from Table 2 show that the project is efficient and effective in utilizing its financial resources to achieve the set target outputs. Expenditures on the project were kept as close to the budget as possible. In view of the project committed funds that are not reflected in the figures above, the observed variance of 11% from the planned budget is within an acceptable range. Given that the project is still rolling till Dec 2020, the likelihood of overspending is unlikely given the robust financial controls and effective budget monitoring tools in place. Most of the funding is devoted to strengthening capacity of the implementing partners and change agents to ensure successful implementation of project activities. The project has also continued to adapt to the changing environment and as such some of the

funding were used to support project related activities at the request of governments and communities. However, due to high project running costs, Save the Children Malawi is likely to wind up project implementation in Mwanza and Mchinji in December 2019.

4.4 Involvement of Project beneficiaries

Objective 4: To determine the level at which the project has engaged project beneficiaries (migrants, adolescents and young people and sex workers plus host communities).

Beneficiary involvement and participation are critical for project ownership and sustainability. Findings from the interviews with project staff and partners, reveal that beneficiary involvement has been central to the project strategy. The project is anchored on the change agents who are peer members of the migrants, AYPs and SW, selected within and by the community members themselves based on agreed criteria. The beneficiaries (adolescents, young people, migrants and sex workers) have been involved in the project in all the six countries. The implementing partners (IPs) have collaborated with local communities and structures to educate the community on SRHR-HIV services. Our analysis also confirms that countries that have more change agents had greater coverage of beneficiaries. Also, sex workers are responding positively to the SRH services when they are being educated by their workmates. The project has encouraged participation of the beneficiaries and gate keepers (cultural and religious leaders) in planning and implementation of the project at all levels.

> "As I indicated previously, it is a peer to peer. We train the migrants as the change agents. So, when they do the door to door visits, they are doing the visits to their fellow migrants. We also involve them when we are having engagements with the authorities i.e. the police, immigration and health authorities. This is done so that their issues can be heard. They also refer their fellow migrants to health facilities, if their rights are being violated among their groups they report whoever is responsible. This is also applicable to sex workers. (South Africa-IP)"

It was evident from the review that some of the change agents, AYPs, sex workers and migrants championed advocacy efforts through participation in regional, cross border and national events. These forums ensured that their voices and demands are heard and taken into consideration in policy reviews and programs at the country level. The project has helped to organise the beneficiaries into groups – such as clubs, village saving groups and hubs which have acted as an entry point for ART treatment adherence among those infected with HIV, enhanced unity among sex workers and initiation of income generating activities.

As evidenced by the discussions held with CAs and IPs across the six countries, involvement of migrants and sex workers in the project has shown a great impact to their peers as well as the community.

> "…….. At the moment, as sex workers, we have nothing to complain about as we have mobile clinics coming to the workplace (referring to brothels). We also have condoms delivered to us at the brothels. So overall, we are happy with the services that we are getting. (South Africa-CA)"

> "…… Sex workers were trained and they are also distributing information to several sex workers; they also distribute condoms and demonstrate how to use condoms to fellow sex workers. (Zambia-IP)"

> "With the sex workers, once they come out, they are free to voice out the services they need once given the; platform especially when it's only us the

> CAs, not community members. They have been instrumental in showing us where to find the others. (Kingdom of Eswatini-CA)"
>
> "The roles of sex worker change agents are to sensitize clients talk about HIV, talk about condom use, and talk about how to prevent themselves from undesirable pregnancy, diseases (Mozambique-CA)"

AYPs, Migrants and Sex workers are greatly being involved in the project and are playing critical roles in sharing knowledge about SRHR-HIV in their communities and peers. For example, in Mozambique, the sex workers group played a key role in building a community school in the mining area of Mussenguereze in Tete province. The adolescent and young girls were no longer attending schools due to their involvement in sex work and the Change Agents-Sex workers mobilized parents, guardians and community leaders to educate them about SRHR and ensure the children regularly attended school. This helped the young children to acquire knowledge, life skills and learned how to choose healthy lifestyles as an empowering, safer and healthier alternative to sex work.

In the Kingdom of Eswatini, AYPs, Sex workers were amongst the represented groups which were able to flag issues of concern and suggest solutions to those issues affecting their lives at national and provincial events. In Malawi, the project, in collaboration with European Commission, trained youths as Youth SRH advocates with the aim to build their skills on how to package targeted messages for various audiences including Area Development Committees, District Councils to advocate for SRHR issues that affect adolescents in Malawi. The trained youth participated in the National Youth conference on SRHR-HIV organized by the Ministry of Youth, National Youth Council with support from the National AIDS Commission. Within South Africa, six forums were established. These are composed of project target beneficiaries (AYP, migrants and sex workers) and have provided the platform to advocate for the rights and needs of their peers.

In addition, adolescents and young people in Lesotho have been fully involved in the project and during the dialogue process; the AYPs raised the issue for lack of safe spaces for them to access SRH-HIV services. They regarded health facilities as not youth friendly as they queue for services with older people and that discouraged them to go for services. The project managed to advocate for HIV testing services being integrated into organized sessions with AYP. A safe user-friendly environment was created for AYPs to access HIV testing. Dialogues with migrants and other reproductive age individuals indicated that there is insufficient information on SRHR services, particularly Family planning, realities about STIs and understanding of other HIV services.

4.5 Partnership and collaboration

Objective 5: To assess the level of coordination, partnership and collaboration between the consortium, implementation partners and other stakeholders in the implementation of the project.

The partnership approach adopted by the project includes engagement of various stakeholders at the local, national and regional levels involving a multi-sectoral approach in which government and the civil society are involved. With this in mind, a horizontal approach of the partnership was adopted based on the premise of partners working together towards the mutually beneficial cause, shared responsibility, continuous dialogue, capacity building and technical cooperation. For example, according to the 2018 annual report for Mozambique, Save the Children, government representatives from Zambia (16 government officials) and Mozambique (25 government officials) and Civil Society Organizations conducted a collaborative cross border coordination meeting between Zambia and Mozambique in the third quarter of 2018. In addition to this horizontal partnership approach,

a regional consultative process was also considered as an additional layer integral in successful managing migration governance.

The project has held regional consultations including the Consultative Regional Technical Round Table Conference in South Africa in November 2018. These regional events involved key Ministries from the six countries (Lesotho, Kingdom of Eswatini, Malawi, Mozambique, South Africa and Zambia) to review regional SRHR-HIV issues, exchange lessons learned and best practices, and develop country plans to deal with emerging identified barriers to achieving SRHR sensitive service provision and access by migrants, AYP and SWs (Project Annual Report 2018). The above is an indication of the level of partnership and collaboration that exists at regional and country levels as reported by data collected from the field. The department/ministry of health plays a key role in the project through the establishment of accessible health facilities close to the affected community as well as the provision of condoms, contraceptive pills and HIV testing centers. In Lesotho, border clinics have been established and those that were in existence have managed to offer more friendly services to AYPs, SW and migrants.

> "We have the border clinic called the Wellness center. It offers HIV services such as contraceptives, PREP and PEP to key populations including migrants and sex workers. Since SRHR project inception, we have strengthened the Wellness Center at the border to through referral and linkage of clients for HIV services made by the change agents. Also, the client's rights are being respected in which they are able to access services at their convenience according to the demands of their jobs. We also have a filter clinic which receives referrals from the border clinic (wellness center) (Lesotho-DHMT)"

Data revealed that the Ministry of health in Lesotho are mandated to oversee health issues in the country, hence, IOM officials coordinate with the ministry on all the SRH services or activities conducted in the community. This collaboration among IOM and MoH exists between the clinics at the borders from national to district level health facilities and service delivery points. IOM indicated that the ministry of health invites stakeholders on their behalf while they are responsible for drafting the agenda that covers SRH issues for discussion during the meeting.

In South Africa, there is an existing partnership with the department of health. The department acts as a gatekeeper to ensure that project objectives are met as agreed and approved with stakeholders. The department has also fostered relationships with Save the children and stakeholders; there are existing working groups made up of representation from all key stakeholders. The department supports with the selection of CAs and on a continuous basis support programmes implemented by the different organisations.

> "First and foremost, I am a gatekeeper. I basically make sure that the promises that have been made are fulfilled in the sense that the program does what it set out to do. When they came (referring to the\SRHR project team), I had to introduce them to all the stakeholders. I had to run sessions at various venues in Ekurhuleni and in government including the DOH provincial just to introduce Save the Children. Ekurhuleni and Save the children have a partnership that works in the sense that whatever they do I am part of. When they recruited the change agents I was there as part of the interviewing panel. I organised the venues for us to have the interviews. We support each other in most project activities. When they have campaigns, the SRHR project team lets me know so that I can assist where possible. So, our partnership with the project is strong. (South Africa-DoH)"

The project annual report for 2017 further shed light on partnerships by forming a Project Management Unit (PMU) that takes on a horizontal approach of governance and comprises of IOM, Save the Children and Wits School of Public Health, with each having designated roles. The PMU provides an opportunity to discuss progress updates across the consortium. Furthermore, the PMU forum facilitates the coordination, collaboration and communication at the regional level ensuring that issues at both regional and country level are collectively addressed and managed. At the national level, the project coordination is led by IOM who work closely with SCI teams and local partner NGOs to ensure delivery of SRH and HIV services and engage various relevant government institutions project as a way of bringing them on board to gain support and buy-in.

Findings from the KIIs indicates that IOM regional office in South Africa managed to establish inter-sectorial collaborations with Police, Home Affairs, Health, Education, Social development, traditional and religious leaders. Aim of the inter-sectoral collaboration is to improve social cohesion and enhance peaceful co-existence of the migrant population and reduce stigmatization and xenophobic tendencies when conducting the SRH activities in communities. The collaboration is effective, and IOM ensures that there is bilateral and tripartite involvement of multi-stakeholders in the delivery of the project goals so that target beneficiaries access the services the project was designed for.

For instance, Mozambique, Eswatini and Zambia collaborate with high-level stakeholders at the provincial health department, education and migration. In the health department, the SRH project is well integrated with the existing health structures across the three countries. The evidence from the interviews with key informants from the health departments indicates that the SRHR project has managed to build a strong collaboration with local clinics so that it improves the outcomes of the project. However, there is still opportunity to strengthen collaboration with countries MOH.

> "…….. Practically this has been the follow-up that we have been doing because afterwards we are obliged to present, at the cooperation meetings with the partners at the government level, at district level; practically we must give our point of view. So, it is more in this sense, to analyze, to do the supervision, to do the monitoring, and ultimately to give some guidelines. (Mozambique-Provincial department of health)"

> "We represent the government in coordinating SRH projects which should include this one as it touches on SRH. (Kingdom of Eswatini-SRHU)"

During project implementation, at the grassroots level, both IOM & SCI have worked closely with local implementing partners who have experience in working with communities and engaging with beneficiaries at the community level. Capacity building was undertaken at individual and institutional levels to provide relevant skills to partners in implementing the project. The project has built the capacity of these partners to deliver migration responsive services to AYPs, migrants and SWs in the different district sites through the change agents. CAs acts as facilitators of the project by going door to door and educating the community. Intended beneficiaries have been mentored and a rigorous effort made to educate them on SRHR- HIV issues and how to get necessary assistance and services which has resulted in a heightened level of awareness amongst them. In Malawi, the KII with IP indicates that IOM collaborated with an organisation called Evangelical Rosary and Development Services (ERDS) to be implementing partners for this project. ERDS is a religious organisation that caters for religious people that are affected or living with HIV. The aim of collaborating with this organisation is because in Malawi there are several religious beliefs that discourage people from taking contraceptives or even stops taking ARVs.

At the sub-national level, the project has managed to train several professional health workers mainly nurses on SRHR-HIV services offered to AYPs, migrants and sex workers. Other than the department of health, the project has partnered with the department of

education through the provision of comprehensive sexual education. Teachers have been trained on how to administer CSE to learners in a more effective way. A total of 62 schools across the six countries are now offering CSE since the inception of the project.

Community leaders and religious leaders also play a pivotal role in this project and have been incorporated as gatekeepers. The major role played by the gatekeepers is to mobilize the community and give the project implementers the platform to educate the community on SRHR and HIV. The gatekeepers have welcomed the project into their communities and they do conduct regular update meeting with change agents to assess the progress of the project.

Working closely with the IPs, technical capacity (training and mentorships) of health service providers have been strengthened to improve implement ability capacity in providing migrant, AYP and SW responsive services. Similarly, the capacity of non-health service providers including the private sector has further developed to ensure a functioning community referral system for health and support services to migrants, AYPs and SWs. There is an existing cross border health tripartite committee among the Kingdom of Eswatini, Mozambique and South Africa. The tripartite committee exists to develop and harmonize a referral tool to facilitate referral and linkages to care between the three countries.

Data Management & Reporting systems

The evidence from the qualitative interviews showed that the project monitoring and reporting systems are effective in timely management of the project data and reports. The lines of communication from the community level to the regional level are well articulated and followed by all the stakeholders involved in this project. At country level reporting, IOM and SC officials indicated that they had all the necessary tools to capture information/data generated from the project activities especially the change agents. These tools included the door-to-door tool, referral logs and attendance registers for community-based events/activities.

The flow of data/information is clearly understood by the change agents and the project staff. However, recent data quality assessments revealed the need to reduce or merge the door-to-door with the referral log tool to avoid duplication and reduce CA work load. All data and reports generated at the field level are consolidated at the country level by SC and IOM into one country report that is submitted to regional office on a quarterly basis. Division of labour in reporting among SC and IOM project teams was clearly articulated and deemed fit for purpose. Some countries need to upgrade their database to electronic system to ease data consolidation and reporting.

4.6 Project successes, challenges and lessons learned

Objective 6: To document successes, challenges and lessons learned in the project start-up, project implementation and consortium management systems of the project to date.

The project has had numerous successes, challenges and lessons learned from its inception period, implementation and management to date which is presented below:

4.6.1 Successes

- Improved knowledge on SRHR-HIV to AYPs, migrants and sex workers
- The number of AYPs who know their status has increased
- More testing centers and mobile clinics have been established at the border areas, for example, the adolescent health clinics and men clinics as well as health corners in schools.

- Improved uptake of SRH services for AYPs, migrants and sex worker.
- The project has resulted in employment for AYPs and migrants.
- Community leaders support the project and during their community gatherings, they invite change agents to come and address the community members on the importance of SRHR-HIV and migrants rights.
- Tripartite meetings conducted among the six-member countries resulted in agreeing to the development of referral forms that are used at health clinics by migrants.
- Training offered to health care providers has improved the services offered to adolescents, migrants and sex workers.
- Teen clubs are being conducted during weekends and present are clinic staff who provide the adolescents with PEP and contraceptives.
- The project has reached a lot of people that did not have information on SRH because most of the information they gathered was when they visited the health facilities but with the work of Cas, they are able to reach them at their communities and educate them.
- Awareness campaigns are also being conducted in Trains because the train is a mode of transport used by many people. This approach has proved an effective method to educate the beneficiaries about SRHR and HIV.
- Adolescent being educated about SRH by their peers has been reported to be a success because the participants managed to interact with the CAs compared to when they are taught by someone older.
- It has been reported that adolescent pregnancies have begun to decrease around the communities where the SRH services are being implemented across the six countries.
- Through engagement of the civil society and religious sectors, the International Network of Religious Leaders living with, or personally affected by HIV (INERELA+) made a declaration on “No Child Marriage” during the regional dialogue for religious and traditional leaders convened by the project in June 2018 in Johannesburg.

4.6.2 Challenges

- The project took a long time to kick start due to delays in the recruitment of implementing partners as well as drawing up the memorandum of understanding between partnering organisations.
- Attrition is high at community level among the change agents such that the project continues to train new CAs. This slows the project progress in achieving target objectives of reaching beneficiaries as well as the expenditure for recruitment and training increases.
- Change agents getting paid a low stipend and this made them look for other paying job opportunities.
- There as some difficulties engaging with Government departments because of the high level of bureaucracy and decision to support the project in other departments is still undergoing.
- Social and cultural sensitivities around sexual and reproductive health still exist in some communities such as Zambia and Malawi. Change agents find it difficult to talk about sexual issues with adolescents as their parents do not allow them to do so.
- Commodity stock outs such as contraceptives, condoms etc., at the youth corners and brothels where sex workers operate.
- Delays in the payment of change agent’s stipends resulted in some activities being postponed and others change agents not reporting for duty, specifically in South Africa.
- Human capital constraints due to understaffing or project staff. This calls for the need to improve staff capacity to improve project implementation and delivery of interventions.

- Differing government policies on SRHR-HIV among the participating countries.
- Negative migrant sentiment/xenophobic tendencies are still prevalent in some areas as migrants are seen to overburden health systems especially in South Africa. The lack of proper documents among migrants hinders their access to health services.
- The mobility aspect of migrants is a challenge in terms of being hard to reach and track by service providers as they might move without notice to other areas or even cross borders. This can be very typical of migrant sex workers.

4.6.3 Lessons Learned

- The evaluation team learned that for acceptance and support for project acceptance by the community, Change Agents recruited should be residents of community in which they operate, and this resulted in the project being welcomed by stakeholders (chiefs, ward councilors, religious leaders and teachers) and supporting the SRHR activities.
- The project has engaged community leaders as advocacy champions for the projects to promote corporation of community members, hence, in Zambia, the project forms part of the Kawaza Chiefdom Strategic Plan for the promotion of SRHR activities under the leadership of the Chieftainess Kawaza, this best practice is being rolled out in other constituencies within Zambia and in other countries.
- The project team understood the risk of attrition of Change Agents was because of a) empowerment to take up other more lucrative forms of employment using skills gained from program delivery, b) mobile populations changing places of regular residence and c) out of more regular forms of occupation such as return to formal schooling or learning. In recognition of the risk in all countries, more Change Agents were trained beyond the allocated target for the country.
- During the start-up phase of the project, government officials took long time to accept the project and this delayed the implementation processes. For effective coordination and collaboration with government officials, it is required that project activities are included in their operational plans so that it forms part of their planning and schedules. To this end, the Project Team participates in country technical working groups and assists countries to conduct National Dialogues which inform country planning and country participation in Regional Advocacy engagements.
- A best practice by the SRHR project has been to conduct regular consultation meetings with countries implementing the project as well as the consortium to ensure regular updates on the status and progress with project activities. This provides an opportunity to timely address and resolves any emerging issues or challenges. There is effective monitoring of the project activities for example, IP supervise the activities conducted by change agents and during their supervision they compare the reports submitted with the actual work done on the ground.
- Over and above the highlighted engagements, the Project has conducted two successful Regional Technical Consultations that informed various recommendations that have been endorsed by the 16 SADC countries during the last MIDSA.

4.7 PROJECT STRENGTHS, WEAKNESSES AND OPPORTUNITIES

Objective 7: To identify project comparative strengths, weaknesses/gaps and opportunities and how these are perceived by the stakeholders for the future of the project.

4.7.1 Strengths

Evidence from the various country activity reports and field interviews shows that the respective project member states of SADC are working together to successfully attain the objectives of SRHR-HIV project. Cross-border coordination has been formed between the member countries. Tripartite cross-border forums such as those held between Zambia, Mozambique and Malawi, and between South Africa, Kingdom of Eswatini and Mozambique create an interactive action planning, result based platform of engagement amongst participating governments. Partnerships, networks and multi-country cross-border and inter-sectoral cooperation and collaboration on migrant health have been enhanced by this project within the SADC countries. This partnership has strengthened relations between the member states. Findings revealed that IOM regional visit in Lesotho aimed at enhancing shared learning and strengthening the day-to-day collaboration of the SRHR-HIV project with external partners and managed to track the implementation progress made both at national and community level. The partners included National AIDS Commission (NAC), UNESCO, Ministry of Health (MoH), Ministry of Education (MoE), Police service, WHO, UNAIDs and UNICEF as well as Ministry of Local Government. The meeting with the stakeholders in Lesotho helped to strengthen the relationship with IOM and Lesotho.

The regional office conducts regular site visits to partner countries to provide technical support, when needed, as part of their routine monitoring and supervision process. During these visits, stories of change and shared learning among other countries have been enhanced and hence enabling the country teams to correct any challenges/problems faced during project implementation.

National level dialogues with senior government officials and gatekeepers (tradition, cultural and religious leaders) on migration and SRHR have been conducted in the six countries where the project is being implemented and the acceptance of the project by communities has been successful. In the Kingdom of Eswatini, an SRH technical team was recommended and the team is being commissioned by the MoH SRH unit to spearhead the process of developing a comprehensive action plan. The meeting also recommended the inclusion of high-level policymakers and influencers from the government ministry. On the other hand, a dialogue with gatekeepers (traditional leaders) was successful and they agreed to support the project and they requested for quarterly update meetings to be conducted to assess the progress and assist when the need is required. With ongoing changes in political leadership at the national level in many SADC states such recent elections in Lesotho, Eswatini and Malawi, calls for the need for engagement of parliamentarians is vital to achieving the desired advocacy outcomes of an enabling environment for the realization of SRH rights of migrants, AYP and SW.

The use of change agents who are recruited from the community in which the project is being implemented brings unity, corporation and support as the community perceives this as employment creation in their community. The involvement of project beneficiaries as CAs has fostered co-existence and social cohesion among migrants and host communities and hence reducing on xenophobic tendencies that have been found to be common among international migrants in the southern region. Also, the use of implementing partners that work around the community enabled the community members to welcome the

ideas/information from their own people as they understand the dynamics of the community and its people.

The beneficiaries such as AYPs, migrants and sex workers are engaged to implement the SRHR-HIV health promotion to communities and its peers. Sex workers are more open to their colleagues because they are not judged and share the problems and solutions on how to solve them. Also, the involvement of migrants to educate the affected communities eliminates language barriers as migrants conduct the dialogues and door to door in languages understandable to beneficiaries

4.7.2 Weaknesses

Behind the success story, some weaknesses exist during the implementation of the project. Among these are:

- High attrition rates among change agents especially in some of the project sites in South Africa, Lesotho and Kingdom of Eswatini that resulted in continuous training or providing orientation to new change agents. This to some extent slowed down implementation activities.
- While the project has deliberate strategies to reach all populations, the review reveals that most activities about SRH/HIV benefitted more Adolescents and young people than migrants and sex workers. Reaching out to the same migrants and sex workers is not easy because of high mobility nature of migrants & sex worker and their failure to disclose their personal information to the public and project. This allows for admission of new entrants to the project during implementation cycle.
- Sex workers are classified as hard to reach population and are a group of people that are highly stigmatized in the communities.
- Infrastructure such as suitable buildings to use is a challenge at some border communities as some are still classified as rural communities. The project should consider motivating staff working within the existing wellness centers, build structures, and partner with other organisations providing health services for adolescents and sex worker. These structures improve access to services by the AYPs and sex workers and reduce the stigma and fear of being seen at service delivery points within their communities.
- One of the weaknesses of the project is the inability to effectively address the non-behavioural and structural factors such as poverty that are a major cause of vulnerability to HIV infection and SRH problems among the target beneficiaries. If the gains of the project are to be sustained, future interventions should also integrate the issue of livelihoods and vocational skills for the target beneficiaries.

4.7.3 Opportunities

The project has unravelled different opportunities that could be explored to improve coverage and sustainability of the project interventions.

- Even though efforts on building capacity of partners in country have been ongoing, there is still much scope – and much need – for improvement. The focus should be on use of an integrated development approach to address both the drivers of the RH and HIV infections along with the ongoing SRHR service delivery approach. Another important area to focus on would be strengthening data management to improve reliability and use at all levels of the project implementation.

- The project has an opportunity to be introduced and supported by other SADC countries within the framework for Migration Dialogue for Southern Africa (MIDSA). The project will enhance the development of regional institutional capacities from experiences gained during the implementation as well as to improve migration governance. The project could strengthen the capacity of governments to meet their migration challenges in a comprehensive, interactive, self-reliant and ultimately, sustainable way.
- The lack of adequate infrastructure and inadequate functioning of service delivery structures that exist at cross border points presents the project with an opportunity to support governments in Infrastructure development in the form of adolescent health corners, men clinic, mobile clinics, and testing centers in migration affected communities, in collaboration with the ministry of health and the road and transport sector.
- The project intends to reduce the risks and vulnerabilities migrants face at different stages of migration by respecting, protecting and fulfilling their human rights and providing them with care and assistance. The current global commitments under the Global Action Plan for migrants and refugees (GAP) and the 2017 World Health Assembly (WHA) resolution on healthy migrants and refugees provides an opportunity for further development of effective programs that target migrants and refugees. and to ensure full integration of migrants and migration health in regional, national and sub-national policies and programmes.
- Despite existing SRHR policies in region and implementing countries that do not focus specifically on the peculiar needs of migrants, there are past and ongoing programmes/interventions aimed at improving SRHR. While migrants are recognised in global instruments as key populations, most country policies do not have specific mention of migrants or interventions that target them. Only a few programs focus on cross border populations. There is a need for further engagement and support to ensure full integration of SRHR and migration into the emerging policies and programs.
- The presence of a regional platform of religious and civil society actors in such as the INERELA+ presents the project with an opportunity for further engagement on issues around SRHR – especially sex work, abortion, child marriage and sexuality. The religious sector remains one of the stakeholders that to be actively engaged under the multi-sectoral approaches enshrined in most national strategic health plans of the implementing countries.

4.7.4 Crosscutting issues

Some of the crosscutting issues that were examined during the MTR include the extent to which the project has applied the gender, human rights and integrated development approached during implementation.

Our analysis from the field interviews with stakeholders reveal that the project has, integrated gender and human rights-based approaches within its programs. At service level, the project conducts capacity building for duty bearers to be sensitized on rights of beneficiaries and follow a rights-based approach to service provision. Migration affected communities are educated about rights to access to quality healthcare as a foundation for achieving universal health coverage. All trainings and awareness activities cover topics on gender and human rights. Both men and women are involved in the project activities – community dialogues, provision of SRH information, and national and regional level activities based on the roles and

positions they play in the community. Both girls and boys have also beneficiaries from the project equally.

As an unintended outcome of the project, the formation of groups among beneficiaries– such as sex worker associations and youth clubs - has enabled the beneficiaries to engage in income generating activities and community development programmes. The SRH-HIV have been incorporated in strategic plans in countries such as Malawi, Zambia and Lesotho. For instance, the Kawaza Chiefdom in Zambia has integrated HIV and SRH in its strategic plan. The SRHR and HIV services are delivered through mobile clinic and community outreaches in partnership with the government health departments and public health facilities.

5 CONCLUSION & RECOMMENDATIONS

5.1 Conclusion

The review reveals that the SRHR Knows No Borders project is on track in terms of achieving the planned project outputs across the six countries. Th project has systems in place achievement of the project results. The project has a strong community engagement and participation component that needs to be sustained. Participation of project beneficiaries and stakeholders in project implementation remains strong and well acknowledged by the stakeholders. Collaboration and partnerships with government and other stakeholders during project implementation has made it possible to reach beneficiaries at health facilities, communities and schools with SRH-HIV services and information. However, for the project to be sustainable and keep the programme running for a longer period, there is need to uphold the effective approaches and respond to the emerging country priorities including SRH and HIV response within migration or humanitarian crises such as the cyclonic crisis in Mozambique. For long term sustainability, there should be a deliberate effort by the project to ensure integration of change agents into the existing government community health workers/volunteers which is common to all the countries. Evaluation questions on relevance, impact and sustainability will be addressed in detail at the end line evaluation.

5.2 Recommendations

Based on the findings of the MTR, the following are recommended.

a) Project progress against overall objectives

- There is a need to support the expansion of the service delivery points and SRH supplies to these points to improve coverage and scale up project activities to reach more of the target population. In the future, expansion of scope and coverage of activities will also mean the increased impact of the project activities on these communities.
- In the future, the project should consider providing stipends to all change agents across the problem and in line with country policies on the remuneration of community-based health workers. This will help with the retention of change agents and significantly reduce the high turnover of change agents at the community level.
- To continue increasing the number of beneficiaries reached, the project needs to work with more implementing partners that are based in communities where the projects are being implemented.

b) Effectiveness of strategies and approaches

- Introduce fully equipped mobile clinics in communities where main health facilities are far from residents to significantly reduce the pressure on main health facilities and reduce the waiting period for patients. Where appropriate, the mobile clinics must also be extended to the schools to cater for AYPs.
- The project has an opportunity to introduce entrepreneurship strategies for the target population and encourage them to start their own businesses. For example, in Mozambique, Sex workers assisted in building a school so that their children can go to school. In Zambia, sex workers formed a saving group that has helped them to boost their incomes and nutrition.
- Greater involvement of gatekeepers in the mobilisation of the communities towards the project to ensure sustained advocacy and full integration of activities into the district and traditional structure strategies.
- Sustain the current approaches that have been found to be effective (e.g. door-to-door) and at the same time, innovate new approaches to maintain the good work of the change agents in the program such as the provision of transport to communities that are far and provision of stipends on time.
- Given the migratory nature of sex workers and migrants, training of health and non-health providers should include health facilities beyond the project sites to ensure adequate coverage of responsive SRH/health services offered to migrants and sex workers along the mobility continuum. In all trainings, place a stronger focus on health worker attitude, human rights approaches and equitable access/use service deliver for vulnerable populations.

c) Involvement of project beneficiaries

- Peer to peer education has been reported to be effective in this project, therefore, the implementing partners need to recruit more AYPs, migrants and sex workers to be change agents and share the SRH information to their peers.

d) Project co-ordination and collaboration

- The consortium should organise a forum with the different basic education departments in the six countries and present the SRHR-HIV project to get further buy-in and support for the inclusion of CSE in the existing learning curriculum.
- The consortium should investigate the development of a comprehensive regional SRHR plan where beneficiaries' human rights related to sexual and reproductive health are respected, protected and fulfilled and a region in which countries, individually and jointly, work towards reducing inequities in sexual and reproductive health and rights. The regional SRHR plan will require collaboration with other countries to ensure sustainability.

  which can be designed and developed from the experiences and lessons learned from the implementation of the project to date.
- Formal or informal external partnerships across countries and other programmes in the project sites have been more uneven calling for the need to be strengthened or formalised. Implementing partners should continue to strengthen partnerships including the media and private sector.

9.0 References

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