PEPFAR South Africa OVC Partners
M&E Meeting

REPORT

ISIPHIWO HOTEL, KAMEELDRIFT, PRETORIA

20-21 FEBRUARY 2014

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DAY ONE: THURSDAY 20 FEBRUARY 2014

1. WELCOME, INTRODUCTIONS, PURPOSE & ANTICIPATED OUTPUTS

Ms Anita Sampson, United States Agency for International Development (USAID)

Anita Sampson welcomed all to the meeting and explained that the purpose of the meeting was to review new United States Government (USG) reporting requirements for Orphans and Vulnerable Children (OVC) including new indicators; indicators for systems strengthening; discussing biennial survey requirements; and checking in with partners on how indicators relate to what partners do in their current programmes and how they measure outcomes.

The year commenced with the information from Washington DC regarding new indicators and the need for Monitoring, Evaluation & Reporting training. Monitoring & Evaluation (M&E) has assumed a greater importance in recent years.

It is important to measure the work being done by partners so that an accurate indication can be given in relation to the required funds. Such requests need to be informed by evidence and outcomes that must be presented to Congress in order to obtain the necessary funding support.

It is necessary to assess the extent to which the funding given to OVC work is attaining measurable outcomes that can be taken to Congress and whether the OVC outcomes are in line with Congressional expectations. The key question that must be answered is whether there has been an improvement in the lives of children and how this is supported by the evidence.

2. REVIEW RATIONALE & CONTEXT FOR MONITORING, EVALUATION & REPORTING

Ms Amy Gottlieb, Strategic Information Advisor, United States Agency for International Development (USAID)

It has become necessary to redefine PEPFAR support within the MER Definitions of Direct Service Delivery; Technical Assistance Only; and Sites. This forms part of the Monitoring Evaluation and Reporting Strategy. Phase Three of the strategy includes measuring capacity building and technical assistance.

In a recent global evaluation two reports emerged that were critical of PEPFAR and which stated that indicators did not measure what people were doing in a way that was current. The initial aim of PPEFAR had been to provide an emergency response to save lives, but over time there has been a shift to health systems strengthening and capacity building in communities.

The Office of the United States Global AIDS Coordinator (OGAC) has now decided to implement Monitoring Evaluation and Reporting (MER) as a direct response to the call for greater accountability and more accurate measurement of the work being done. This has seen revised definitions being developed that will help to define impact in more detail than previously.

The revised definition of PEPFAR support divides into both individuals and sites and above sites. It also makes provision for multiple criteria to be met. More accurately it describes PEPFAR's evolving contributions in alignment with national HIV strategies and programmes. It has refined the definition of direct service delivery (DSD) support to individuals and has introduced a definition of technical

assistance (TA) support to sites and above sites. The definition of sites has also been refined. Above site indicators include district, provincial and national level sites.

As a result of this shift in required indicators, all partner agreements are undergoing a process of review and re-classification. It is important to note that value judgements are not being applied. This is rather a process of working to gain a better understanding of what is being done by partners. At present the programmes support 2.5 million people on treatment and there could be changes to this. It is important that Congress is fully informed of both the work being done and possible implications of the changes being undertaken.

When applying the MER definitions in the Country Operation Plan (COP 14), it will be seen that there are overlaps between the indicators, and the proportion of results that are attributed to direct service delivery, technical assistance or neither of these. This revised reporting approach will assist PEPFAR in obtaining a better understanding of what is being done in the field.

There are also revised PEPFAR reporting timelines. Quarter 1 reporting has been done and Quarter 2 will already see some changes being made.

Discussion and Comments

1. How can targets be set since the previous targets will no longer apply, and how will reporting on the new targets be done? *Response:* Direct Service Delivery (DSD) and Technical Assistance (TA) are broken down into different targets. An award to a partner can be broken down into these two categories, then thought given to how the programme is being implemented and the proportion of resources being used. An inventory of sites is the first step. OVC sites tend to be more difficult to assess than a clinical facility. Firstly examine the proportionality of the work being done. Also look at where capacity is being built but not through direct services. More detailed information around the counting is provided later.

3. REVIEW OFFICE OF GLOBAL AIDS COORDINATOR (OGAC) NEW REPORTING REQUIREMENTS FOR ORPHANS AND VULNERABLE CHILDREN (OVC)

Ms Janet Shriberg, M&E Advisor, Office of HIV and AIDS (OHA) (USAID/Washington); Ms Elizabeth Berard, Youth Advisor USAID /Washington

3.1 Review OGAC new reporting requirements for OVC

The mission in relation to working with OVC is to mitigate the social, emotional and economic impacts of HIV/AIDS on children and to reduce their risk and vulnerability while increasing their resilience, with the goal of caring for 5 million orphans and vulnerable children. In this context, it is important that OVC work is properly reported so that the significant contribution being made can be properly recognised. In October 2012 USAID developed its first youth development policy to be applied at the global level. Most donors do not have such a policy so this is a useful tool that can be used to prioritise youth interests. USAID is keen to work with youth across the board in all aspects of their lives, with HIV being but one aspect.

PEPFAR's Blueprint from December 2012 highlights prevention, outreach, care and support for adolescents living with HIV, and also has a strong focus on the transitioning of OVC into adulthood. This is a very important time for youth support. South Africa has good OVC programmes but there is

a need to provide greater support to OVC that goes beyond their 18th birthday. It is critical that they are given skills to take them forward.

The challenges that have been encountered include a high level of investment in OVC programmes but with limited information about the impact of this investment. This gives rise to questions about what actually works when attempting to improve household and child well-being. Part of the challenge is a lack of standardized measures and tools for child and household outcomes or well-being.

3.2 MER versus Next Generation Indicators

The OVC MER strategy has made a strong shift towards an outcomes focus. This is seen as a positive shift. It seems that the OVC portfolio was not indicating the extent of effectiveness and it is important to be able to demonstrate that work done outside of the clinics is a key and critical area of work. The well-being of young people and their families is of critical importance, yet there seems to be a perception that work has been in an ad hoc way and it is thus important to demonstrate scientifically the impact and effectiveness as seen in positive outcomes.

The Programme Evaluation Toolkit has been developed that identifies critical outcomes to be broadly applied over time. There has been a stronger response to the IOM report that shows greater effectiveness and provides information about children and their caregivers that feeds directly into the work being done. It is important to identify what exactly it is that our work aims to address and what it is about children that we care about. This has provided a stronger foundation for the OVC work and the pilots that are currently underway in Zambia and Nigeria.

Reviewing the outcomes around OVC has been in process for the past four years and has now been escalated to the MER level. This means that there will be specific shifts in the collection of data for partners. A key aspect is programme effectiveness and outcomes which must inform all the thinking. Another important aspect is to focus on the developmental milestones across ages and stages since the scope of the work is an age range from birth to 17 years, which is very broad.

Coverage should be tracked through active beneficiaries for OVC – a shift has been made in that there is a differentiation within Active Beneficiaries. Quality programming requires active engagement and the minimum interaction is on a quarterly basis. This will help to track our contribution to the overall continuum of response. OVC work is done in the space where people are living; OVC work often functions as a conduit between people and health services. The Core Indicators from the OVC Survey toolkit need to be elevated to the MER level.

3.3 Review of Indicator Sheet for OVC Level One Indicators

There is no longer an umbrella care indicator as this has been replaced with OVC-specific indicators. Level One indicators are compulsory and are reported to Congress – these are key indicators that are rolled up, and there are two – OVC Access and Active Beneficiaries Served.

3.4 New Indicator: Active beneficiaries served by PEPFAR OVC programmes for children and families affected by HIV/AIDS

This is a new Level One indicator that replaces the care indicator. The overall intention with the new Level 1 indicator is comparable with old indicators. For example, a key question relates to how many

people are reached through OVC programmes or what the coverage is. This is now dealt with in more detail.

This defines that there is quarterly contact with the beneficiary and that the person is being serviced by the programme. This is an important indicator that demonstrates quality programming. A key question to ask is what would happen if a particular programme were not being supported by PEPFAR. Most of the work being done may be considered as critical and needed work.

The shift towards more detailed sex and age disaggregation is an improvement although it depends on continuous data collection. The reference sheet provides more detail of each indicator. Much information can be generated from the rosters and registers of partner organisations and guidance is provided in the 2012 OVC guidelines.

The number of active beneficiaries is an indicator that will demonstrate how OVC programmes contribute to the continuum of care. There is a learning year 2014 and reporting starts in FY2015. OVC programmes do a lot of work around promoting access to HIV services, including access to PMTCT, paediatric and adult HIV testing, and treatment programmes.

The current Reference Sheet is being reviewed and it is hoped that some aspects can be expanded. This links to understanding the realities on the ground. Countries not in this phase of OVC work will do counting under OVC service delivery rather than TA work. Both are considered equally valuable.

Discussion and Comments

1. If OVC are enrolled in the programme in Q1 must we wait till Q2 to count the child? Must the child receive a service in each of four quarters to be counted and can the child be counted only after a full year? *Response:* Commence counting in Q1 but if service stops after two quarters then that child cannot be counted.
2. Reporting is in September so if a service is only provided in two quarters can they be under-counted? Maybe they only needed two services in that year and not four? Do we only count children needing four services? *Response*: A service does not have to be extensive. It could be a check that the child is still in school and is doing well or a check at home to ensure the situation is acceptable.
3. What is an active beneficiary? It is correct that in the recent quarter, children will be counted as OVC even if they have not yet received a service? *Response:* They must be counted if there is going to be a contact in that Quarter. A Sampson clarified that in South Africa this is not supported as the child should only be counted once an actual service is rendered. This may require an amendment for the South African reporting requirements.
4. Regarding access for OVCs, how is a referral to another service counted? In South Africa a referral can be counted only once the referred service has been provided as an end product. *Response:* This does count, but there is ongoing discussion in OGAC.
5. Targets are set on an annual basis as is reporting. But we could, for example, provide a service to a family for three quarters and then in Q4 they do not need a service. A service should not be provided just to support a count. *Response:* Visits are not encouraged if there is no reason to visit but checking in or regular contact is also counted. What is needed is to verify that such a contact was made to ensure that the OVC does not need assistance at that time. There is no form being completed at present but some verification is needed that OVC were indeed contacted.

6. There is a concern as a partner that this might reflect poorly on the work being done. If services are offered for three quarters but not in the final quarter how can this be counted? For example, 500 children could get a service for three quarters of the year but only 200 in Q4 because they are away from their school on holiday. How can this be counted? There should be a way to identify the number of services or visits received across a whole year irrespective of which quarter it was.
7. At year end the numbers will show a zero balance for number of children and then new counting starts in the new year. How will children stay on the programme and how will we know if they received services in a particular quarter? If HIV services are already provided, should the service be suspended with regard to reporting until 2015? *Response:* This is being done in other countries, and pilots are being run in learning year 2014 around the new counting approach.
8. A Sampson: The counting makes allowance for new and continuing counts. In Q1 go to zero and list new children. The same is done for other quarters. Differentiate between continuing children and new incoming children. Who are the active beneficiaries in the programme? Add initial quarter new children, the subsequent quarters new children to provide a total for the year. Then the only remaining question is whether each child was contacted four times in that year. It is recognised that some children may only join the programme in Q3.
9. Regarding the reference sheets, where for example a CD4 count has been done, so in a particular quarter that person might not be seen in person, but a phone call to a health facility may have been done for them, this is a service to them and should be counted. *Response:* Text messages and telephone calls cannot be counted as a response.
10. On age disaggregation for 18+, does this relate to the OVC who has been in the programme who is now a youth, or is it the caregiver? *Response:* There is continued discussion on this and what is happening to the 19-24 age group. There should ideally be a further age disaggregation. A key question in transition to adulthood is what happens to a 19-24-year-old that heads an OVC household. There must be a way to track their transition to adulthood. There is also a need to protect under-18 reporting which is a Congress requirement. It is a concern that ways need to be found to track the 19-24 group separate to other adults. A referral can only be counted when successful and a child has received an actual service and hence a text message or phone call cannot be counted. There must be follow-up to ensure the child received the required service from elsewhere. Regarding the treatment of OVC over age 18, this requires further discussion and specific proposals.
11. If providing a service in a specific quarter, it still counts towards annual total reporting. The problem arises with the four required services in a year. But what if there is a lot of work being done in a specific quarter – this would then not be counted? *Response*: This is indeed a challenge to monitor from the M&E perspective. Reporting will be more complicated. The definitions are not fully clear and there is some grey area. These are important messages that will be taken back to OGAC. South Africa will need to report in a country-specific manner. There are systems in place that work well and will need to be incorporated in conjunction with the new systems. Some modifications may be needed. It is not the intention to use further resources to track what is already being tracked. The intention is to reach the most optimal reporting system.
12. Q2 reporting will soon commence and information is needed urgently. There is a concern that OVC and caregivers are not sufficiently disaggregated. It will create confusion to combine them. Referrals are an important part of OVC work being done and should be considered as a service. How can this be accounted for?

13. What are the definitions of active beneficiary and quarterly contact definitions? Contact is a service but a phone call is not considered a contact. Yet it is important to note that referrals also take up resources and time. So what does contact mean? *Response:* There is a distinction between what is required to be reported to PEPFAR and what the programmes can collect. Initially referrals and home visits were counted but no longer. This may not be a current PEPFAR definition but the programmes should continue to collect this information. Response A Sampson: The way referrals are counted in South Africa is useful and provides a focus on services provided rather than the act of a referral. It costs more and takes more time but it improves the programme quality. We know the referrals we count have happened. That is how it is being done in South Africa and it works well. However, regarding under and over-18s – caregivers and transitioners – these have not been previously counted and this is the first opportunity. These are only now being included as beneficiaries and this is a positive opportunity to increase numbers. For example, a 16-week session is conducted with OVC which is intensive but then they are not seen in the other quarters. However, a significant intervention has been made in their lives. The type of service also depends on the child. If they report abuse there would be additional support. How to report in all four quarters therefore remains a challenge.
14. In counting the OVC served, they must have received one of the subsets of services within the quarter in which it is being reported. What are the subsets that inform this direct reporting? We need to know the subset being reported on as this could help to differentiate service and contact definitions. Caregivers were not counted previously and a monitoring tool is needed to explain how to count them. What service must be provided in order to count the caregiver and would the support be considered direct or indirect. Specific details must be recorded of the support being provided to the 18+ caregivers. *Response A Sampson:* To count as per the definition there must have been contact with the caregiver four times a year – as in visiting the household and providing a specific caregiver intervention to the family four times a year. The responsibility lies with the partners when rewriting their reference sheets to include services and identify them. This must remain flexible since each programme has different approaches.
15. What if more services are provided in one particular quarter? For example, if a child is raped by a family member, much work will be done immediately and all within a month – but the child would not necessarily receive counselling through all the quarters. How would this be counted? *Response:* This could vary across countries – examples have been provided. A referral counts as a contact. There is a need to move away from just service provision. If someone on the list is seen as an active beneficiary, there must be some relationship and interaction between the child and the programming that happens at least once every three months.
16. The definition of "active" then informs the discussion. Could it be active in the year rather than active in the quarter? The danger is that people might go to extra lengths to make sure that a further contact is made which might not be needed and this will shift resources from other priorities. For example, would the 16-week course now be spread over a year which would negatively impact on the nature of the intervention which is presently working very well.
17. For example, when running a school programme with a social worker who is there for four years, a 16-week intervention is run. Is the requirement then to confirm every quarter a child participating in the school with access to the required services? Is the child still part of the school community and if not must the programme either locate them or count them as inactive? *Response:* That is the intention and the aim is to ensure continued support for the

children post-intervention. We are interested in outcomes, and even though the numbers may drop in terms of coverage, the quality of the intervention will improve and the children will be better enabled to go out into the world.

18. There is often a case where a field worker visits a home to find beneficiaries based on reports and yet they don't find evidence on the ground – Are those six children still in that house? There must be a shift towards more evidence-based interventions that are more cost-effective and produce better outcomes. The importance of counting the interventions remains but there must be a stronger focus on return on investment. There needs to be a balance between the counting of basic interventions and a shift towards doing higher impact interventions.
19. What is the likely impact on the project targets that were initially set? *Response A Sampson*: There is an annual opportunity when work plans are approved to review those targets. Some targets were set four years ago when the context was very different. This provides an opportunity to revisit the targets and how they can be differentiated into DSD and TA. There is an expectation that the targets will change. The community system strengthening indicators have relevance. Furthermore, the targets are no longer tied to legislation as the requirement to reach 5 million OVC does not apply. The focus is now more strongly on quality rather than quantity. The outcome on children's lives has become more important. There are presently very high numbers of people being reached, but the efficacy of those interventions must be assessed.
20. The definitions of the four types of contacts and the kind of services to be provided need to be reviewed and made more robust. It cannot just be the same services as before. There could be just one home visit but what happens on the visit is important. The quality of the intervention must be substantiated. *Response*: It is important to ensure that the child is on the list and the child is doing well. This is sufficient. Then move to outcomes and assess the extent to which the child's life has improved. Each programme will have a specific indicator that speaks to the work being done. There cannot be generic indicators as these depend on the content of the programme. A key question is the number of interventions that may be needed to attain a programme-specific outcome.
21. A request has been made that some programmes continue to report as they have been – not only counting every quarter but adding definitions to submit to OGAC. However, for the 2014 report the same reporting could continue while a shift is made towards reporting against the new definitions. There are many real concerns around how to actually implement this new counting approach. PEPFAR South Africa will make a submission as to how it can respond to the stated new requirements. *Response:* Counting children just for the sake of counting them is not the point. It is more than whether a child was given a pencil or a blanket. How has your particular intervention changed the life of a child for the better? This is the key question. Keep in mind that PEPFAR is also tied to legislation around direct service delivery. Bringing in the quarterly requirement should be seen as moving towards a better use of resources.
22. Anita Sampson: Partners should continue to do what they have been doing. South Africa has developed an excellent M&E system, and counts useful interventions. This has often been assessed externally. Some modification will be needed to meet the new requirements but the current approach works well and should be continued.

4. SOUTH AFRICA REPORTING: MONITORING, EVALUATION & REPORTING (MER); Department of Social Development (DSD), South African Strategic Information manual

Mr Ozius Dewa, USAID Strategic Information / M&E Specialist

The partnership between PEPFAR and the South African Government (SAG) forms the basis of all work done, with the aim of supporting the SAG priorities as espoused in various laws and policy documents. A key aspect of the work is to build a strong evidence base to inform decision-making and targeted resource allocation, and to strengthen systems for better service delivery to those in need. This will contribute to a better response to the developmental needs of the country. There is a need to tell the stories better in relation to the work being done to support OVCs and their families.

There is a high degree of alignment between the SAG-Social Development reporting requirements and the OGAC indicators. PEPFAR works in partnership with SAG-Social Development to improve all indicators and outcomes. For example, in South Africa the inclusion of TB OVCs is key and TB defaulters is an important statistic.

The new MER is more streamlined with only three main areas of reporting areas: Total OVCs and Adults served; OVCs and Adults served with access to ART services; Human Resources Training. A key activity is the roll-out of the Community Based Interventions Management System (CBIMS) through a comprehensive structure of Community Based Organisations (CBOs) in South Africa. PEPFAR assisted with the development of CBIMS and must support its implementation. There is a stronger focus on outcomes and quality rather than numbers and quantity.

It has been suggested by Tulane University that it may be possible to collect data on an annual or periodic basis as this will impact the sample size that is being used on a two-year basis – if surveys are set up, each partner can collect data periodically and then send to PIMS automatically and every two years do a survey to compare with the collected data.

Discussion is required around the details of the indicators – this includes the age disaggregation indicators to be finalised. The other OGAC indicator that will be required in 2015 is the number of active beneficiaries receiving support to access HIV services. This is a DSD indicator with no TA reporting. The SASI indicators can be combined to an extent. The indicators track different groups such as people potentially at risk as well as people who are already infected. A further indicator to report on is the number of DSD and TA sites being supported and this must be disaggregated.

Health care workers who graduated as a result of PEPFAR support are an important indicator. An issue here is that only Home Care Workers are defined, yet all the people who deal with partner projects are linked to SAG-Social Development to a large extent. This therefore requires some re-definition in relation to the social service workers and new graduates licensed and registered.

The way forward could require a realignment of the SASI manual; a rollout of the new SASI manual; defining the nature of special studies in terms of outcomes package indicators; training partners on CBIMS; defining systems strengthening and measurement; and strengthening evaluation.

Discussion and Comments

1. Where would HIV services such as PMTCT be included? In terms of community systems strengthening, are there different levels of strengthening? *Response*: PMTCT is not always used to report HIV services, and it would depend on what is being done in this area.

Regarding TA and community systems strengthening, there is a project in partnership with PACT on government capacity building support which is a flagship project to define systems strengthening indicators. The focus will be on developing indicators for that project but also indicators that will cater to the broader OVC work.

2. There are indicators for services such as ART HCT and SR services, but with regard to household economic strengthening and other prevention services already being done within OVC work, how can these be accounted for? *Response*: Indicators are not being discarded as there are many indicators that must be reported on irrespective. If partners feel that in their particular programme certain indicators are important, then data can be collected and used in a narrative to SAG-Social Development and PEPFAR. Some of the indicators have been moved to the outcome packages that are going to be collected on a two-year basis to assess change over time in the community.
3. A concern has been expressed regarding in-service training, where existing cadre workers in service are being capacitated to deliver better services but where this work should be reflected is unclear. *Response*: Such information can be included in the narrative report – questions to be addressed include the value of collecting data routinely and how such data will be used. If partners feel strongly about a particular indicator it can be retained and reported on in PIMS.
4. If 100 Care Workers have been trained including support and supervision on a quarterly basis, this may need to be reported under TA rather than direct service depending on the kind of follow-up being provided.
5. Regarding CBIMS – there are instances where PEPFAR and CBIMS indicators overlap – will the OVC database be replaced by CBIMS, and if so how will the overlap be addressed? *Response:* The overlap is not only applicable to the OVC database but the broader information systems of all partners. In terms of aligning information systems, this can be addressed in more detail in the proposed framework. The point is to support CBIMS as the central information system for OVC work.
6. A Sampson: The long term goal is that once partners have graduated from PEPFAR to SAG-Social Development funding, they will already be on CBIMS so this will contribute to improved integration. This is a five-year programme so it is important that partners begin to reflect on what they will be doing after five years.
7. Is capacity building and accredited training to teachers through the Department of Education considered as technical assistance or human resources for health? This includes psycho-social support to OVC in schools via teachers. *Response*: Pre-service training is where someone is not yet trained and the teachers start with this programme and then provide services to the children. Once the teacher is in training then the teacher can be considered as a social service professional in the making. Children being provided with services by teachers that partners have trained will count as TA. Examples of partners doing this type of work are REPSSI and HIVSA.
8. With regard to the indicators list of CBIMS – both the indicator and definition are needed. When reporting to CBIMS there are different indicator definitions depending on the work being done by the specific partner. *Response*: This has been highlighted as a current information systems challenge. There is no common data dictionary. The SAG-Social Development should be asked to consider doing this, as per the Department of Health. This relates to a revised national indicators dataset.

9. With regard to age groupings – there are many different age groups including per district – are the unknowns being counted as adult or child and what is the mechanism for differentiation? On age disaggregation, there are some discrepancies around age group and survey –age groups are not aligned to the existing SAG-Social Development age groups. It is preferable to standardize age disaggregation. *Response*: When OGAC changed the age disaggregation, it used age and when the child received a service to calculate when the service was offered and how old the child was. The OVC database requires some tweaking with the next version.
10. Advice is needed from partners as to whether the current and partly automated proposal should be further developed.

5. IDENTIFICATION OF CHALLENGES IN REPORTING ON NEW INDICATORS

Mr Ozius Dewa, USAID Strategic Information / M&E Specialist & Mr Derek Kunaka, John Snow International

The aim is to examine access to HIV services and how this can be broken down into three aspects: ART; SRH; and HCT. There is discussion needed with partners on how best to represent this indicator within PIMS. This also links to data quality issues. When these indicators are divided into three, it is possible that one child might receive all of them, so how will that data be treated? There are not always unique identifiers that can track each child across quarters. If the three indicators are retained and people are counting the children across services, one child could be interacted with three times. The parent indicator could be kept open to count the unique aspects of that specific indicator. This relates to explaining the detailed services offered with the broader services, and how this is represented in PIMS.

Discussion and Comments

1. It would be preferable to change the indicator to be a referral or provision of HCT. This had been agreed. Partners must report separately on certain indicators such as SRH and HCT, and then be required to report the unique count of individuals reached with those three services in the parent indicator for each quarter in the same disaggregation. At year-end they must say how many were unique. Can this be done within PIMS? It appears that this is possible but there are concerns about the data capturing burden that this represents. For that indicator, being split up into three services, partners must now capture data and split it three times into the three required aspects.
2. Should adults and children be combined into one indicator? There seems to be agreement that these two aspects should be combined. The definition will then be adults who live with HIV.
3. The PEPFAR age disaggregation should correlate with the SAG-Social Development age disaggregation. *Response*: The current age disaggregation is a requirement of Congress. However, it may be possible to request that children are captured only via their age and date of service received and not their gender.
4. If outcome indicators are required to be measured should partners continue to capture but not count in the first indicator the active beneficiaries in relation to areas like psychosocial support? *Response*: Those services will count toward the first indicator but are linked to the outcomes indicator.

5. On age disaggregation – when a child is first captured there does not have to be an allocation to a specific age group – the date of birth is needed and the system will produce reports. PEPFAR will run a background report on age breakdown. The same applies to SAG-Social Development based on their disaggregation. This does not happen in PIMS and CBIMS.
6. Regarding the training of HCW – there are 2 groups or subsets – new graduates licensed and registered and social service workers – what is the difference and which body are new graduates registered with? Should partners track how many of their HCW are council registered? *Response:* This links to training. Currently registration is not available. Partners should report on that indicator from 2015. DSD targets are required for both 2014 and 2015 ands should therefore be commenced immediately. Some partners are already collecting that data so the foundation is there to improve on during the year.
7. Should the reporting that has already been done for the previous six months be reworked to comply with the new indicators? *Response:* This depends on a number of issues, such as whether PIMS will be ready – this is the main concern. If PIMS is ready then DSD and TA in PIMS can be captured. If partners want to break down those numbers they might have to do it proportionately. This is likely to present a challenge for a number of partners.
8. Is it not possible to adjust the database to do the TA and the DSD before the PIMS? This could be done via the OVC database so that the numbers are produced and uploaded to PIMS. *Response:* The database can do many things and provide numbers in the new required format. It is a robust system. To generate the required reports going forward a further layer will need to be added.

It was agreed that a small pilot group should be set up to test the changes. It as agreed that the group will comprise SACBC; Africare; HIVSA; NACOSA; and NACCW.

6. ALIGNING & SYNCHRONIZING REPORTING REQUIREMENTS – USG / SAG / DSD

Mr Ozius Dewa, USAID Strategic Information / M&E Specialist

The intention is to strengthen information systems and streamline reporting. PEPFAR remains committed to support efforts to harmonise data management and reporting systems to foster country ownership and leadership. A central information depository is recommended. It is important for partners to be forward thinking as to what will be done when PEPFAR leaves South Africa in five years. It is essential to invest in viable information systems.

Mutual accountability, transparency and alignment with the existing systems is important. The MBIPS is being rolled out in conjunction with the SAG-Social Development. The challenges are not new. There are issues of inter-operability and synchronisation between existing information systems. However, any challenges can be overcome jointly.

One of the main gaps is a data dictionary since there are no standardized definitions of the indicators being collected. The focus is presently on inputting data but there is limited attention given to how best to use the data and greater strategic use and analysis is required. There is also a need to shift from quantitative to qualitative data. There is a lack of electronic interface.

CBIMS is envisaged as being the system that will become the most widely used. There should be a basic minimum of indicators to be collected. All partners can begin to work on defining indicators for inclusion in the dictionary. CBIMS is presently a work-based information system. There are some connectivity challenges, but such a system could be desk based and rolled out to those CBOs who have poor connectivity. This is a viable alternative that will complement the CBIMS roll-out.

Streamlining reporting requirements is required and CBOs should play a greater role in reporting to SAG-Social Development, although it is acknowledged that some capacity strengthening may be required. Data exchange between the parallel systems is needed and full systems alignment is necessary. The gaps perceived by the SAG-Social Development need to be properly identified and addressed.

7. CBIMS AND THE DSD

Mr Chris van Rooyen, Department of Social Development

From the departmental perspective, CBIMS is not seen as being owed by government. The owners are the implementing organisations. These are the most critical building block. With regard to training with partners, the SAG-Social Development is planning for five-year intervention via PACT-SA that will build in a training plan. Roll-out of CBIMS is already under way in five provinces and data has been migrated. It is important to know that partners are encouraged at district and implementation level where SAG-Social Development is keen to include all partners in capacity building. A training manual has been developed that will also be shared online. Thus far there has been roll-out in Northern Cape, Mpumalanga, North West, Limpopo, KwaZulu-Natal and Free State although not yet in all districts. The system is live and being expanded. Within CBIMS are other departmental systems, such as the national child headed household register which CBIMS is already linked to.

The system is cloud-based and is the only system that will be housed outside of government's SITA system. This provides better 24/7 connectivity. There is also an advantage in working with Global Fund partners who have had good training. The main aim is to centralize OVC information nationally. All partners will be included for provincial training and there is strong interest in developing a mentoring process between partners.

Discussion and Comments

1. If partners are keen to start engaging with CBIMS should they wait for a roll-out plan or contact SAG-Social Development to book training? *Response:* The focus is on funded organisations, including global funding partners. It is appropriate to build into the broader plan a stronger training and capacity building response. Partners need to allow time for the plan to be finalised although the URL and view data can be provided now. There is a need for a more structured approach before massifying the system. Implementation is expected in the next quarter. CBIMS provides a platform for all the various parallel systems especially in relation to children's services.
2. PACT-SA and the SAG-Social Development should be engaged to review standards and data dictionaries. The standards are important. The sector must inform government about the kinds of standards that will be appropriate and functional. Government itself is clear on the norms and standards that it wants to see but there needs to be discussion as to what is feasible.

3. There are shortcomings in evidence-based reporting and it is critical that accurate data is obtained. There is limited information coming in from CBOs via C Forms. The SAG-Social Department can assist by encouraging CBOs to use C Forms consistently. Furthermore, there is a need to understand how the structures on the ground work together before trying to map what they do. When reporting on the basis of a site, there is a need to align the site definition to the actual work being done.
4. The SAG-Social Development has developed C Forms for those organisations funded by the Department. However, over time collaboration with the Department of Health decreased because of reduced impact. It has been established that clear aggregate data can be produced but no detailed beneficiary data. There is a growing increase in proper evidence being provided to support the numbers. A recent external assessment has highlighted shortcomings in the system. C Forms have been rolled out over the past five years but not to all CBOs, and there are also provincial differences.
5. It has been acknowledged that a review of all the tools is required and that there must be alignment with the CBIMS as well as with other indicators. A process has commenced to update the tools and move them into the field fully aligned to CBIMS. Updated forms are available that are aligned with existing indicators. While there are challenges in the field it is hoped that these can be addressed through capacity building with USAID. Existing tools include a training manual and DVD that has gone to all provinces.

8. INTRODUCTION TO OVC OUTCOMES PACKAGE

Ms Janet Shriberg, (USAID/Washington) OVC team

The background to Level Two Indicators emanated from the IOM report and the increased need to demonstrate the impact of work being done by partners. The E in MER is essential for OVC work and the technical working group in Washington DC has developed a programme evaluation toolkit. This toolkit, *Evaluating Orphans and Vulnerable Children Outcomes*, is a new PEPFAR resource that offers global indicators and tools to assess child and household well-being. It was developed over some years.

PEPFAR has seen a shift towards outcomes and impact with participation from all the technical areas (Care, Prevention, Treatment). There have been specific changes made for the OVC programmes that include two compulsory Level 1 indicators and 2 education educators which are attendance and progress made. Recommended indicators include systems strengthening and social protection at Level 3.

In deciding on core indicators, the team began with what is known of OVC programming, identified gaps, did an analysis against eight criteria and then a shorter list of questions for discussion in terms of what indicators make sense on the ground. The key question to address was the difference being made on the ground as a result of partner programming being in place.

The toolkit assists partners to examine their outcomes and effectiveness. The toolkit had to be elevated to meet the MER requirements and an outcomes package including surveys was developed. The MER outcomes package includes biennial reporting (new to many countries); greater age disaggregation using all indicators; assessing how the programmes are addressing actual needs; using data collection providers external to service delivery so that the care providers are not overburdened with data collection; and building the capacity of local research institutions to

do the M&E work. Evaluation must be done by suitably trained people and it is important to draw on local research institutions.

The outcomes package is currently being refined and piloted. Supplemental guidance is being developed to form part of the toolkit. Guidance is needed on improving the way that sampling, design and ethics approval is done.

Amongst the indicators that could be included – although this could vary between countries – are how children are involved in daily activities (links to mental health issues which many countries have an interest in); birth certificate (relates to child protection and legal issues – children need to be in a legal system to ensure protection); school attendance (including concerns around school drop-outs); school progression (which links to gender discrimination); the extent to which the under-5s group interacts with over-15s (a UNICEF indicator that speaks to the growing ECD focus); and indicators related to household strengthening. Keep in mind that Level 1 indicators must be reported on to Congress.

There has been strong and widespread support of the shift to outcomes-based work, in part influenced by a desire to better recognize the good work being done. Work is done at every level to promote stronger reporting and to report in a way that will continue to assure the funding needed for this necessary work.

Discussion and Comments

1. Progressing to the next grade is an important indicator but some children stay behind so they can continue to receive the child care grant which stops at age 18. Foster care grants also end when the child leaves school. In school children get a daily meal and for this reason they might opt to stay in school as long as possible. The indicator should be revised to consider the actual work being done. This could also apply to OVC aged 17 about to exit school. However it does not seem likely that this kind of observation would apply to a ten year old.
2. Psychosocial support for OVC is very important but there is no indicator for this. *Response*: some of the questionnaires and indicators address some concerns and interests around psychosocial support. Using the MER it can be difficult to report nationally – therefore it is useful to have feedback on the toolkit in this regard and how psychosocial aspects are measured and defined.
3. REPSSI is keen to do work on psychosocial indicators that will examine the available measures and the possibility of doing expert consultation internationally. There is a need to refine the use of psychosocial indicators and measures.
4. Indicators around the social isolation of children and the linkages to poverty and vulnerability are important but it is not clear where they can best be included. In South Africa the grant system is important for child protection and has a positive impact. In the Zambian pilot study it is not entirely clear what is being measured around social isolation – a construct is being worked with and developed around what support is available relative to psychosocial measures.
5. To what extent will the Zambian pilot study have variances if compared to the South African situation? For example, why are 18-year-olds excluded from indicators especially since PEPFAR has a new focus on youth – finishing school would thus be a key indicator. *Response:* It is not clear if we are including older OVC sufficiently in the MER indicators,

although in the toolkit they are included and it is indeed a concern that is not being sufficiently addressed in the MER.

6. Keep in mind that the indicators are flexible up to a point, and if people believe psychosocial support is an important aspect then suggest indicators. What is important is that the indicators must resonate with a wide range of audiences, be easily understandable and make a difference. Demonstrate the diverse impacts the OVC progammes are making. For example, the household economic indicators are currently under review and there are also indicators there that are specific to South Africa. However, there is little on nutrition and Early Childhood Development and these could be added. There is space to propose additional indicators specific to a programme.
7. Further to the pilot study in Zambia, it must be noted that cognitive piloting is being done to ensure the rigor of the results. Language translation might have had an impact. At this point all the indicators in the toolkit are embedded at baseline and are open to review. It might be that addressing the language issues could be a good starting point. The child protection indicators should also be tested. South Africa has much experience in these areas and could make useful input. These indicators are not yet at Level 3 but the intention is to focus on systems strengthening and social protection. South Africa seems ready to advance to this level.
8. If people already have data on grants and birth certificates, this is useful to track for the country, so no sample would be needed as there is a lot of data already in place. *Response:* It is hoped that further recommendations can be made in the supplemental guidance. However, there is no reason to finance something that is already happening and put resources into it, so the main initial questions to any country what relate to what is already being financed and how the data is holding up to scrutiny. Is the data being collected for the right reasons? The final supplemental indicators are due in May but where systems are in place and working there is no need to create new ones.
9. PEPFAR has been collecting data for some time – for example, birth certificate and grants data has been collected for five years. This provides a good opportunity to test the data and identify gaps.

DAY TWO: FRIDAY 21 FEBRUARY 2014

9. BRIEF RECAP FROM DAY ONE

Sinu Kurian, United States Agency for International Development (USAID)

The focus of the meeting is to discuss how the work being done in the OVC sector is reported to OGAC and the introduction of required outcome level indicators every two years. The impact of these new requirements for partners is not very different from the current requirements. The intention is to focus on the implementation of comprehensive, quality programming for OVC, caregivers, households/family as a whole while building systems to sustain the work.

The two new Level 1 indicators draw on the work already being done. The current database should be updated to track services provided per child per quarter without duplication or double counting. Extensive guidance will be shared shortly. Databases will be upgraded as needed to track services per child per quarter and de-duplicate over the four quarters for APR—this is already being done by most of the partners.

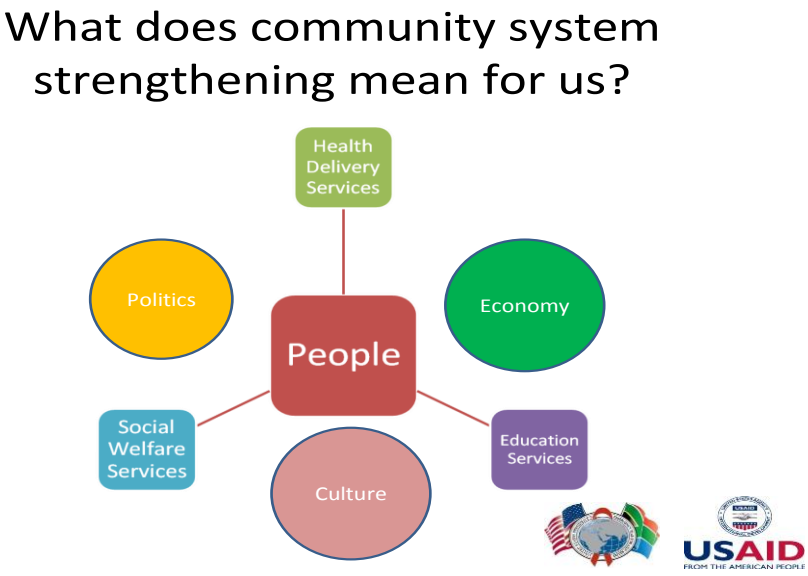
Parking Lot matters that had been raised include definitions that need to be better defined such as a definition of "active" OVC and what constitutes a contact. The general advice is simply to continue with the current work being carefully recorded to provide a solid evidence base. Structured follow-up is encouraged as well as identification of further needs. It was noted that home and school visits are considered contacts but not phone calls or emails. There is no minimum duration for a contact or service – there could be at least 10 sessions for HIV education on prevention, so there needs to be alignment with the SASI manual guidance.

There was a question regarding quarterly versus annual reporting. It was explained that if the child was active in first 2 quarters, but not later, then it cannot be reported and be removed from the count. The only advice then is to consider how to follow up with the child in quarters 3 and 4 such as a school or home visit. Where problems are encountered the partner should contact the activity manager immediately for advice. PIMS will provide templates as needed.

10. MEASURING SYSTEMS STRENGTHENING

Ms Sinu Kurian, United States Agency for International Development (USAID) & Ms Rita Sonke, PACT-SA

Role-players in systems strengthening include at national level: GCBS, NACCW, REPSSI; at provincial level, GCBS and REPSSI; at district level GCBS, Nacosa, HIVSA; and local community based level support by OVC partners; CINDI.



There is an organized public space within the circle that links how people interact and the services that they need. When thinking about beneficiaries, needs were identified such as high HIV and OVC burdens. People tend to start CBOs or services to meet a need. Systems and sustainability are required to take the response forward and these processes require standards. USAID has conducted a literature review on capacity building and systems strengthening.

Partners are often doing systems strengthening or capacity building at the community level without realising it. So the next step is to begin to document the work and demonstrate what is being done. Many organisations have made significant investments in strengthening communities and this work needs to be documented and shared so that it can be taken forward locally when PEPFAR transitions out.

The most common areas of systems strengthening are:

1. Enabling environments and advocacy
2. Community networks, linkages, partnerships, and co-ordination
3. Resources and capacity building
4. Community activities and service delivery
5. Leadership and organisational strengthening
6. Monitoring and evaluation (M&E) and planning

Cross cutting issues include Gender; Leadership; and Reporting and Learning.

The primary customer is the child and family that we want to achieve results for. There is a strong need for inter-sectoral collaboration and co-ordination is essential to achieve good results. Working on the ground with CBOs is where to influence real change. The process of care includes how partners identify, report, refer and provide a comprehensive package of services to children is linked to indicators. Follow-up and active interventions are thus important. There is a strong focus on improving accountability.

The Department of Social Development provides R7 billion annually to NGOs in South Africa to undertake service delivery and it is important to examine what value-add this has brought about by examining the tools, strategies, plans, policies and legislation.

There are many challenges to measuring systems strengthening, where the social development sector does not have sufficient indicators in place. The building blocks of the various systems are not standardized, unlike the health sector which draws on the World Health Organisation building blocks. There are thus many options for indicators with few being properly tested, and few standard tools and systems for gathering data.

There are also challenges around issues of attribution and contribution and the difficulty of testing the effect of non-services. There is a need to use innovative approaches that include ongoing evaluation and constant improvement, as well as improving the indicators that are being tracked over time.

11. GROUP WORK

Good indicators need to be measurable and applicable in more than one context – all must benefit the child at the core even where there may be a range of programme indicators that measure different contexts and different levels.

There must be the capacity to measure what the programme aims to achieve and the measurement must be reliable.

Indicators should respond to multiple levels and not just one and be applicable to different contexts and settings.

Indicators must clearly define what to measure and how the measurement will be done.
Indicators must also contain what the partner is willing to commit to.

Six groups were formed to discuss the six interest areas below, and participants were asked to keep in mind the following points:

- At what level is work in your particular organisation currently being done – ward, district, provincial, national?
- How are you currently documenting and reporting on this work?
- What kind of information is most important to your specific organisation?
- Are there indicators in place that are already being used and what are these?
- What capacity building indicators for OVC programming work for your current work?
- Develop draft indicators that you feel could work and share these.
- Draft TA indicators for the South African PEPFAR programmes that you feel could work.
- How is capacity building around TA being reported on and what can be improved?
- Develop 2-3 indicators for your own area of work.
- Discuss the key components of a good indicator.

GROUP WORK REPORTBACK

3.1 Service Delivery

What should be measured is the organisational development of sub-grantees including mentoring, financial management, upskilling of teachers and professionals and youth care workers. There should be compliance with norms and standards (technical assistance) and IT support provided to implementers.

Work is being done at provincial level in Mpumalanga and Limpopo and this work feeds down to district and local levels.

Reporting needs to be done in accordance with donor requirements. Tools needed in order to develop quality services includes data collection tools, capacity to feed into stronger documentation, producing narratives and good stories, and improved communication, both internal and external.

Key indicators around the impact of such training being undertaken relate to the youth and children who are reached through capacity building interventions, and identifying and measuring those children who demonstrate increased resilience.

To properly assess the impact of training a good baseline study is essential and must be done before any programme work is undertaken. Sustainability needs to be measured in terms of programme work that continues once the partner is no longer working there.

Possible indicators include the number of individuals trained; the number of organisations capacitated; the number of young people and children reached through interventions; the number of organisations rendering quality services within a prescribed rating; the number of children with increased resilience in accordance with agreed standards.

3.2 Social Services Workforce

This is a limited context outcome, as broader input is needed. High level indicators are produced but information is needed on what influences the selection of indicators.

It is important that training is fully accredited. Information is needed on the number of trainee social workers being mentored or supervised. Experienced mentoring and supervision is key to strengthening the social services workforce.

One indicator would be the number of qualified workers by the relevant SETA as well as the number of actual licensed and registered professionals. Another important gap to be addressed in South Africa is the number of people in the sector who are adequately trained in children's legislation and policies.

The number of trained people being deployed needs to be established, including via government. There are sometimes bureaucratic blockages that impede needed deployments such as employment contracts not being completed. These are administrative matters that should be simple to remedy.

Areas of concern that need to be addressed from the aspect of improved human resources include:

- Stipend and salary inconsistencies across provinces that cause problems when trying to develop a workforce. The impact is that people are not deployed to where the children are most in need of the service.
- Within organisations there are retention and succession planning issues.
- Staff need to be well trained in all legislation to be able to do proper referrals.
- The training that is being provided needs to be assessed in terms of how well it responds to the needs of the children, and be linked to norms and standards.

3.3 Budgeting and Finance

Budgeting and finance underpins all the work that is being done by partners and is a cross-cutting area. Without money it is not possible for partners to manifest their passion for their work. There has been a lot of capacity building in the area of financial management but more is needed, in particular in relation to improving good governance and accountability.

Financial staff need to be informed about the different pots of funding that are available, especially from government programmes. Areas of training should include sustainable financing, pre-award financial assessment, financial review, risk assessment including IT aspects, and good governance and statutory compliance.

Indicators include:

- The number of CBOS that have secured two years of core funding after PEPFAR interventions so as to take the work forward on the basis of a sustainability plan.
- The number of CBOs that submit timely and accurate reports.
- The number of CBOs that have complete and sound financial management systems in place and an annual work plan.
- The number of CBOs who receive technical support for financial systems strengthening.

3.4 M&E / Research / Information

The main area of work is to provide training and then mentoring support. The aim is to strengthen referral systems and linkages on the continuum of care for OVC. Organisational development capacity building will contribute to such improvement. All training needs to be done across all three levels of government.

Good in-house documentation such as reports and case studies is essential – there appears to be a high level of accountability but little standardisation across organisations. There are furthermore very limited standardized donor reporting frameworks or platforms in place and these are recommended. The standardisation of a range of databases will also make a strong positive contribution.

What needs to be measured is the impact of programmes at different levels; the level of transitioning out of young people into adulthood; and the uptake of work by government structures.

Indicators include:

- Number of programmes with accredited training
- Number of CBOs reporting to CBIMS
- Percentage of organisations identified by Isibindi as successfully exiting the programme.

3.5 Leadership, Governance and Management

Leadership underpins all else that happens in any organisation. The starting point is to conduct good assessments at organizational level even though strengthening work is done with individuals. Any leadership and management training must be accredited, and supported with mentorship coaching and other processes. It is important that work is done at the appropriate level of government.

Indicators include:

- The number of CBOs assessed in relation to good governance and accountability
- The number of individuals who received accredited training in leadership and good governance – are there board meetings being convened and are there minutes available, for example.
- The number of individuals who have had leadership coaching and mentoring.
- The number of organisations with functional boards and audit committees.

3.6 Policy and Legislation

Promoting shifts in policy and legislation to support the work that must be done is a critical area of work. TA is needed but is limited. Support should be provided through policy and legislation that supports the integration of OVC programmes and issues into key guiding documents such as the Integrated Development Plan at local and district level. Engaging at provincial level is essential and this requires a clear understanding of the provincial priorities and an acceptance that these are subject to change.

Points of insertion into policy formulation processes need to be identified so that organisations can exert some influence. Child protection issues need to be integrated into structures at all levels.

12. OVC LEVEL TWO INDICATORS & OUTCOMES PACKAGE

Ms Janet Shriberg, (USAID/Washington) OVC team & Ms Anita Sampson,

The PEPFAR OVC Survey Toolkit can be found at
http://www.cpc.unc.edu/measure/our-work/ovc/ovc-program-evaluation-tool-kit
The Toolkit provides information about Level Two Indicators and the OVC Outcomes Package as well as guidelines for application in South Africa. Much work has been done to emphasise the importance of evaluation within the OVC portfolio. Key areas of interest going forward relate to interventions that work to improve household well-being as well as child well-being.

Standardized questionnaires have been developed that are intended for use in local and international research institutions and partners who have a strong evaluation agenda. The intention is to standardize population level child and caregiver well-being beyond what is available from routine surveys and then draw on this information to produce actionable data for impactful work. This will also require comparative assessments to be done. The indicators must be amenable to change so as to meet the needs of specific partners and the contexts in which they work.

Developing the Toolkit has been a highly participatory process with many people involved. An intensive process was undertaken. A core set of 12 child and 3 household measures was finalized based on input from 49 stakeholder groups. Pilots are presently under way in Zambia and Nigeria with a baseline study being done in Zambia.

The structure and content includes a Caregiver questionnaire with household questions; a Child questionnaire for ages 0-9 years requiring adult consent; and a Child questionnaire for ages 10-17 administered with parental consent and child assent. The relevant forms are provided as informed consent templates. The questionnaires are child-friendly and include an optional module around violence related to child protection.

When using these tools it is advised that there may be some limited use since there is no single tool that can cover all areas. Advice may be needed on sampling. The tool is not appropriate to target case management, nor individual households as it is a sampling tool. There are no performance indicators so the tool cannot monitor programmes. It is, however, highly appropriate for evaluation.

The toolkit is presently only in electronic version with a manual to provide guidance. It includes templates around protocols and consent and assent forms. Methodological guidance is provided. The tool is currently being tested and validated in Cameroon.

The toolkit has helped with the MER and much work has been done around best questions and sampling, so when doing evaluation work in programmes this provides a useful starting point.

Discussion and Comments

1. CINDI: Survey templates were short enough so that own information can be included to meet specific needs. Draw on existing tools and adapt these. The basic indicators are provided around the key outcomes – especially in relation to required reporting – but for each programme additional indicators may be proposed for consideration. There is so much information available to us at no cost. This is also an opportunity to explain what partners are doing. The baseline study assesses where the work is at present and then a further baseline study in five years time will assess whether there has been any difference or not.

Tulane University has a guardian survey which asks about every child in the household, and a template for adolescents aged 12-17 in the schools, and even though some indicators might not be useful it provides a useful opportunity to obtain baseline detail.

2. REPSSI: It is important to assess how partners are operationalizing or using the PSS conceptual framework in South Africa and to identify gaps in service provision. There is also training being provided in KwaZulu-Natal that looks at knowledge and skills that caregivers have already. There is a need to assess how the training has improved the situation and the link to service provision. Data has been collected and is being analysed. An important experience was that tools were being developed there was a process with DSD input on the tools and methodology, providing information not only for REPSSI but also for SAG-Social Development work.
3. Tulane University: The intention is to build capacity around psychosocial skills in the community so it might not make sense to collect beneficiary data, for example. The utilization of existing psychosocial services is being mapped to serve as a baseline. It is the hope that there will increased use in the communities. It also links to the national plan. However, PEPFAR data might require an isolated impact assessment. NACOSA and HIVSA now have baseline studies unique to their programme. REPSSI in relation to a two-year cycle could look at that level and the fact that people are already trained, and do a mid-term review.
4. NACOSA: A data collection baseline has been completed that also provides information about the capacity of the actual organization. A specific capacity assessment tool is used that will incorporate outcomes of PACT meetings. Situational analysis is another area of work – understanding the context of different sub-districts where work is being done and align this to baseline processes just completed. With new indicators – youth and entrepreneur strengthening – economic strengthening of the household as well as with youth can be undertaken. A baseline study and follow-up will be done.
5. HIVSA: A baseline evaluation was done through PACT support and the Prime Institute using the same questionnaires. This examined organisational capacity building and a baseline evaluation is being done for HIVSA and NACOSA.
6. Anita Sampson: On economic strengthening interventions, there is some funding available with a target of young people 15-18 to look at matched savings, a financial literacy component, an HIV prevention component, and a sexual communications component to NACCW-HIVSA-NACOSA-Future Families: Additional funding has been obtained to do an economic strengthening package that includes baseline evaluation, annual monitoring and impact evaluation at the end of three years. There will be an evaluation of 18-year-olds exiting school now and three years later and also measure them at 21. This is an exciting intervention.
7. Tonya Thurman: HIVSA and NACOSA are both doing capacity building, with a focus on baseline CBO capacity that will inform other efforts to identify useful CSS indicators. These baseline activities will inform such work going forward. There is also a beneficiary level survey being done across a sample of the CBOs that HIVSA and NACOSA work with. It is expected that the operations of CBOS will improve and that improved outcomes on children's lives will be seen in the survey sites. Work has also been done by external evaluators and there is a wide application for this information.
8. PATH: Together with colleagues at HAD and AIDS Alliance it is planned to do evaluation work on capacity building initiatives that were undertaken over the past five years. We are keen to link up with those who are also conducting evaluation of capacity building initiatives

or different levels of training especially at beneficiary level. A literature review has been completed in preparation for evaluation work but the design and methodology is not yet finalised so possibilities for collaboration are very welcome.

9. Anita Sampson: PATH has done three modules of training of community caregivers and needs to demonstrate how the training has improved their interactions with beneficiaries. This is not easy to do and evidence is needed that training is improving what caregivers do. Another task is to assess whether accreditation has made a difference in terms of providing a career path. The sample is 2 500 community caregivers who have been trained, and the aim is to locate them and find out how they have used that training.
10. Childline Free State and Child Welfare Bloemfontein: A ten-session grief support programme is run that is now in the phase of indicator identification. OVC psychosocial challenges remain a concern. Expected qualitative changes will be explored and then initial testing. If the programme shows promise an impact evaluation will be done. The current templates that are used do not contain sufficient psychosocial information and are not applicable across South Africa. There will be a stronger focus through this programme on psychosocial help where a literature review is also being done and will also present working examples. Similar work is being done in Mpumalanga.
11. Isibindi: Formative evaluation of mentorship and training through the Isibindi model is planned, to assess community systems strengthening and impact on service delivery. The first stages are being done with Tulane University. An external research organisation will be contracted. This provides the opportunity to produce community systems strengthening indicators, what quality services are, and the importance of supervision and mentoring. An impact evaluation was recently completed and is a nationwide application. Isibindi is a national programme run in conjunction with Government so must also incorporate government evaluation requirements.
12. Future Families and Childline: In partnership with Tulane University on a baseline study, a schools evaluation has been completed and the findings show that boys feel isolated in the programmes. Given the strong focus on women and girls this is a concern that must be addressed. The Fathers & Sons programme will be revived as a starting point to include more males in the programming. It is essential to do an evaluation in order to have a defined starting point that provides a comparison. Programmes should make sure that evaluation is built in every time new work is started. For example, Future Families is starting two new sites, so that opportunity can be used to develop a true baseline. Always seek out opportunities when scaling up to develop baselines for M&E purposes.
13. SACBC: A baseline evaluation process has commenced and early data collection is under way. A comprehensive approach will be developed in conjunction with Tulane University and the opportunity to learn from others is welcomed.
14. Janet Shriberg: The evaluation was done with the aim of establishing if organisations that have received grants are still operating and doing the work. The second level aim is to check on the impact of what has been done and the results of ten years of investment and commitment. An important area is to promote income generating activities and document the successes. A strategic meeting is being planned to strategise this work. It is useful to draw on baseline reports that other organisations have already generated and use the information that is out there.

13. DATA QUALITY & USE

Ms Tonya Thurman, Tulane University

It is important to ask how good the data is in relation to beneficiary service delivery and outcomes. How can it be improved and will it stand up to an external quality check? How valid are the beneficiary lists? Recent investigations show that there are often discrepancies and concerning deficits in information and quality. Information is outdated, incorrect or inadequate. Many programmes do not update regularly. For example, a programme in a particular province showed an original number of beneficiaries of 1519 and when an evaluation was done this was adjusted to 1098 beneficiaries currently being served - a reduction of one third due to a range of reasons. This speaks to the importance of capturing accurate birth dates and ages.

In Kenya and Tanzania 20% of listed beneficiaries could not be found; 29% of households in the programme could not be located; 9% of the newly enrolled children could not be found. It is important to ask beneficiaries what they have received and then match to what organisations say they have provided.

Regarding the prevalence of home visits, it was established that half of the beneficiaries do not get the stated home visit in Kenya and Tanzania. In South Africa, where paid care workers are used 75% of people had a visit but where programmes used volunteers only 34% had a home visit. There is a key difference between volunteer-driven and para-professional approaches. This is why OGAC now insists on the active beneficiary approach. Beneficiaries have been listed but have not received the required support. Serious gaps have been identified during the validation processes.

It is also important to assess who has graduated out of the programme since it is not viable to simply keep adding people to lists but not moving anyone on. The extent of the services being received needs to be assessed and data must be continuously updated and quality checked.

Discussion and Comments

1. NACOSA: The OVC database is being standardized including data collection tools. Programme officers make monthly visits to check on data and emphasise the importance of household checks. Do the children actually exist in a particular household? Data verification is done with M&E officers working in 6 provinces who trace children from the database down to the actual organization. Checking is done on the Household Intake form. A monitoring tool has been developed but the programme officer does not verify at organisational level with the household level. As data flows up there data are also checks done. Data cleaning is done before it reaches PIMS. We want quality on the ground
2. The USAID database is being used based on identity numbers which avoids duplication. Regular site visits are made to offices with care workers to confirm their information rolling up. Where beneficiaries die a Lost To Follow Up form is completed and there may also be a family no longer interested in the service or that has moved away. Care workers are encouraged to tell their stories.
3. Care workers are supported to provide better data – this helps to improve the quality of the visit. There are records of feedback from care workers and annual visits by social auxiliary workers will pick up if the care worker is not visiting a household. Report and review the information through talking with the care workers. Data might be collected but no one talks about it. Data needs to be used and is also useful to keep care workers motivated.

4. The database is increasing and it is important to graduate people out. This is an important area to consider as part of verification. Do a manual printout per care worker and do a manual check.
5. PIMS requires a data quality check to be conducted every three years. This was done for some organisations under the previous quality programmme and by 2015 all partners will be eligible for a data quality review by an objective outsider. All data entered into PIMS will undergo review. This provides adequate preparation time.
6. No data is perfect so reviews are welcome. From the academic perspective all datasets have errors, so what is the acceptable margin of error? On data to PIMS, there are quarterly entries, but this does not take into account all the cleaning of data that is required through the year. There is a need to mitigate the missing or lost data or issues that are reported on. The data can never completely match.
7. The acceptable margin of error is 5-10% but not higher. Of greater concern is the higher levels of error where one third of supposed beneficiaries cannot be located. A key question is what outcome data do partners have? Even where there is good information, how is it being used, or is it just being reported to PIMS? A lot of the programmes are already capturing information on the core indicators that have been specified. Which OVC are progressing through school / Have a birth certificate / Been tested / Attend school regularly.
8. M&E data is not always well received because people question the credibility of the data – it is therefore important to ensure the accuracy thereof. We must convince people our data is valid since often it is not.
9. When the reference sheets for Level 2 outcomes are supplied, there will be indicators elevated from the toolkit, where these have already been piloted and developed, so relevant questions will be available. There is a standard level of information across the partners, where each has a registration and enrolment form, but need to standardize the way certain things are asked. Many questions are very vague, such as questions on a grant. Is it the right grant? What is needed is child information rather than household information.

14. USING QUALITY DATA FOR DECISION MAKING – HOW GOOD IS YOUR OVC DATA?

Tonya Thurman, Tulane International University

It is important to ask if all data is relevant, useful, current and validated. Much of the information is already being captured by programmes, such as the percentage of children who progressed in school during the last year; the percentage of children whose primary caregiver knows the child's HIV status; the percentage of children regularly attending school; and the percentage of children who have a birth certificate.

The quality of services being provided is often highly inadequate. In KwaZulu-Natal there are examples where care workers have visited every month for two years yet the children still do not have a child care grant being paid over. In Rwanda, however, illiterate care workers devised a method of providing a quarterly graph on outcomes that had improved the situation with one graph per family. It is important to give care workers feedback on information submitted.

ME officers hold the data and can inform the programmers as to what they do on the ground and highlight gaps or concerns, so it is important that they are proactive and creative. Data must be used to enhance service delivery. The evidence is also needed for programme impact. The data should

demonstrate why a particular programme is worth investing in and can make a difference so quality data is key to fundraising.

It is important to establish whether data would pass an external quality check, that it is regularly verified, and that the methods used for verification are of an acceptable standard.

Some important questions that must be addressed include:

- What will your organization do to enhance your data quality and use?
- Are services being tailored to family and/or child needs?
- Are you reporting back to programme implementers and other local stakeholders?
- Are you using the data for programme improvement?
- Are you going to have evidence of programme impact?

15. DATA QUALITY CONSIDERATIONS

Mr Ozius Dewa, USAID Strategic Information / M&E Specialist

Possible data quality issues are being experienced at partner level around how data is generated. The OVC Matrix provides the starting point. The basic principle three years ago was that children listed must not be carried over to the next year. The intention was to focus on counting children who received services using "New money-new year-new child" which is effectively zero-based counting. Therefore the number of OVC served should be pre-populated with zero all through. This has not always been the case, and this raises concerns about the accuracy of the numbers. Therefore in Q1 only the NEW column can be populated. The reason for this kind of calculation is to ensure quality and accuracy about the service being provided.

Some partners have expressed their concern about adding the TA and DSD columns as previously agreed, and this will remain and not be further disaggregated. If the information was being included in PIMS the two columns would not be combined and partners would separate the DSD from the CSS indicators on the database. These do not yet exist but will be added when developed.

The main question to be posed relates to whether there should be continuing and new totals for both TA and DSD. Reporting on DSD and the non-TA relates to the requirement to have follow-up contact four times a year, once per quarter. It was agreed to revise this based on separating TA from DSD and capture it separately depending on what kind of work the partner is doing.

One of the challenges is the many different programmes being used and the need to maintain a certain level of quality. How can the indicators then be defined to ensure consistency in the definition and understanding of the indicators. When indicators are defined, the onus is on the partners to ensure that activities and evaluation approach are synergized. However, some programmes are very diverse in their implementation which contributes to concerns about reliability.

The systemic issues include the need to avoid duplicate reporting with CBIMS and another database used by a CBO partner as this would constitute double counting. This has been addressed with the Department of Health where PEPFAR partners are working, divided into district, and relative to the kind of work being done by either PEPFAR or CDC.

Data Quality Assessments are planned for 2015 via external contractors with the aim of strengthening the systems related to data collection and quality assurance.

16. WAY FORWARD & SUMMARY OF KEY POINTS

Ms Naletsana Masango, USAID Pretoria

The main action items that have emerged from the meeting include:

- The active beneficiary approach on a quarterly basis is a key requirement.
- Data integrity needs to be improved and include reporting on services provided to caregivers and not only children.
- Documenting the systems strengthening work that is done at different levels.
- Measuring the work being done in alignment with systems strengthening.
- Drawing on the comprehensive toolkit that is now available for data collection and stronger evaluation.
- Adding to the specific questions that have been posed to OGAC M&E teams about improving data quality within each organization.
- Finding ways to graduate beneficiaries. This is an important gap.

17. CLOSURE

Ms Anita Sampson, USAID Pretoria

It is important to keep in mind that where programmes face challenges these should be raised so as to be addressed together. The USAID team are the advocates of the work being done by partners. Proposals regarding changes or improvements are welcome. It is to be commended that partners are shifting towards a transition from PEPFAR funding to other resources in a measured and orderly way. The professionalism, commitment and participation is greatly appreciated.