M&E for improved services: Setting up and implementing a clinic-based M&E system for the rehabilitation of torture victims at CSVR, Johannesburg

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Contents

Introduction 3
A brief history of M&E in CSVR: 2000 – 2014 4
Describing the Client Information and Monitoring and Evaluation Process 6
Methods 7
M&E at the Centre for the Study of Violence and Reconciliation: Challenges, Achievements and Reflections 7
Set up and ownership of the M&E system 7
Monitoring and Evaluation cycle 7
Ownership of the M&E system 8
Buy in and paradigm shifts needed to ensure M&E systems work 8
M&E as improving client services 9
Performance and management within M&E practices 9
Performance and performance management through the M&E system 9
Management support and involvement 9
Staffing and Human Resources for M&E 10
Dedicated M&E Staff member/s 10
Using a consultant to assist in designing the M&E system 11
Pressures of the work 11
Technical aspects of setting up and implementing an M&E system 11
Instruments timeframes 11
Implementing client assessments 12
Intervention Process Notes 13
Data cleaning 13
Database 13
Adherence to the M&E system 14
Reflection and learning in M&E processes 16
Reflection within the organisation 16
Formative evaluation 16
Internal reporting 16
External Reporting 17
Partnerships and relationships 18
Donors as partners 18
Partnerships and relationships with peer organisations 18
Adaptation and Flexibility within M&E systems 19
Flexibility in the M&E system 19
Some positive outcomes from our M&E system 19
Organisational priorities and shifts 20
Model development 20
Client services offered to victims of torture 20
Increased reporting 21
Decreased drop-out rate 21
Future work for M&E 21
Lessons learnt 22
Limitations to this report 23
Conclusion 23
References 24

Introduction

"Building and sustaining a results-based M&E system is not easy. It requires continuous commitments, champions, time, effort, and resources. There may be organizational, technical, and political challenges. The original system may need several revisions to tailor it to meet the needs of the organization. But doing so is worth the effort"
(Morra Immas and Rist, 2009: 135)

The purpose of this report is to better understand what it has meant to develop and sustain a useful M&E system that informs clinical work and assists in improving services to clients. The CSVR has a history both of providing psychosocial services to clients, as well as developing and implementing a results-based M&E system that allows us to better understand and improve the work that we are doing with clients.

The Centre for the Study of Violence and Reconciliation (CSVR) began offering free counselling services to victims of political violence in 1989. After the turn of Apartheid, we began seeing more victims of criminal violence and fewer victims of torture[1] or political violence. However, in the early 2000s, with the opening of the South African border to refugees and asylum seekers, the CSVR saw many people who had suffered war and traumas in their countries of origin and had come to South Africa for refuge. These victims may or may not have suffered criminal violence, or violence at the hands of the police while in South Africa.

Currently, the CSVR sees clients from all over Africa, primarily from the Great Lakes region, the Horn of Africa and Southern Africa. On average, we see clients for 10.25 sessions with a range from 0-170 sessions. The clients experience a number of different types of traumatic events with most clients having experienced torture as well as war, rape or sexual assault and witness to trauma. Clients have an average of two traumatic events each, with a maximum of 9. This does not include the continuous traumas that clients experience on a daily or weekly basis.

In 2007, the CSVR embarked on an undertaking of developing and implementing a contextually based monitoring and evaluation[2] system that is appropriate to our client base. While this process has been challenging, it has also been exciting. It has given us the opportunity to better understand the clients that we serve, to reflect and learn as to how to improve our services, and to see

[1] "Torture" is used in this document to denote the range of experiences of abuse which the United Nations Convention Against Torture (1984) defines as torture and cruel, inhumane and degrading treatment (CIDT). This convention defines torture as:

> "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act which he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions"

As Bantjes and Langa (2011, p.7) state,

> "Often there is a fine line between incidents that meet the legal criteria for torture and those that are considered cruel, inhumane and degrading treatment under international law. Furthermore, an incident can start off as CIDT and escalate into torture."

For this reason, we choose not to differentiate between torture and CIDT for our clinical interventions, and so, for the purposes of this report, "torture" may connote any of the experiences that fall between CIDT and torture.

[2] The CSVR distinguishes between client information systems and M&E systems. For more information on this, see Walker and Dix-Peek (2014)., In this report , however, client information systems and M&E systems have been used generically to indicate a system for learning and reflection regarding our clients.

provisional impact in the work that we are doing. It has also allowed us to generate knowledge in the field of torture rehabilitation and share with partner organisations. The information gathered in the M&E system has been fundamental in assisting us to develop our contextually informed individual psychosocial model (See Bandeira, 2013, and Bandeira et al, 2013).

For the CSVR, the M&E and client information system has been essential in ensuring that

- Client services are followed up on; helping prioritising the best service is given to each client
- The mental health professionals working at the CSVR are reflecting on their work and ensuring that they are providing the best services to their clients possible
- Our internal and external reporting is assisted through the documentation and learning of work happening within the CSVR
- Decision making within the CSVR is informed by data collected through the M&E system

In the case of torture rehabilitation, M&E allows for increased understanding and knowledge about clients and can help shape future work in the field. M&E should give an accurate reflection of the prevention and rehabilitation work being done within an organization, as well as the impact of work done. Consensus in the literature forms around a results-based M&E approach, which allows for "Assessment of a planned, ongoing, or completed intervention to determine its relevance, efficiency, effectiveness, impact, and sustainability" (Morra Immas and Rist, 2009: 108)

This is a reflective report that is based on informal and formal conversations with clinicians, managers, Monitoring and Evaluation (M&E) staff, researchers and a consultant who was involved in the setting up and implementation of the M&E system, as well as notes taken at M&E evaluation meetings.

A brief history of M&E in CSVR: 2000 – 2014[3]

Prior to 2000, the psychosocial team had discussed the need to have our psychosocial work linked to research and to monitor and evaluate our work. Over the course of the next five years, discussions began internally and with funding organisations – specifically the Research and Rehabilitation Centre for Victims of Torture (RCT) – now Dignity – and government institutions who encouraged CSVR to begin to monitor and evaluate our work.

It was in 2007, when monitoring and evaluating was formally put into our contract with RCT that the CSVR began to formally monitor and evaluate our work. There was a new phase of working with torture victims, and M&E became a priority area in this work. A position for a monitoring and evaluation researcher[4] was deemed essential to the work and sustainability of the project; and this staff member was hired to head up and lead the M&E within CSVR.

In order to set up the M&E system, there was a consultative process between the M&E researcher[5], the clinical staff, the programme manager and an external consultant. This consultation has assisted

[3] Described in an M&E evaluation meeting – December 2011, with additional information coming from the M&E Coordinator from 2012-2014. The information in this section has not been corroborated.

[4] The M&E staff member is termed generically, and may refer to the M&E researcher, M&E coordinator or M&E officer. Each of these positions have been essential in ensuring the continued implementation of M&E within CSVR.

[5] When designing the M&E system, the CSVR employed an M&E researcher who was a qualified counsellor and had experience in working with tortured clients. This was imperative to the M&E development because she had the clinical experience to know what M&E tools and indicators would be useful when designing the M&E systems. Furthermore, she could have the discussions with the clinical staff when disagreements arose as to the most important indicators or what needed to be monitored and evaluated.

in ensuring buy-in to the M&E system throughout both the set up and implementation of this work. The clinical team was asked what information they would like to monitor and evaluate and thousands of indicators looking at a broad range of clients' functioning, psychiatric conditions and medical conditions were indicated as important. Through a consultative process asking clinicians and managers whether information was vitally important, important or not at all important assisted the M&E researcher and research consultant to filter these questions to a manageable number. These questions have been adjusted to suit the needs of the clinicians, M&E staff and researchers, however the basis of the questions have remained stable since 2007. The needs of clinicians and what they felt was important were included in the forms, which assisted in ensuring that they felt that it was a useful process to them. Training in M&E was given, and the database was designed so that information could be captured in a centralized space. The M&E system went live in July 2007

Feedback is provided to clinicians and managers through regular, ongoing monitoring reports that include but are not limited to:

1. Weekly, monthly and/or quarterly adherence reports, which look at how much information is being captured in the M&E system within the time constraints
2. Monthly statistical reports, which gave a breakdown of the client information from the screening forms (Discontinued in 2011 with information gathered being reported back through the quarterly statistical reports)
3. Quarterly statistical reports, which give a breakdown of the client information from the screening forms
4. Annual statistical reports looking at client information for that year

Additionally, we complete monitoring reports and reports to better understand our services. These are typically more analytical and engage with international developments and specific intervention challenges that are seen in. They are also often more specific to the needs of the clinical team and may not be routinely done. These include

1. Annual reports, which include an impact report and a dropout report (Done in 2009-2012). This is included in the annual statistical report mentioned above
2. No-show report, comparing how many sessions a client comes for, to those that the client never came for, and possible reasons for no-shows (done in 2013 and 2014)
3. Comparison report, looking at the similarities and differences of clients who drop out very quickly (with two sessions or less) and those who stay for 19 sessions or more (done in 2014. Would like to complete a follow-up in 2016)
4. Client progress reports (CPRs), which use graphs and tables to visually represent a client's progress after each assessment. CPRs can only be done after two or more client assessments have been completed (done monthly or quarterly depending on the needs of the clinicians)
5. Clinician-specific reports, looking at the clients that each clinician has, the information coming into the system and the change from baseline to first assessment. This is not an external report and is only shared internally with each clinician and management (Done in 2014. Would like to complete a follow-up in 2016)

In 2011, the United States Agency for International Development (USAID) became a partner / funding organisation for the CSVR. For this reason, from October 2011 to 2014, the clinical psychosocial M&E work was funded by both RCT (later becoming Dignity) and the USAID.

Using the clinical M&E system, it became evident that we were seeing a decrease in the psychiatric conditions and an increase in functioning of the clients who came to us for counselling. However, it was not evident that this was due to our services or other things happening in our clients' lives.

Additionally, the clinicians who work at CSVR come from a number of different backgrounds with varying theoretical approaches. For instance, we have social workers, community and counselling psychologists and clinical psychologists. The types of interventions given to clients would vary depending on the clinicians and their individual judgements of what treatment was appropriate for each client. In order to ensure that clients were receiving the same treatment in response to specific symptoms no matter who their clinicians were, and in order to ensure that the clinicians were using international best-practice in terms of their approaches, it was decided to develop a contextually informed individual psychosocial model for the rehabilitation of people who had experienced torture and CIDT.

The CSVR is proud to be an innovator in torture rehabilitation sector through both the development of the individual psychosocial model and the methodology designed to develop the model. This model stands on its own. As far as we know, a similar model that takes into account of the contextual realities of clients and the needs of the clinicians has not been developed anywhere else. Not only have we developed an individual psychosocial model that is contextually specific and appropriate to our needs, but we have written up the process as to how we did it so that, if any other organisation would like to replicate the process, or part of the process, they can use lessons learnt through CSVR to inform their own process. This will be explained later in this report.

Describing the Client Information and Monitoring and Evaluation Process

After going through a screening process[6], a client has one session with his/her counsellor in order to receive immediate support and containment, after which a more comprehensive baseline interview[7] is completed.

Prior to 2014, CSVR used a session-based time-frame for the completion of assessments: After every six sessions, the client is asked to complete a self-assessment to assess his/her improvement in functioning or reduction in symptoms. In 2014 this has been updated towards a time-frame of three months between assessments to adjust to the needs of the clinical team and the model testing.

After every session, the clinician completes a counselling Intervention Process Note[8] (IPN). Additionally, all interventions are captured on our database under the IPNs. This includes referrals

[6] The screening process obtains information about the client's demographic information as well as a brief description of the traumatic event(s).

[7] The baseline interview and client assessments include:

- Questions regarding the trauma / torture event and whether it was witnessed or experienced personally
- Five functioning questions adapted from the International Classifications of Functioning and Disability (ICF) looking at how the client is coping / managing with:
  - Family related stressors
  - External stressors
  - Anger
  - Pain
  - Emotional or psychological difficulties
- Three questions looking at a client's locus of control, cut down from a questionnaire of six because three of the questions were felt to be confusing and not useful to our clients and clinicians
- 40 questions from the Harvard Trauma Questionnaire (HTQ) assessing a client's Posttraumatic Stress Disorder and Self-perception of functioning
- The Hospital Anxiety and Depression Scale (HADS) assessing the client's anxiety and depression
- Questions about pain experienced by clients

[8] The Intervention process note asks for an indication of change in terms of how the client is able to cope or manage with his / her contextual situation since the last session, or in the last month. It then asks for a description of the client's context in the last month. It further includes a summary of what happened in the

and telephone calls made; follow-ups from other centres and telephone calls received, consultations with the interpreter or colleagues, and escorting the client to the hospital or assisting the client with interpretations. When counselling ends, the clinician completes a Termination Intervention Process Note[9] (Termination IPN).

Methods

This report uses the retrospective views and memories the M&E Coordinator /researcher to understand the achievements and challenges of the M&E system. To attempt to solidify these memories, the report is also based on notes and minutes of M&E evaluation meetings to attempt to verify some of the information, and to decrease the possibility of lost information and/or distortion of memory. The report further takes into account formal and informal discussions with researchers, M&E staff and clinicians involved in the setting up and implementation of the M&E system.

M&E at the Centre for the Study of Violence and Reconciliation: Challenges, Achievements and Reflections

Set up and ownership of the M&E system

Monitoring and Evaluation cycle

We have found that there is a circular process that is essential for Monitoring and Evaluation and reporting to work consistently. Furthermore, success of both internal and external reporting (see p.16 for more information regarding external reporting) requires staff adherence (see Adherence to the M&E system below) with the M&E systems. The diagram below indicates the cycle that we attempt to use in the monitoring and evaluation of our work:

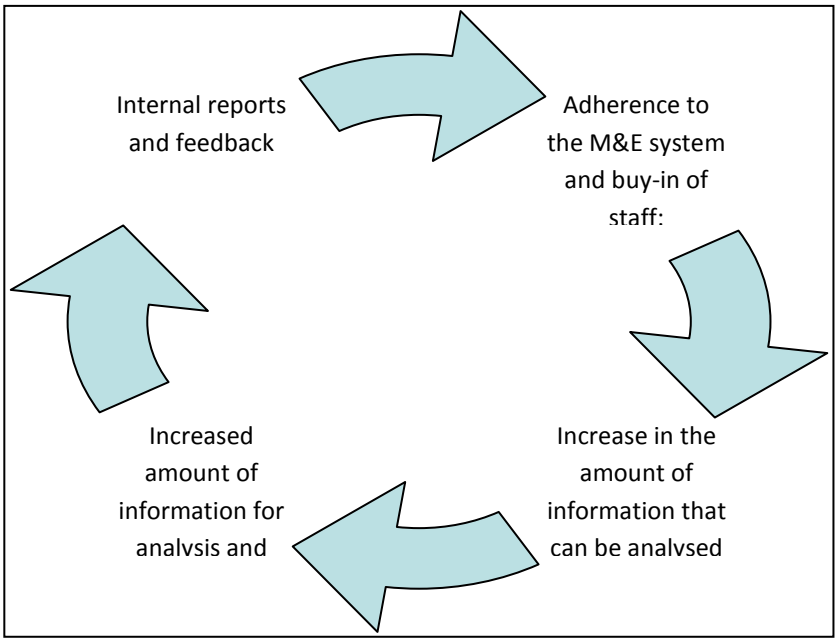

Figure 1: M&E reporting and feedback loop

The greater the adherence to the M&E programme and general buy in from staff, the greater the chance of successful and coherent reporting and monitoring and evaluation. However, the more

session; a reflection of the session including information to take to supervision and themes coming out of the session. An indication of reports and telephone calls written or received is included in the IPN.

[9] The Termination IPN includes indications of why the client or counsellor terminated the counselling process

feedback (often through internal reporting) to staff, the more likely that there will be buy in and thus adherence to the M&E system.

Ownership of the M&E system

As mentioned above, the Monitoring and Evaluation was encouraged by partner / funding organisations, with internal discussions happening within CSVR. In 2007, Dignity, through the Danish government, funded CSVR both for the work being done in providing counselling services to victims of torture, and for the monitoring and evaluation of that work. However, despite it being funded externally, the M&E at CSVR has been set up and implemented as a means of better understanding and learning from the work that we do, and providing the best services that we can to the clients that we see. CSVR has attempted to ensure throughout the whole process of developing and implementing its M&E system, that there is ownership of the M&E system within the staff of CSVR.

While there are pressures from funding organisations to report in a certain way or give certain information, the reports that are produced and the feedback that is given through the M&E system, encourages the clinical team to feel that the M&E system is there for their needs rather than being imposed by the funding organisations. Additionally, the M&E system was developed through a consultative process between M&E staff, management and clinical staff which assisted in making sure that the information gathered through the M&E system was useful to the needs of the clinical staff, management and M&E / research team.

In many respects, the CSVR is better equipped to understand the consequences of torture and how to assist torture survivors because of our M&E system. We understand our client base better and are better equipped to provide better services to them. We are better able to evaluate whether our services are assisting our clients and where training or capacity building may be useful or important for the CSVR staff members.

Buy in and paradigm shifts needed to ensure M&E systems work

One of the biggest challenges experienced in the implementation of the M&E system has been ensuring that there has been a culture shift within the organisation regarding the importance placed on M&E, guaranteeing buy in and shifting the way the work has been done.

Whilst new staff who came into CSVR after the set up and implementation of the M&E system tend to fall in with the requirements of M&E and often mention the value that they see in it, it has taken a long time to ensure that this is true of the staff who had been working at CSVR prior to M&E being set up and implemented. On the one hand, the clinical staff – new and old - have mentioned the value of the M&E system and how they feel that it has improved their work. The discussions and reflections within the team verify this. However, on the other hand, there have been difficulties in ensuring that clinical staff input their information into the M&E system.

One possible reason for this is the value placed on M&E and the time it takes. For the reflection, learning and capturing of information to happen, time is taken away from clients – what is usually considered to be the priority for the clinical staff. One of the most essential paradigm shifts that have occurred in the CSVR has been assisting clinicians to see how spending time reflecting on their practice and entering information into the M&E system inherently helps their clients and makes their services better. However, this is an ongoing challenge and a conversation that happens often in many different ways. An essential way has been through the feedback of client progress reports and the impact information coming from the M&E system.

A second possible reason for this is, as mentioned above, the time it takes to input information into the M&E system. M&E is time and resource heavy and it requires a great deal of input for it to be useful and ensure that practice is improved. While the clinical staff see the value in the M&E system,

they also experience how much input it needs in order to keep it running smoothly. This means that, while the value is not questioned, the input it needs from their side may make them less willing to input the data. We have tried to adjust the clinician's work plans, the way that they capture data, and how much information should be captured in order to make this easier for them. It is, however, an ongoing process.

M&E as improving client services

Fundamentally, it must be clear right from the start that the purpose of M&E is to improve client services. A possible way of doing this is introducing some degree of client feedback, the results of which are used to fine-tune instruments, etc. This can be done in a number of possible ways:

1. An evaluation form for the clinician and/or organisation
2. Some kind of client feedback reporting in which information analysed in the M&E system is used to show the client how they are progressing over time
3. Analysing trends in the change over time of clients and feeding this information back to staff. This can be used to discuss why the trends in change over time is the way that it is, and if improvement is needed, to discuss how this can be achieved

The CSVR stopped using the evaluation form that looks at client's views of the clinic and/or the organisation in 2011, however, another client evaluation process will be beginning in 2015. However, for us it has been very useful to use client progress reports and trend analysis to see change in individual clients and all clients over time. This has assisted us in improving our services and allowed the clients to see how the M&E system can benefit them directly.

Performance and management within M&E practices

Performance and performance management through the M&E system

The M&E system cannot run unless staff members are inputting data into the system. For this reason, we routinely monitor whether or not clinicians are capturing their Client Assessments (including baseline assessments) and intervention process notes (IPNs) into the database.

On the one hand, performance should not be based on the outcomes of whether or not clients are improving, since working with torture victims is complex and the CSVR feels that we are attempting to intervene with a highly vulnerable population group who have many different problems. Our clients are prone to high levels of psychiatric conditions such as posttraumatic stress disorder (PTSD), anxiety and depression, as well as low levels of functioning. Additionally, due to the fact that our clients also experience continuous traumas and experience many different and difficult problems on a daily basis (Higson-Smith, 2013), for us to attempt to manage the performance of the clinical team based on whether or not clients were improving would be naïve and problematic.

However, on the other hand we have based performance management criteria for the clinical staff on whether they are inputting information into the M&E system or not. This will be elaborated below when looking at Management support and involvement, and the section entitled Adherence to the M&E system.

Management support and involvement

Management buy in and input is necessary throughout the set up and implementation of monitoring and evaluation systems in order to ensure a well run M&E system. The collaboration and involvement of management in the implementation of M&E is essential to the smooth running of the M&E system.

The implementation of the M&E system at CSVR would never have been possible had the management not been supportive and invested in M&E and its implementation. There has been an organisational and programmatic commitment to M&E at CSVR. This has included management in CSVR ensuring that M&E is prioritized and seen as something that is part of the work of the clinicians, rather than separate to their work, which has been fundamental in the M&E system being a success.

However, there have been varying degrees of management involvement throughout the project. For a results-based M&E system to work, it is essential that information inputted to the M&E system throughout the process (see the section above entitled "Performance and performance management through the M&E system". Additionally, this will be described in more detail in the section outlining adherence below, p.14). We have found that the M&E staff should be involved in monitoring whether information is being captured and reporting this information back to management. It is then up to management to put practical measures in place if /when performance management measures are necessary.

For CSVR, there has been role confusion as to how to ensure that clinical staff adheres to the M&E system. Largely it has been seen as the role of the M&E staff to make sure that clinical staff is adhering to the M&E system. However, the M&E staff does not have decision making power or line management responsibilities to deal with clinical staff who are not properly adhering to the M&E system. When it became evident that clinical staff members were not adequately adhering to the M&E system, performance management decisions were inconsistently applied or not applied at all. This has made the implementation of the M&E system very difficult for M&E staff because they have been forced into a position where they were made to "police" the M&E system, without being given the decision or implementing powers when needed.

Staffing and Human Resources for M&E

Dedicated M&E Staff member/s

Within CSVR, the M&E process was centralized to a single unit in the organisation but supported by all staff. Additionally, an M&E officer / M&E researcher was essential to hold, head and champion the M&E system. This ensured that M&E implementation has been prioritized, that information is analysed and fed back and reporting is completed.

Because M&E was seen as a programme and organisational priority, the CSVR has ensured that there have been a number of staff dedicated to M&E over the past several years. We believe that the success of the M&E system has been because there has been at least one M&E staff member involved in the design and implementation of the M&E system throughout the project.

The CSVR has been fortunate in having an M&E coordinator / researcher dedicated to this project for the past 5 years. This has allowed for continuity in the M&E work and ensured institutional memory within the M&E project.

However, despite the achievement of having a dedicated M&E staff member to prioritise and champion M&E, monitoring and evaluation can be time and resource heavy. It takes a great deal of human resources just to keep the M&E system running smoothly, to ensure that information is inputted into the database, and to analyse and feed this information back to staff, as well as to report back to funders and management. To then use the information for knowledge generation and sharing in the torture rehabilitation sector is a great add-on to an already heavy workload. We have found that with the commitments to the M&E work, as well as other CSVR M&E priorities and funding requirements, it has taken a toll on the M&E Coordinator. Because M&E is, and should be, part of the work in the whole organisation, the time and resources of the M&E Coordinator is pulled in many directions, making focus and prioritisation difficult.

Largely, the M&E work has been held by one person – the M&E Coordinator. However, because of the time it takes, CSVR recently committed to having an M&E officer to assist with the workload. This is essential in ensuring that M&E work is done and feedback given to relevant staff throughout the process.

Using a consultant to assist in designing the M&E system

CSVR chose to use a consultant in the design of the M&E system. The consultant used is experienced in research, monitoring, evaluation and therapeutic work. For CSVR, it was necessary to use a consultant to ensure that there was support for the M&E researcher and to guarantee that the information would be applicable and useful to the clinicians.

However, it was also necessary that capacity was built inside CSVR, and that skills and knowledge wasn't held exclusively by external people. For this reason, we used a consultant that we had a relationship with, and continued the relationship after the set up and throughout the implementation of the M&E system. The consultant was used in the training of the clinical team and managers. He has also been used in various M&E evaluations and when / if training or capacity building needs arose. He has been a support for the M&E staff and researchers when implementing the M&E system and assisted with specific questions that the M&E staff / researchers had at various times throughout the project.

For us, the success of the M&E system has been in part due to the support and technical advice received from this external consultant.

Pressures of the work

Torture rehabilitation and psychosocial healing is a difficult area of work. It takes passionate and interested people to ensure that the work gets done. However, the work takes its toll on all staff in one way or another. M&E, in many ways is fortunate, since the work is at a secondary level – M&E staff may not have direct contact with clients, which may mean burnout or compassion fatigue is less likely. However, that does not mean that what is happening to clients does not impact the M&E staff. It can, and it more than likely will, impact the M&E staff member at some stage of the work. Given this, and the workload mentioned above, it is essential that self-care is prioritized.

At CSVR, supervision has been offered to the M&E staff members at various points, however, this was mostly turned down. Given this, CSVR encourages its staff to enact self-care strategies. Additionally, largely it is felt that it should be the responsibility of the M&E staff member to tell his /her manager if supervision or some kind of debriefing is necessary. Alternatively, the M&E staff member should feel comfortable enough with the manager and other staff members to let them know if they are feeling overwhelmed, and be proactive in self-care activities. However, the manager may need to keep an eye on the M&E staff member to ensure that if the staff member showing signs of burnout, this may be halted before it becomes a problem.

Technical aspects of setting up and implementing an M&E system

Instruments timeframes

The CSVR has chosen to prioritise a number of instruments in our M&E system. These comprise of client assessments, including a baseline assessment, and assessment every three months[10].

[10] The baseline assessment and the three month assessment are exactly the same, but information about pain is not focused on in the three month assessment, since the CSVR clinical team does not directly impact pain in the client.

Additionally, the clinicians are asked to complete an intervention process note (IPN) after every intervention, and a termination IPN when clients terminate or end counselling.

A summary of the instruments and their timeframe is given below. Currently all instruments are given to clients and captured by clinical staff, however given the time this takes, we are deciding whether or not to employ someone to assist with data capturing. The instruments are described above (see Describing the Client Information and Monitoring and Evaluation Process):

Instrument	When given to client	Instrument timeframe for capture
Screening	When client first comes to CSVR	Within a week of completed screening
Baseline assessment	Before counselling starts	Within a week of completed baseline
3 month assessment	Every three months	Two weeks before or two weeks after due date of assessment
Intervention Process Note	After every intervention	Within two weeks of intervention
Termination Intervention Process Note	At the end of counselling	No cut-off

Figure 2: Instrument timeframe

These instruments have been decided and agreed upon with the clinical team and managers. When discussing the management of the clinicians above (Performance and performance management through the M&E system), the timeframes are essential in ensuring that the information comes in and gives the information needed to allow analysis and feedback of the M&E system. More about the challenges and achievements regarding instrument timeframes will be elucidated in Adherence to the M&E system below.

Implementing client assessments

The assessment tool that we developed, in consultation with the clinical team, captures a lot of really important and valuable information. However, this tool can take long to administer, with an average of an hour, but can take up to two sessions to complete. It contains many different questions asking about many facets of the functioning and psychiatric conditions of the client. We have found that the tool can be emotionally tiring for the client, the clinician and interpreters, if there are any in the session. Additionally, containment of the client is essential in order to ensure that the client's wellbeing is prioritized. Clinicians have raised the concern about harming or re-traumatising the client through the assessment process.

The CSVR has been very clear about the fact that we would like to stick to the "do no harm" ethical principle in therapeutic work. One part of this is being very clear right from the start as to why the assessment is necessary and important both as a treatment planning tool and as a means to assist the client. A lot of explanation as to the purpose of M&E and its importance is essential right from the beginning of the counselling process. However, if it is clear that a client cannot continue with an assessment, the CSVR has agreed that the client should not complete the assessment and support and containment given to the client. From our experience, there are very few clients who, once M&E and its importance has been explained, absolutely do not want to and /or cannot continue with an assessment. More often, as mentioned above, the assessment may continue over two sessions rather than one.

In addition to the time it takes to complete an assessment, as mentioned above, the CSVR conducts assessments every three months (previously every six sessions). This has meant a lot of information coming in, but it comes with difficulties as well. Clients may get "assessment fatigue" – meaning lack of motivation for completing assessments that have been done three months ago. In certain M&E

evaluation meetings, we have discussed one of the impacts of this being that the clients may bias the results – potentially not answer accurately because of their lack of motivation for the process. The primary way that this has been dealt with, again, is by providing client progress reports – actual feedback where the clients can see how they are progressing in sessions and where they see where the information that they are inputting into the system is going. It opens up doors for conversations and assists with treatment planning.

In order to ensure that the different languages of our client base are being met, we have interpreters who have been trained in the assessment tool who have translated the tool for clients. We only have the French version of the tool, and do not have the equivalent in other languages spoken by clients including Swahili, Amharic, Somali and so forth. The translation of the tool is something that we would like to do, but recognize that it is expensive and a lengthy process to translate and then back-translate these tools.

Intervention Process Notes

Intervention process notes (IPNs) are completed after every intervention. They give a summary and a reflection of the session, and allow the clinician to cogitate on what happened in the session as well as difficulties and issues arising. This assists the clinician in meeting ethical requirements to the Health Professions Counsel, as well as to learn from each session and improve services. IPNs are useful in ensuring that reports give accurate reflections of the clients functioning and where assistance is needed. Additionally, IPNs have been useful when the clinician has needed to reflect for case management and supervision sessions.

Unfortunately IPNs take time to complete. We have averaged that for every hour session, the clinician should be spending half an hour on his/her IPN. This takes away time in therapeutic spaces, and dealing with this proactively has been part of the paradigm shift mentioned above.

Data cleaning

Data cleaning has been part of the role of the M&E team. Data cleaning is important because it means that the information coming in is correct and representative of the clients that we see. Initially, data cleaning was completed on all data coming in monthly by the M&E officer. However, as more data started being captured, this became too time consuming and logistically difficult. In order to deal with this, two methods were used:

1. Data checks were done on random samples of the data. If mistakes were found, they would be corrected and a larger sample found. In this way, we were able to make sure data was clean
2. When reports were needed (typically every three months), the data was checked to ensure that all necessary information was captured. If information was missing, the M&E staff would follow up with the clinician concerned

Whilst we have found small amounts of information that needed to be added, largely these two methods of data cleaning have worked for us and have allowed us to produce the reports that we need to ensure feedback internally and externally to donors.

Database

The database is a key component of M&E. Because when the CSVR initially set up the M&E system, we wanted to ensure that it was replicable in other contexts or other organisations, we chose to use a free database. From 2007, we have been using various versions of Epi Info[11]. This is an

[11] Free software created by the Centre of Disease Control; useful for the rapid creation of data collection instruments and data analysis, visualization, and reporting.

epidemiological database set up by the Centre for the Disease Control (CDC) in the United States with a Microsoft Access backing. There have been many positives to using Epi Info, including:

1. Epi Info is free, which is a huge advantage for many non-governmental organisations
2. Forms can be created or adjusted at any point (see point 4 below)
3. No IT specialist / database designer is necessary since the forms can be created by people within the organisation (see point 4 below)
4. It is user-friendly – It has three sections – one in which you create forms (This is essential for creating and adjusting forms to suit your needs and your changing M&E system). The second section has the form in which data is entered. And the last section is an analysis section in which basic analysis can be done or data can be pulled out of the database for more complex analysis
5. There is basic support from employees of the CDC / Epi Info. There used to be a blog or question / answer page with the old version of Epi, however I have not been able to find a similar web source with the latest version of Epi Info

However, there have also been difficulties with Epi Info. For instance, the way that it is set up means that the staff can only capture data while at the office – it is not web based so cannot be done when in the field or at a partner organisation. Additionally, we found that a very small proportion of the data captured went "missing", i.e., disappeared from the database even when there was evidence that it had been completed. This increased when we upgraded from Epi 3 to the latest version (Epi 7). And randomly the analysis section of the system would give trouble. In discussions with IT consultants and people from the CDC, there were indications of corruption in the Epi system; however, we could not find the corruption to correct it.

As a team, we agreed to alternative ways of capturing information when Epi was giving trouble, so there was no point at which data could not be captured, or was not being inputted into the Epi system. While it was inconvenient for both clinical staff and the M&E team to not have the Epi database to capture information in, the clinicians largely continued to input information into the M&E system through other means, such as using soft copies on Microsoft Word.

Because the difficulties with the latest version of Epi have been frustrating to both the clinical staff and M&E team, it was decided that a new, secure, web-based database would be set up. This involved hiring someone familiar in the IT language necessary to creating the forms. The system is currently being designed and will be piloted in 2015. Many of the benefits of using Epi fall away with the creation of this database – such as it being free and fully adjustable by any staff member within CSVR. However, the new database became a priority since Epi 7 has given so many difficulties in the past.

Because we found it more user-friendly, we have exported the more complex statistics to a statistical analysis software programme such as Statistica. This has allowed us to perform descriptive or inferential statistics if /when needed.

Adherence to the M&E system

Psychosocial torture rehabilitation is complex and involves different facets. The CSVR has chosen a results-based M&E system to attempt to better understand the work that we do and improve our services. This has been an important and useful M&E system and it has allowed us to gather information and understand what it means to conduct torture rehabilitation practices within our context.

Two of the primary reasons that data should be obtained when required are:

1. Practitioners have an ethical responsibility to assess their clients and to document their work
2. To increase the amount of information available for analysis

In order to ensure that this information is collected at the correct time, an adherence system monitors what information needs to be collected and when. Additionally, the system should ideally send reminders to practitioners to remind them what information is needed.

The difficulties with performance management have been indicated above, so will not be ventured into here. However, there are a number of lessons learnt about implementing an M&E system that came out of the adherence of the tools and indicators.

One of the difficulties with the implementation of the M&E system that came out for some clinicians was that the value of their work may be prejudiced by the M&E system. During an M&E discussion, there were indications from certain clinical staff that they felt that such a heavy focus was placed on adherence to the M&E system, that their work was not valued unless their M&E adherence was up to date. At times the M&E system feels inflexible to the clinicians who input information into the M&E system.

What became clear from this discussion was that both the quality of the work and the M&E adherence is important. Until recently, CSVR has not observed sessions, so we rely on the intervention process notes to understand what is happening in the session and what the quality of work is. If the clinicians do not capture their work through the IPNs, and using the M&E system, there has been no other way to understand the work being done and what the quality of the work is. Furthermore, it has been essential to emphasise and reiterate that the point of the M&E system is to improve the services given to clients. Without the M&E system, it is very difficult to see the shifts in clients and make decisions as to the best way to improve services. Client assessments and reflections through the intervention process notes are both means to ensuring that we are able to see change in our clients. Furthermore, benchmarking achievements as well as using reflection sessions to discuss the challenges and successes of the M&E system are essential in ensuring that clinicians remain committed to M&E and the way that it can assist them. Allowing them to see that the M&E system ultimately assists to improve service and assist their clients is an important part of this.

Additionally, it has been important to point out that the clinicians decided what tools and indicators should be included in the M&E system and were fundamental in ensuring that it was useful for their own work. This has assisted in emphasizing the ownership and how the M&E system is based on the needs of the clinicians.

Another pressure that arises in M&E work is that part of the work involved in M&E is to ensure that other, potentially more senior, staff members are capturing information and adhering to the M&E systems and procedures. Moreover, M&E staff likely can see the reasons why the clinical staff are not adhering to the M&E system and feel sympathetic to their needs and difficulties. This can put the M&E person in a difficult situation, where they need to ensure that the information is coming in, because without this, no feedback or reporting is possible. On the other hand, they understand the difficulties and pressures of the clinical work. They may have to choose between being overly flexible in the M&E system, which may mean that the information does not come in on time, or being overly strict. And these two extremes may come out in different ways in different times. For this reason the M&E staff members will need to be able to negotiate, discuss or use more assertive means to ensure that the information comes in. This is an uncomfortable space to be in, especially when it feels like “policing” colleagues who you respect and look up to. This goes back to the discussion above regarding the role of management in M&E, but still does not negate the difficult space that needs to be taken into account when doing this work.

In spite of the difficulties outlined above about the challenges in ensuring that clinicians adhere to the M&E system, much progress has been made in this area of work. There is considerably more buy

in to the M&E system, and we agree that there has been a paradigm shift in this area of work in the organisation. The paradigm shift has been slow, and needed constant work and feedback, but it is there and can be seen through the reports that we produce and the work that we do. We have kept track of our adherence rate over the course of the M&E implementation. In 2009, average adherence to the collection of intervention process notes was at 20%. This has gone up to between 70% to 100% over the course of the implementation of the system (fluctuating over time). The clinicians see the value in it because information is fed back to them.

Management support has also been crucial in ensuring adherence. The M&E staff members cannot do this without the support of managers.

Reflection and learning in M&E processes

Reflection within the organisation

It is essential that the goals and instruments of the Monitoring and Evaluation system are directly linked to those of the organisation. Because M&E is an essential tool that can be used to assess and demonstrate whether an organisation is meeting its goals, the M&E needs to reflect what those goals are and how they should be evaluated and monitored.

Reflection within teams should be done routinely to ensure that motivation to the M&E work is constant and to improve the work done. It also allows for systems to change before there is a problem within the project / organisation.

Additionally, the CSVR has found that having a good and systematic M&E system in one project has been fundamental assisting other areas of the organisation to reflect on, and learn from the work that is being done in those projects. This can be summarized by Morra Immas and Rist (2009) who state, “Evaluation must sometimes take a big-picture view. Doing so means going beyond a single project, programme, or policy to also evaluate related projects, programmes, and politics” (p.416)

Formative evaluation

Unfortunately due to meeting fatigue and capacity difficulties, formative evaluations / evaluation meetings have not been prioritized in the past year. However, the CSVR has found that appraisal of the work done through M&E evaluations (ideally quarterly) are essential in terms of teasing out difficulties and focusing on achievements. The evaluations allow us to see where and how we need to adjust to ensure that the work that we are doing is assisting in improving practice and we are accounting to the people who fund us and ourselves. It further assists in ensuring that we meet our outcome goals, and that learning and reflection is happening within the team.

In addition to the evaluation meetings, the CSVR has been completing annual reports that observe our client base using the screenings, baseline assessments and ongoing assessments. These reports have been useful in evaluating our services and seeing how clients change over time. They have also been useful in learning from the work that we are doing. We have used these reports to ensure capacity building needs for our clinicians that come out of the evaluations are met.

Internal reporting

Internal reports serve a number of different purposes: to make management or strategic decisions; to update the clinical team on the client information / clients being served at CSVR and to better understand their needs; to improve our services; to see whether and in what way clients are getting better (or worse) and how we can better assist them. The reports have many different formats and timeframes depending on who needs the report and what the purpose of the report is.

As mentioned above (see p.7), internal reports are essential to the feedback loop and assist clinical staff and managers to be motivated and excited about feeding information into the M&E system.

The M&E staff attempt to give internal reports that reflect both the client information systems (e.g., biographical data and events experienced by our clients) as well as M&E systems (e.g., looking at impact and / or change in the clients over time). This assists both with ensuring stimulation of the M&E staff members and keeping the clinicians up to date with what is happening in the clinic and how their interventions are affecting clients.

The reports themselves can be time-consuming, some taking hours to do, and some taking days or even weeks. This means that there is often a lot of pressure on the M&E researchers to compile and send reports to internal staff.

Additionally, it has been interesting that clinicians seldom give feedback as to the usefulness of reports unless pressed for this. Much like the feedback loop needed in the M&E process mentioned above, it is often more motivational for M&E researchers to continue providing reports when these have been seen to be used and discussed. Often this feedback is more forthcoming in meetings with the clinical team; however, because of time constraints and what we call "meeting fatigue" in CSVR12, often meetings are seen as a second choice. However feedback via email is seldom forthcoming. A solution to this has not yet been found.

External Reporting

Reporting should be seen as a means to reflect and learn on the work that is done and how to improve it. In this way, reporting should go beyond donor reporting to ensure that information and best practice is shared between organizations, and to ensure that the best services are being provided to clients as possible. Additionally, learning and reflection within the organisation should be prioritised when reporting. The external reporting done through the M&E system appears to be linked to two primary areas:

1. Peer sharing and knowledge generation
2. Funding from donors

Peer sharing and knowledge generation:

One of our goals at the CSVR is to feed into knowledge about what it means to provide psychosocial support to victims of torture in the African region as well as internationally. One of the ways that we have done this is to use certain internal reports, such as the impact reports and the comparison reports, and shared them with partner organisation and our funding organisations. This has assisted us in sharing our knowledge with other organisations in the field, and ensured that peer organisations are sharing and learning from each other.

Through the reports, we have gained contact or formed relationships with other M&E staff and participated in peer learning exchanges. This has been a great achievement in the M&E work.

However, much like the comment above regarding the need for feedback from the clinical team, it can be demotivating to write reports, send them to peer organisations or funding organisations, and not receive any comments or feedback. Alternatively, however, we need to be aware that torture rehabilitation work is difficult and time consuming and this kind of feedback is seldom possible

[12] Meeting fatigue is the term used when staff go to so many meetings that they find themselves unmotivated and tired not only while in meetings, but at the thought of another meeting

Funding from donors:

Donors or funders are accountable to the public for the money that they spend, just as CSVR is accountable for the money that is given to us by the funding organisations. Funders, and the public want to see what their money is being spent on, where the achievements are, and where necessary, what steps are being put in place to ensure that difficulties are overcome.

The M&E system has been essential in the reporting for donors. It has made reporting streamlined and easier. In the past, before the M&E system, information about who the clients were that came in for services at CSVR was found by going to each clinician separately and asking them to report on their client base. The clinicians would count their clients and give a brief description of demographics. Reporting is now done using the database, and is simpler and quicker to do.

However, different funders often ask for different information or have different timelines. This means that many reports with different focus areas need to be done, which can take time to complete. Additionally, at times, donors ask for information immediately, without acknowledging how long it takes to complete a report or get the data. The CSVR has attempted to "push back", i.e., give timelines as to when a report can be completed and how much time it will take given the other work that also needs to be completed. At times this has yielded positive results, while at other times the funding organisations have not accepted this, creating difficulties and scrambling to write the reports while still continuing to ensure that other outputs are met.

External reporting for donors may or may not be fed back to the practitioners. Often they are not fed back to practitioners simply because of the busy schedules that practitioners have and the time it takes to report. However, the clinical manager and/or M&E staff will attempt to report back when planning and implementation meetings come around.

In spite of these difficulties, however, we have found that external reporting assists us in reflecting on the work that we do, how we can improve it and ways that we can change our work to ensure that it better serves the needs of our clients.

Partnerships and relationships

Donors as partners

One of the reasons that we feel that our M&E system has worked so well is because our donors have prioritised M&E in the CSVR and have been willing to fund it. In addition to this, we have found that specific funders are willing to share and learn. For instance, RCT/Dignity have been willing to share their challenges and achievements, and have been very excited with seeing how well the CSVR's M&E system has been implemented, the amount of data that we are getting in, and what we are and can learn from it. This has assisted with motivation for M&E at CSVR. Other partner organisations have also been essential in our reflection process. As mentioned above, the reports written for external organisations have been essential in assisting the CSVR with our own reflection and learning processes. Additionally, we have found that when donor organisations visit the CSVR, it assists us to reflect on our challenges, and be proud of our successes. Many of our successes can be seen through our M&E system.

Partnerships and relationships with peer organisations

M&E should be seen as a way to share knowledge and develop relationships between organisations involved in the field. Ideally, understanding both how to develop an M&E system, as well as knowledge coming out of the M&E system, should be shared between partners to ensure that best practice and increased understanding of how to do torture rehabilitation within our context is prioritized.

The CSVR has been able to share information with other organisations, and has been involved in a peer learning exchange, in which the M&E coordinator at the CSVR went to another organisation providing torture rehabilitation services in the sector to share knowledge and experience regarding M&E work and its implementation in the different organisations. Feedback was that this was very helpful for both organisations and assisted both organisations with their reflection of the rehabilitation work and how it is being monitored and evaluated.

Adaptation and Flexibility within M&E systems

Flexibility in the M&E system

The M&E system must never be seen as complete. Organisations must be open to, and reflect on, potential changes to improve the system. The M&E system should be flexible to ensure that it is useful to the people involved. Part of the flexibility is the assessment of instruments and tools in order to ensure they gather all necessary information and are appropriate to the needs of the staff and organisation as a whole.

However, there should be fundamentals that are agreed to be essential in the M&E system so that the system is not continually changing. This means that the goals of the M&E system are clear and linked to the work done. The stability in the M&E design also guarantees that the practitioners know what they are doing and furthermore ensures that information gathered can be analysed over a longer period of time and fed back both internally and externally.

Evolution and change are an important part of M&E. The M&E tools at CSVR have shifted and changed depending on the needs of the clinical staff and management. However, the fundamentals of the M&E tools and indicators are still the same. This has meant that the M&E system is flexible enough to deal with the needs of the clinicians, but stayed similar enough that we have gathered data in areas that we see as important and can now analyse this data to see shifts in our clients and to ensure the smooth running of the clinic.

Additionally, as the content of M&E work changes so too does the role of the evaluator and M&E officer. "As the concept and purposes of evaluation have evolved over time, so have the roles and activities of evaluators" (Morra Immas and Rist, 2009: 17). The CSVR continues to ensure that we check that data is coming in through the adherence reports. However, the analysis has changed over time to ensure not only the monitoring of the work, but also some evaluation. Due to the increased information coming in, and the increased statistical and analytical ability of M&E staff, the reports produced are of a higher quality and can look at different aspects of our clinical work. Such reports are important in the running of the clinic, however, so are the ongoing monitoring reports (see p.5) While the monitoring reports were prioritized at the beginning of the project, these are now dually prioritized with the more in-depth evaluation reports.

Some positive outcomes from our M&E system

Monitoring and evaluation is a process. The CSVR is constantly attempting to improve the quality of the data, the efficiency, the ways in which we work and the feedback that we are able to give both internally and externally. We have made sure that the goals of the M&E system align to the project goals and the organizational goals. This has been essential in ensuring that M&E is seen as useful for everyone involved. Additionally, the M&E staff attempt to make sure that there is continuous reflection and learning in the M&E system. As Morra, Immas and Rist (2009) emphasised "It [a results based M&E system] must receive continuous attention, resources, and political commitments. It takes time to build the cultural shift, but the time, effort and rewards are worth the effort" (2009: 134). We have felt that with the M&E system at CSVR.

Organisational priorities and shifts

M&E highlights the room for change in the organisation. One area where this has been overt has been through the development of the model and the implementation of community work for torture survivors.

Because of the success of M&E within the clinical work, M&E has increasingly been seen as vital to the running of other projects within CSVR and the organisation as a whole. Additionally, practitioners who are not clinicians, such as community practitioners, have been excited about the notion of implementing M&E into their work and have systematically documented their work. Practitioners involved in advocacy initiatives have also indicated the need to monitor and evaluate their work. The importance placed on M&E is significant to CSVR and indicates that CSVR is committed to ensure that it is an organisation committed not only to reflection and learning, but also to knowledge generation and sharing what we have learnt with other organisations working in the sector.

Model development

Through the M&E system, it became clear that the CSVR needed to standardize the work that we do in the clinic, and ensure it was evidence based. Through this, we have developed the contextual individual psychosocial model for the rehabilitation of victims of torture and CIDT (See Bandeira, 2013, and Bandeira et al, 2013).

The process of developing a model included a literature review of interventions with torture survivors internationally, regionally and in South Africa as well as what the impact of torture was on survivors of torture. We furthermore analysed information coming from the intervention process notes of a randomised sample of clients who had at least 5 sessions and were reflective of the nationalities and genders of clients seen in the clinic over this time period. 17% of our total client population was sampled in this analysis. Additionally, we conducted a Delphi process. This involved a panel of 18 people experienced in the field of torture rehabilitation including researchers, clinicians and supervisors. The role of the Delphi process was to build consensus on the impact of torture and the most adequate intervention options.

This process has ensured that we use local and international expertise in the development of the model. From this, a list of 18 impacts was decided upon through the various processes and 18 interventions. Through intense focus groups consisting of the senior researcher, the clinical team, the clinical manager and the psychosocial trainer, it was decided how to best intervene with victims of torture in our context. This was written up in a clear intervention model. Three of the impacts that were included were specific to the needs of the clinicians in CSVR, and through the process, it is clear that the model is contextual to the needs of the clinical team.

The method of developing the model, the consensus built through the Delphi technique and the process of developing consensus within the clinical team has ensured there has been engagement and ownership by staff throughout the process. It furthermore ensures that that the individual psychosocial model is owned by the clinical team and reflects their needs.

The model will be tested using data gathered in the past year, using a quasi-experimental approach. Information is gathered using adjusted M&E tools and systems.

Client services offered to victims of torture

Through the M&E system, it became evident that we were not accessing victims of current torture within South Africa. Because of this, we conducted the research attempting to observe what torture was happening in Kagiso, a township in Johannesburg, and began working with young men and

women who had been tortured, or who were at risk of being tortured. This has opened a whole different sphere of work within CSVR and the M&E of our interventions. We are more able to in reflect and learn from our community work. We have furthermore used this information to write a community implementation model for the healing of young men and women who have been tortured or are at risk of being tortured in Kagiso – a township in South Johannesburg (at the time of writing this report, the community model was still in draft form).

Increased reporting

Due to the information gathered, we are better able to report on different aspects of the work that we do and the clients that we see. Two examples of this is the comparison report, comparing clients who had received two or fewer sessions at CSVR (see Decreased drop-out rate below), with those who had had 19 sessions or more, to see whether there was a difference between these two groups, and to ensure that we were intervening in the best way possible (See Dix-Peek, 2014). This report has been fed back to clinicians and managers and has informed practice making us more aware of possible reasons why clients may drop out quickly (what we term "early leavers", and how to intervene with clients that ensures that they stay for an adequate amount of time (between 8-18 sessions) without becoming over-reliant on our services.

The second example is the recently we completed clinician-specific reports that look at what information has come in for each clinician, as well as trends over time for each clinician and for the clinical group as a whole. The report further compares areas of the work such as whether some clinicians are significantly more likely to see a certain demographics of clients. This is useful in evaluating the services that we provide to clients and in ensuring that the work that we do is appropriate to the needs of the CSVR's clinic. It further looks at the work done by different clinician and highlights possible capacity building needs. These reports are only available to clinical staff and managers, and are not available for external viewing.

Decreased drop-out rate

Prior to 2009, CSVR had a very high drop-out rate of clients leaving within the first three sessions. It appears that CSVR was used as an initial stop for people coming from other African countries looking for refuge and asylum. However, using the M&E system, we were able to see what our attrition rate was, and make adjustments to the way that we worked. The people conducting screenings ensured that it was clear what services were that CSVR could offer. This assisted in assisting that clients were not trying to use the CSVR to get alternative services such as accommodation, medical or legal assistance. The CSVR also did a lot of work in assisting other organisations to understand what the services are that we offer and what we can / cannot assist with.

Because many referrals come to CSVR from partner organisations and referrals from current/past clients, the information gained through the screenings and information sharing with referral organisations has assisted in ensuring that clients are not coming to CSVR for services other than what is offered. This has assisted in decreasing how many clients drop out and made sure that those who do come for services are doing so because they want the psychosocial services on offer at the CSVR.

Future work for M&E

Due to the large amount of information being captured in the M&E system, the scope for analysis and knowledge generation is huge. Aside from the ongoing monitoring that we see as essential, and routine evaluation meetings, we have discussed a number of different reports that would be useful to have within the organisation, including, but not limited to:

- A full impact report, looking at the impact over time of the work that we do through our psychosocial interventions at the CSVR clinic
- A gendered impact report, seeing whether there is a difference between change over time of male and female clients, and whether the gender of the clinician makes a difference in this therapeutic relationship
- A report looking at the risks, resilience and protective factors of South Africans and non-nationals, and whether there is a difference between the two

Furthermore, the CSVR would like to increase and improve the peer learning and peer exchange with other organisations providing torture rehabilitation in the region. There is a lot of lessons learnt in other organisations that we feel could benefit our organisation and the torture rehabilitation sector. Additionally, we feel that this knowledge generation and sharing is essential to ensuring that all organisations working in the sector are providing high quality services, are reflecting on their work, and are considering best practice in their interventions with victims of torture.

Lessons learnt

The CSVR would like to ensure that there is knowledge generation and sharing of how to best intervene with victims of torture in our context. We hope that other organisations may learn from our challenges as well as achievements, and implement as exciting an M&E system as we feel that we have developed.

The following gives 14 points that we have found imperative in the development and implementation of our M&E system.

1. M&E needs to be an organisational and programmatic priority for it to succeed
2. A primary purpose of M&E is to improve services to clients and ensure that staff are reflecting on their work. This needs to be emphasised throughout the set up and implementation of the M&E system
3. Feedback should be provided to clients, since they are the people who are inputting their information into the system. This allows them to see the value of the M&E tools and ensures that they are benefitting from the process
4. All applicable staff (clinicians, management, M&E personnel and potentially researchers) should be involved in the design of the tools and indicators, and agree upon timelines for data capturing and reporting. This ensures ownership in the M&E process
5. Management is essential to the implementation and smooth running of the M&E system. For the system to work properly, management needs to prioritise M&E and see it as an essential part of the work of the practitioners
6. M&E staff should monitor adherence to the M&E system, but unless given the line-management capabilities, should not be involved in the performance management of staff
7. Adherence should be given to the manager of the clinicians, who can use this information to make decisions as to the best running of the clinic and to ensure that the project runs smoothly
8. Performance decisions based on adherence should be consistently applied amongst all clinicians
9. Feedback is essential to ensure motivation and guarantee that information is captured consistently
10. Internal and external reports should be used to better the services of the practitioners
11. A dedicated M&E staff member is essential to head and champion the set up and implementation of the M&E system
12. Consultants used should ensure capacity building of staff within the organisation to ensure that the M&E system is sustainable

13. The M&E system should be flexible to ensure that it remains useful to the clinicians and M&E staff, but should also be stable to ensure that information over a period of time can be fed back to the clinicians and clients
14. Donors should be seen as a resource, and may be useful in reflecting on the work done as well as in partnering with to discuss achievements and challenges

Limitations to this report

As mentioned above, this is a reflective report and it uses the retrospective views and memories the M&E Coordinator /researcher to understand the achievements and challenges of the M&E system. These memories are corroborated by notes and minutes of meetings, as well as formal and informal conversations with staff members at the CSVR. However, due to the reflective nature of this report, information may be subjective and/or may be distorted due to memory and perceptions of situations and scenarios.

In this way, it is a subjective report and should be seen as such.

Conclusion

It is hoped that this report will be useful to organisations who would like to set up, and/or implement M&E within their organisations. Through learning from the challenges and achievements of CSVR's M&E system, we would like to ensure that other organisations may create ever better M&E systems that increase knowledge and best practice within the torture rehabilitation sector.

This report is reflective, and in being so contains the subjective accounts of the author. While this may be problematic, since it does not allow for full objectivity and impartiality, the subjectivity may also create a better report because the difficulties and achievements are so much more pronounced. Additionally, it assists with ensuring that reflection and learning is ensured in the M&E of torture rehabilitation. Indeed, it has been useful to reflect on the CSVR's M&E system and observe how far we have come and how well many areas of the M&E are going.

The report emphasises that setting up and implementing an M&E system is not easy or quick. It comes with many challenges. M&E work itself can be challenging and resource heavy, and the context of the organisation and its operations can be a great challenge. This report shows the importance of staff 'buy in,' management support, as well as how important both internal and external reporting are. A competent M&E staff member is essential to ensure the success of the M&E system.

Improving M&E and reaping its benefits commitment from all levels of the organisation and the donors, as well as a willingness to adapt to new systems. Finally, the needs of torture survivors must be remembered at all times throughout the M&E process and manifest in instruments used.

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